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Sandra C. Paivio ^a; Josée L. Jarry ^a; Helen Chagigiorgis ^a; Imogen Hall ^a; Margaret Ralston ^a

^a Department of Psychology, University of Windsor, Windsor, Ontario, Canada

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Efficacy of two versions of emotion-focused therapy for resolving child abuse trauma

SANDRA C. PAIVIO, JOSÉE L. JARRY, HELEN CHAGIGIORGIS, IMOGEN HALL, & MARGARET RALSTON

Department of Psychology, University of Windsor, Windsor, Ontario, Canada

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Abstract

This study evaluated and compared emotion-focused therapy for trauma (EFTT) with imaginal confrontation (IC) of perpetrators ($n = 20$) and EFTT with empathic exploration (EE) of trauma material ($n = 25$). Clients were women and men with histories of different types of childhood maltreatment (emotional, physical, and sexual abuse; emotional neglect). Clients were randomly assigned to treatment condition. Outcome measures assessed symptom distress, self and interpersonal problems, and abuse resolution. Results indicated statistically and clinically significant improvements on eight measures at posttest, maintenance of gains at follow-up, and no statistically significant differences between conditions. There were higher rates of clinically significant change in IC and a lower attrition rate for EE (7% vs. 20%). More severe personality pathology negatively influenced some dimensions of outcome, particularly in EE.

Keywords: complex PTSD; childhood maltreatment; emotion-focused therapy; reexperiencing procedures

The primary objective of the present study was to evaluate two versions of emotion-focused therapy (EFT) for trauma (EFTT; Paivio & Pascual-Leone, 2010), each using a different reexperiencing procedure. In one version, clients use imaginal confrontation (IC) with the perpetrators of childhood abuse and neglect in an empty chair. In the other version—empathic exploration (EE)—clients explore issues with perpetrators exclusively in interaction with the therapist. Because treatments were identical in terms of trauma focus, the model of resolution, process steps, and intervention principles, we expected both to be effective in bringing about and maintaining client change. However, on the basis of previous research (e.g., Foa, Rothbaum, Riggs, & Murdock, 1991; Greenberg & Watson, 1998; Paivio, Hall, Holowaty, Jellis, & Tran, 2001), we expected EFTT with the more directive, evocative IC procedure to have advantages over EFTT with EE, particularly at follow-up.

EFTT is a short-term individual modality that targets the constellation of disturbances typically characterized as complex PTSD stemming from childhood abuse. Complex trauma, such as child abuse, involves repeated or prolonged exposure to traumatic events at developmentally vulnerable times

in a victim's life. Complex PTSD is difficult to diagnose: Symptoms go beyond those of posttraumatic stress disorder (PTSD) to include a combination of other *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition [DSM-IV; American Psychiatric Association, 1994] Axis I (e.g., anxiety, depression) and Axis II (personality) disorders as well as problems with affect regulation (both underregulation and overcontrol) and self and interpersonal difficulties (Courtois & Ford, 2009).

To date, EFTT is the only systematically investigated individual therapy for both men and women who are dealing with different types of childhood abuse (emotional, physical, and sexual; Paivio & Greenberg, 1995; Paivio et al., 2001; Paivio, Holowaty, & Hall, 2004; Paivio & Nieuwenhuis, 2001; Paivio & Patterson, 1999). Other studies have included only female sexual abuse survivors (e.g., Chard, 2005; Resick, Nishith, & Griffin, 2003; Talbot & Gamble, 2008) or female sexual and physical abuse survivors (Cloitre, Koenen, Cohen, & Han, 2002). Moreover, a diagnosis of PTSD was an inclusion criterion in all but one of these studies (Talbot & Gamble). However, the negative effects of childhood abuse, described previously, are not exclusive to this subgroup, and there is widespread

Correspondence concerning this article should be addressed to Sandra C. Paivio, Department of Psychology, University of Windsor, 401 Sunset Avenue, Windsor, Ontario N9B 3P4, Canada. E-mail: paivio@uwindsor.ca

recognition that a diagnosis of PTSD is not a defining feature of complex PTSDs (e.g., Briere & Scott, 2006; Courtois & Ford, 2009; Van der Kolk, 2003). As well, few differential effects of different types of childhood abuse have been identified (Scoboria, Ford, Lin, & Frisman, 2006), likely because multiple types frequently occur in the same family. At the beginning of EFTT, therefore, clients identify the maltreatment experiences and abusive/neglectful others they want to focus on in therapy, and protocol is sufficiently flexible to address individual client processes and treatment needs.

EFTT is grounded in current EFT theory and research (Greenberg & Paivio, 1997; Paivio & Greenberg, 1995) and the literatures on attachment and trauma (e.g., Solomon & Siegel, 2003). The treatment model posits the therapeutic relationship and emotional processing of trauma memories as the primary mechanisms of change. An empathic and collaborative relationship is thought to provide a safe context for exploring trauma material and a corrective interpersonal experience for individuals whose problems stem from profound lack of empathy and interpersonal control (Herman, 1992). Emotional processing in EFTT is consistent with theory underlying other exposure-based therapies (Foa et al., 1991). Interventions access maladaptive feelings (e.g., fear, shame) associated with traumatic experiences so that clients learn to tolerate these experiences and construct new meaning for traumatic events. However, EFTT, like the general model of EFT (Greenberg & Paivio, 1997), also deliberately accesses previously inhibited adaptive emotion (e.g., anger, sadness) in order to access the adaptive information thought to be associated with these emotions (Damasio, 1999; LeDoux, 1996). This is the primary source of new information that modifies meaning.

Another characteristic feature of EFTT is its emphasis on the resolution of past issues with attachment figures. Other recent therapies for complex trauma focus primarily on distress from current symptoms, negative self-concept, and interpersonal difficulties (e.g., Chard, 2005; Cloitre et al., 2002; Talbot & Gamble, 2008). In our view, clients not only are distressed by these current complaints but continue to be troubled by powerful unexpressed feelings, unmet needs and expectations, and disturbing memories concerning particular abusive and neglectful others. They are unable to heal from attachment injuries and to develop a healthier sense of self and a greater capacity for interpersonal relatedness until feelings are expressed and processed and past experiences resolved (Greenberg & Paivio, 1997). This is the primary task of therapy.

Importantly, EFTT is the only trauma therapy that is based on an empirically verified model of the process of resolving these past interpersonal experiences using a specific gestalt-derived intervention (Greenberg & Foerster, 1996; Greenberg & Malcolm, 2002). During this procedure, clients imaginably confront abusive/neglectful others in an empty chair and express previously constricted thoughts, feelings, and needs directly to these others. Steps in the process that discriminated clients who resolved grievances from those who did not included expression of adaptive emotion (anger and sadness), entitlement to unmet needs, increased self-confidence and self-esteem, and increased understanding and/or appropriately holding the other (rather than self) accountable for harm.

Research supports both the efficacy (Paivio & Nieuwenhuis, 2001) and the posited mechanisms of change in EFTT (Paivio et al., 2001). Both alliance quality and emotional engagement with trauma material during IC independently contributed to client change; and 93% of clients who were highly engaged in IC reported clinically meaningful improvements compared with 70% of those who engaged only minimally. However, results of the Paivio et al. study also indicated that about 33% of clients did not substantially participate in IC over the course of therapy. This finding is consistent with low compliance rates reported for other exposure-based procedures (Scott & Stradling, 1997). Although the default protocol in EFTT involved exploring trauma issues in interaction with the therapist, it is possible that clients who did not participate in IC also did not focus on trauma material. Thus, the advantage of IC partly could have been due to a more sustained focus on abuse issues or perceptions that the default protocol was somehow less potent. It is likely that the effects of exploring trauma material exclusively in interaction with the therapist would improve in a more controlled treatment context. The purpose of the present study was to test this hypothesis.

To do this, we developed an alternate version of EFTT in which EE alone was the primary reexperiencing procedure, thus controlling for trauma focus and expectancies. The primary therapist operation during EE is empathic responding to client feelings and needs in order to promote exploration of feelings and meanings concerning self, others, and traumatic events and to construct new meaning. The EE procedure parallels IC but without the enactment component and was thought to be less evocative and less stressful. Indeed, process analyses of the two procedures (Ralston, 2006) indicated lower levels of emotional arousal during EE compared with IC.

For the present study, a dismantling strategy was used to compare EFTT with IC (which included EE

as the default protocol for clients in this condition who declined IC) and EFTT with EE alone. Although studies comparing similar and combination trauma therapies have yielded few differential treatment effects (Foa et al., 2005; Rothbaum, Meadows, Resick, & Foy, 2000), there is some evidence that treatments using directive, evocative, and imaginal exposure techniques are superior on some dimensions at follow-up (Foa et al., 1991; Greenberg & Watson, 1998; Paivio et al., 2001) compared with similar approaches that do not incorporate these techniques. These evocative procedures may have a more enduring impact on memory structures. The present study, therefore, compared the extent and maintenance of change in EFTT-IC with that in EFTT-EE, which was thought to be less evocative. Support for hypotheses stated earlier would replicate previous quasi-experimental research on EFTT-IC (Paivio & Nieuwenhuis, 2001), identify EFTT-EE as a potentially less stressful treatment alternative, and suggest additional benefits afforded by the IC procedure. We additionally explored client variables relevant to this type of therapy (gender, abuse type; severity of trauma, trauma symptoms, personality pathology). Clients with more severe trauma and trauma symptoms may find confronting trauma memories too stressful (Scott & Stradling, 1997), and severe personality pathology may interfere with a short-term modality that requires quick cultivation of a therapeutic alliance (Paivio et al., 2004). Despite the small sample, results could provide information about the intended applicability of EFTT.

Method

Recruitment

Participants were recruited (2002–2004) through newspaper features and advertisements, posters in community clinics, and referrals. The study was described as offering free psychotherapy for resolving issues related to childhood abuse (emotional, physical, and sexual) in exchange for research participation. Clients consented to completion of questionnaires, taping and monitoring of their therapy sessions, and retention of tapes until completion of adherence checks. The study was approved by the Research Ethics Board of the University of Windsor.

Inclusion and Exclusion Criteria

Individuals were considered unsuitable for this type of short-term, trauma-focused therapy with an emphasis on emotion intensification if concurrent presenting problems concerned severe emotion dysregulation with a risk of harm to self or others.

Specific exclusion criteria were as follows: an incompatible diagnosis, such as psychosis, bipolar I, eating disorders, assigned by a professional in the community ($n=25$); trauma/crises, including domestic violence ($n=22$); substance abuse, with less than 6 months abstinence ($n=12$); no conscious memories of childhood abuse ($n=2$); suicide intent or self-injurious behaviour ($n=0$); and a Global Assessment of Functioning (American Psychiatric Association, 1994) score less than 50 ($n=0$). Individuals also were excluded if they wanted to focus on current interpersonal issues rather than past abuse/neglect ($n=11$), were younger than 18 years or participating in an alternate psychosocial treatment ($n=8$), or were taking psychotropic medication that was not stabilized (i.e., dose change within the past 2 months; $n=5$).

Individuals were included on the basis of accepted criteria for short-term, insight-oriented therapy (Beutler & Clarkin, 1990), that is, motivation, capacity to form a therapeutic relationship, and capacity to focus on a circumscribed issue, in this case past child abuse.

Screening and Selection

Graduate students in clinical psychology with experience in assessment were trained and supervised by Sandra C. Paivio in conducting screening interviews. These consisted of a 30-min structured telephone interview, followed by a 90-min semi-structured selection interview for those who met initial screening criteria ($n=87$). Questions assessed compatibility with the therapy; mental health, interpersonal, and abuse history; as well as current level of functioning, symptoms, and diagnoses assigned by professionals in the community. Interviewers also conducted the PTSD Symptom Severity Interview (Foa, Riggs, Dancu, & Rothbaum, 1993), described later. Inclusion/exclusion decisions were based on clinical judgment.

A total of 163 individuals approached the clinic and were screened for suitability, and 75 were accepted into the treatment program (85 did not meet criteria). Of these, 19 declined our offer, and after assessments 56 clients were allocated to therapy (the intent-to-treat [ITT] sample). In terms of attrition, eight clients withdrew from therapy: one before assignment to condition at Session 4 (see randomization strategy discussed later), five from EFTT-IC, and two from EFTT-EE; three clients were excluded from analyses because of missing posttest data (two in IC, one in EE). In total, 45 clients with complete posttest data ($IC=20$, $EE=25$) were included in outcome analyses.

Dependent Measures

Dependent measures assessed the constellation of disturbances typical of this client group (i.e., symptom distress, self and interpersonal difficulties, unresolved attachment injuries).

Impact of Event Scale (IES; M. D. Horowitz, 1986). The 15-item IES assesses intrusion and avoidance symptoms in relation to a specific trauma. Clients rate on a 4-point Likert scale (0 = *not at all*, 3 = *often experienced*) the frequency of symptoms during the past week. Subscale alphas ranged from .79 to .92 (Corcoran & Fischer, 1994), and a factor analysis (Weiss & Marmar, 1997) supported construct validity of the measure.

State-Trait Anxiety Inventory (Spielberger, Gorsuch, & Lushene, 1970). This scale consists of 20 items for both the State and Trait subscales that assess how clients feel at that moment (State) and how clients generally feel (Trait). We used the State subscale in the present study. Items are answered on a 4-point Likert scale (1 = *not at all*, 4 = *very much*). Alphas ranged from .83 to .92 (Spielberger et al.).

Beck Depression Inventory-II (BDI-II; Beck, Brown, & Steer, 1996). The BDI-II consists of 21 items that assess DSM-IV depression symptoms over the previous 2 weeks. Clients rate each item on a 4-point scale with response options appropriate to each question. Beck et al. reported a coefficient alpha of .92 for an outpatient population and a 1-week test-retest reliability of .93.

Target Complaints (Discomfort) Scale (TCD; Battle et al., 1966). The TCD assesses the degree of discomfort on three problems clients wish to focus on in therapy. Clients rate discomfort on a 13-point scale (1 = *none*, 13 = *couldn't be worse*). Battle et al. reported a test-retest reliability of .68, and data from the present study indicated convergence of the TCD and other measures of symptom distress ($r_s = .31-.43$). Problems identified by clients in the present study included negative self-esteem, interpersonal problems, emotion regulation difficulties, unresolved feelings about childhood abuse, and symptom distress.

Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1989). The RSE consists of 10 items that assess self-worth. Clients rate on a 4-point Likert scale (0 = *strongly disagree*, 3 = *strongly agree*) their level of agreement with each item. Rosenberg reported test-retest reliabilities ranging from .82 to .88 and alphas ranging from .77 to .88.

Inventory of Interpersonal Problems (IIP; L. M. Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988). The IIP consists of 127 items that assess distress from interpersonal sources. Clients rate on a 5-point Likert scale (0 = *not at all*, 4 = *extremely*) the

degree of distress experienced over the preceding 7 days. L. M. Horowitz et al. reported a test-retest reliability of .98 and internal consistency of .94 for the total scale and agreement with other measures of improvement.

Resolution Scale (RS; Singh, 1994). This 11-item scale assesses the degree to which clients feel troubled by negative feelings and unmet needs and feel worthwhile in relation to and accepting of a specific identified other person. Clients rate items on a 6-point Likert scale (0 = *not at all*, 5 = *very much*). Singh reported test-retest reliabilities (over 1 month) of .81 with a clinical sample and high correlations between change on the RS and on other outcome measures. Paivio et al. (2001) reported alpha reliability with an EFTT sample ($n = 51$) as .82. For the present study, most clients ($n = 41$ [92%]) completed two RS questionnaires, one for each of the relationships they wished to focus on in therapy. One concerned the primary abusive other and the other typically concerned a nonprotective mother. Means of the two RS scores, indicating resolution of childhood maltreatment issues, were used in analyses.

Pretreatment Predictor Measures

Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998). This 28-item retrospective scale measures the extent of different types of abuse and neglect. Items describe experiences that range in severity and clients rate the frequency of occurrence on a 6-point Likert scale (0 = *never true*, 5 = *very often true*). The CTQ yields a total score and subscale scores (emotional, physical, and sexual abuse; emotional and physical neglect). Bernstein and Fink reported internal consistency ranging from .79 to .95, test-retest reliability, after 3.6 months, ranging between .80 and .88, and associations between the CTQ and measures of distress.

PTSD Symptom Severity Interview (PSSI; Foa et al., 1993). The PSSI consists of 17 items that correspond to DSM-IV criteria for PTSD. Severity of symptoms over the preceding 2 weeks is rated by the interviewer on a 4-point Likert scale (0 = *not at all*, 3 = *very much*). The PSSI yields a total severity score as well as scores on symptom clusters of avoidance, arousal, and reexperiencing. Foa et al. reported internal consistencies for the subscales ranging from .69 to .85 and test-retest reliabilities, after a 1-month interval, ranging from .66 to .77; interrater reliability of 95%; and significant correlations with other measures of distress. In the present study, the PSSI at pretest converged with self-reports of trauma symptoms on the IES ($r = .69$).

Personality Diagnostic Questionnaire (fourth edition; PDQ-4; Hyler, 1994). This screening measure

for the presence of personality pathology consists of 99 items (true/false) corresponding to DSM-IV criteria for 12 personality disorders. A total score greater than 50 indicates the likely presence of personality pathology (Hyler). Fossati et al. (1998) reported internal consistencies ranging from .46 to .74, and correlations with semistructured interviews ranging from .20 to .40. In the present sample, scores on the PDQ-4 converged with interpersonal problems on the IIP ($r = .67$) and insecure attachment on the Attachment Style Questionnaire (Feeney, Noller, Hanrahan, 1994; $r = .61$). Additionally, in the present sample, we found 71.7% agreement between a diagnosis of personality pathology based on clinical judgment and identification of personality pathology based on PDQ-4 screening criterion. For the present study, we used the total score to assess the extent of personality pathology.

Process Measures

Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). The WAI consists of 12 items that assess the quality of the therapeutic relationship. After therapy sessions, clients rate their therapy experience on a 7-point Likert scale (1 = *never*, 7 = *always*). The WAI yields a total score and three subscale scores (Goals, Bonds, and Tasks). Test authors reported alpha levels ranging from .87 to .93 and correlations with other alliance measures.

Post Session Questionnaire (PSQ). The PSQ was developed for the present study to measure the quality of client engagement with trauma material during the IC and EE procedures. Following therapy sessions, clients and therapists completed parallel versions of the PSQ. Four items are rated on a 7-point Likert scale. One item assesses the extent that child abuse issues were the focus of the session (1 = *not at all*, 7 = *all of the time*), and three items assess the level of psychological contact with the imagined other, difficulty exploring trauma issues, and ability to express emotions. In the IC condition, an additional item assesses the level of difficulty imagining and engaging in a dialogue with imagined others in the empty chair. The therapist version of the PSQ additionally requires the technique (IC or EE) used to explore abuse memories. Convergence between client and therapist versions of the PSQ in the present sample was $r = .48$.

Subjective Units of Distress (SUDS). The SUDS is widely used in trauma therapy and research. Following therapy sessions, clients rate their average and maximum level of distress in the session on a scale ranging from 1 to 100 (1 = *calm and free from distress*, 100 = *most distressing experience*).

EFT Adherence Checklist (ADH; Paivio & Nieuwenhuis, 2001). The ADH is an observer-rated

measure that assesses therapist adherence to EFT intervention principles. The ADH consists of 11 mutually exclusive categories. These include nine general intervention principles (e.g., directing attention to internal experience, symbolizing experience, intensifying arousal, and evoking memories), one relationship category (e.g., structuring active interventions), and one category for non-EFT interventions (e.g., provide information). Paivio et al. (2004) reported that ADH ratings were positively correlated with outcome in EFTT-IC. As well, Hall (2007) reported interrater reliability of $k = .92$ for the present sample.

Therapist Facilitating Scale (TFS; Hall, 2007). This is an observer-rated ordinal scale that assesses therapist competence with the reexperiencing procedures used in EFTT. Competence is defined in terms of facilitating psychological contact with the imagined other, promoting client involvement in the intervention, evoking emotional experience, structuring the procedure, and dealing with client difficulties as well as qualitative aspects of intervention such as empathic attunement. The TFS originally was developed to assess competence with IC (Paivio et al., 2004) and was modified for use with the EE procedure (Hall, 2007). In EE, facilitating psychological contact with the imagined other involved asking clients to imagine the other in their mind's eye, rather than in the empty chair, and to disclose their reactions to the therapist.

The TFS consists of five mutually exclusive categories, ranging from minimally to completely facilitative defined according to the proportion of therapist interventions in a 15-min therapy segment that meet criteria for competence. For the present sample, Hall reported interrater reliability at $k = .86$ for IC and EE segments combined as well as agreement between TFS ratings and expert (Sandra C. Paivio) judgment at 86%.

Therapists

Therapists (seven women and four men) included one master's- and six doctoral-level students in clinical psychology and four postdoctoral psychologists (age range, 25–57 years), all of whom had previous clinical experience with this client group. Although training procedures varied depending on therapist skill level, in general, therapists participated in approximately 39 hr of training over a 26-week period conducted by Paivio. This included reviewing the treatment manual and videotaped therapy sessions as well as role-play. Throughout the study, therapists participated in weekly individual and group supervision that included reviewing their videotaped therapy sessions and team meetings. All therapies were monitored for quality assurance and adherence

by Paivio, who also saw four clients and conducted weekly supervision of 32 (71%) cases. Weekly supervision of the remaining 13 (29%) cases was carried out by Josee L. Jarry. Both supervisors were registered psychologists with more than 20 years of clinical experience.

Treatment Conditions

EFTT is a semistructured, manualized treatment (Paivio & Pascual-Leone, 2010) that is based on the empirically verified model of resolving interpersonal grievances (Greenberg & Foerster, 1996), described previously, and applies the general principles of EFT (Greenberg & Paivio, 1997) to this client group. Therapy typically consists of 16 to 20 weekly 1-hr sessions.

The phases of treatment focus on (a) cultivating the alliance, (b) reducing maladaptive fear and shame, (c) resolving issues with perpetrators, and (d) termination. Empathic responding to client feelings and meanings is the primary intervention used throughout therapy. As well, commonly used anxiety management strategies (attention to breathing, relaxation, present-centered focus) are incorporated for problems with severe emotion dysregulation. Within this general framework, two versions of EFTT were offered.

EFTT-IC. In the standard version of EFTT, the IC procedure is introduced during Session 4. Clients are asked to imagine an abusive or neglectful other in an empty chair, attend to their internal experience, and express thoughts and feelings directly to the imagined other. This quickly accesses core emotional processes (including fear, avoidance, and self-blame), making them available for exploration (Paivio et al., 2001). The frequency and length of IC vary according to individual client processes and treatment needs. When clients are unwilling or unable to participating in IC, issues predominantly are explored in interaction with the therapist. Therapist operations during IC have been delineated (Greenberg, Rice, & Elliott, 1993; Paivio et al., 2004) as follows: promote psychological contact with the imagined other, evoke episodic memories associated with abuse, promote expression of feelings, help clients overcome blocks to experiencing, differentiate feelings (e.g., anger, sadness) and associated meanings, promote a sense of entitlement to unmet needs, and explore shifting perceptions of self and imagined others. As well, experiential focusing and two-chair enactments (Elliott et al., 2004; Greenberg et al., 1993) can be used in conjunction with IC to explore and reduce avoidance and self-critical processes.

EFTT-EE. The alternate EE protocol is identical to that described previously in terms of focus on resolving issues with abusive and neglectful others, process steps, intervention principles, and therapist operations. However, issues are explored exclusively in interaction with the therapist, who uses empathic responding to explore client feelings and meanings regarding self, others, and traumatic events. Beginning in Session 4, clients are encouraged to spend the session focusing in depth on their experiences of abuse. The process differs from IC in that clients are encouraged to vividly remember abusive/neglectful others and express their thoughts and feelings to the therapist rather than engage in a dialogue with an imagined other in an empty chair. Blocks to experiencing also are explored exclusively in interaction with the therapist.

Procedure

Self-report outcome questionnaires were administered at pretreatment, midtreatment (after Session 8), posttreatment, and follow-up; the PSSI was conducted at pretreatment, midtreatment, and posttreatment; predictor measures were administered at pretreatment. The WAI and PSQ were administered following therapy sessions beginning after Sessions 3 and 4, respectively. Clients were assured that information on self-report questionnaires would be kept confidential from their therapist.

Clients were assigned to therapists based on scheduling compatibility. Random assignment to treatment condition (coin toss by the supervisor) took place after Session 3 and before the introduction of the IC and EE procedures in Session 4. Because early alliance quality is a robust predictor of treatment outcome (Horvath & Symonds, 1991), including in EFTT (Paivio et al., 2001), this helped to ensure equivalence of treatment conditions. Therapists also were assigned to equal numbers of clients in both conditions so that a single coin toss determined the assignment for a pair of clients.

Therapies were conducted at a clinic in the Psychology Department at the University of Windsor. All sessions were tape-recorded. After completion of all therapies, the ADH and TFS were used to assess treatment fidelity in both conditions. Clients were contacted 6 months after therapy termination; mailed the battery of follow-up questionnaires; and offered \$25 for their completion. Eight clients were lost to follow-up because of inaccurate contact information. Those who did not return the package were contacted again at regular intervals and delivered a new package for completion.

Results

Data used in main analyses (pre–post on dependent measures) were examined to determine whether they met assumptions for statistical tests. No outliers were found; however, distributions for posttreatment BDI and TCD significantly differed from normal ($p < .05$). Thus, algorithmic and square-root transformations were performed, and multivariate analyses were conducted on both the original and the transformed data. These results did not differ in any meaningful way. Therefore, for ease of interpretation, original data and results of analyses using original data are reported. Alpha level for all analyses was set at .05.

Table I presents demographic data for clients who completed therapy. Slightly more than half of the clients were female. Most clients were in their mid-40s, of European descent, married with one or more children, had some education beyond high school, and were employed, with an annual household income of more than \$40,000.

Table II presents client characteristics at pretreatment in each condition. Most clients ($n = 31$ [69%]) reported multiple types of childhood maltreatment. Table II indicates the types of abuse clients identified as the primary focus for therapy. Sexual abuse ranged from a single episode of molestation by a relative, to paternal incest over many years, to repeated victimization by several perpetrators. Emotional abuse included verbal derogation by a caregiver, direct threats of harm, and witnessing extreme family violence. Physical abuse ranged from harsh physical discipline to beatings that required medical attention. Emotional neglect involved failure to provide basic needs for attention, protection, and support. Primary perpetrators of abuse were fathers or father figures ($n = 20$ [44.5%]), mothers ($n = 14$ [31.1%]), others including babysitters and clergy ($n = 6$ [13.3%]), relatives ($n = 3$ [6.7%]), and brothers ($n = 2$ [4.4%]). Regardless of who the perpetrator was, all clients identified unresolved issues with attachment figures (parents) as a focus of therapy.

Scores on the CTQ subscales reported in Table II are well above thresholds for severe abuse (Bernstein & Fink, 1998). Table II also indicates that most clients met criteria for a diagnosis of PTSD, with scores on the PSSI indicating moderate PTSD symptom distress (Foa et al., 1993). Approximately 33% of clients met screening criteria for personality pathology on the PDQ-4 (scores > 50). Clinical judgment, based on information from screening interviews and early therapy sessions, resulted in 11 clients diagnosed with personality pathology and included the following subtypes: narcissistic, $n = 4$; borderline, $n = 3$; not otherwise specified, $n = 3$; avoidant, $n = 1$. Approximately 25% ($n = 11$) of clients were stabilized on a

course of antidepressant medication; and the majority ($n = 39$ [87%]) previously had received some form of psychosocial treatment, most frequently for depression, substance abuse, and marital distress.

Tables I and II also present client data for each therapy condition. There were no significant differences between the two conditions in terms of assessed pretreatment variables shown in Tables I and II and pretest disturbance on dependent measures (Table III).

Therapy Processes

Therapist adherence and competence. For each client, segments of videotaped therapy sessions were randomly selected (one each) from early, middle, and late sessions for rating on each measure. This represents approximately 18% of all sessions. Two trained raters independently coded each therapist utterance in 20-min segments for ADH ratings and assigned a single category code to the entire 15-min segments for TFS ratings.

A total of 5,595 therapist statements were rated on the ADH. The mean adherence rate was .91 ($SD = .06$) in the IC condition and .87 ($SD = .08$) in the EE condition. In terms of therapist competence, the mean TFS for 60 episodes of IC was 3.15 ($SD = 1.09$). The mean TFS for 75 episodes of EE was 2.80 ($SD = 1.01$). Thus, therapists achieved high levels of adherence to general EFT intervention principles (ADH) and moderate levels of competence with the specific reexperiencing procedure used in each treatment, and there were no significant differences between the IC and EE treatment conditions.

Client processes. The mean number of sessions for clients in IC was 16.90 ($SD = 1.65$; range, 10–20) compared with 16.80 ($SD = 1.83$; range, 12–20) in EE. Thus, treatment length was comparable in the two conditions.

The mean number of sessions containing substantial IC and EE participation (i.e., ≥ 20 min), according to videotaped observation, was 5.35 for IC ($SD = 1.63$; range, 2–8), or 31.7% of the total sessions, and 8.81 for EE ($SD = 2.64$; range, 4–14), or 52.4% of the total sessions. Thus, more sessions contained EE versus IC, $t(42) = 5.29$, $p < .001$. The mean alliance quality (WAI) for all sessions in the IC condition was 6.24 ($SD = .58$) and in the EE condition, 6.25 ($SD = .59$). The mean level of engagement with trauma material during IC for all sessions (PSQ) was 29.13 ($SD = 6.96$) and mean distress (SUDS) was 43.16 ($SD = 20.80$) compared with 32.14 ($SD = 7.08$) and 44.64 ($SD = 16.41$), respectively, in EE. Thus, clients in both conditions reported comparably strong alliances and levels of emotional engagement and

Table I. Client Demographic Data

Variable	Total (N=45)		IC (n=20)		EE (n=25)	
	M	SD	M	SD	M	SD
Age	45.62	12.99	45.70	14.96	45.08	11.47
No. children	2.07	1.94	2.00	1.72	2.02	2.13
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Sex						
Female	24	53.4	10	50.0	14	56.0
Male	21	46.6	10	50.0	11	44.0
Ethnic origin						
European	40	88.9	19	95.0	21	84.0
Other (Aboriginal, mixed race)	5	11.1	1	.05	4	.16
Marital status						
Single	10	22.2	5	25.0	5	20.0
Married/common law	22	48.9	9	45.0	13	52.0
Separated/divorced	12	26.7	5	25.0	7	28.0
Widowed	1	2.2	1	5.0	0	0.0
Employment status						
Full time	24	53.3	10	50.0	14	56.0
Part time	8	17.8	4	20.0	4	16.0
Unemployed	13	28.9	6	30.0	7	28.0
Annual household income						
< \$20,000	6	13.3	4	20.0	2	8.0
\$20–39,000	13	28.9	6	30.0	7	28.0
\$40–59,000	10	22.2	4	20.0	6	24.0
> \$60,000	16	35.6	6	30.0	10	40.0
Completed education						
High school	11	24.4	4	20.0	7	28.0
Undergraduate	27	60.0	13	65.0	14	56.0
Postgraduate	7	15.6	3	15.0	4	16.0

Note. IC, imaginal confrontation; EE, empathic exploration.

distress during the different reexperiencing procedures.

Results comparing eight dropouts and 45 completers in terms of therapy processes indicated significantly lower alliance scores (WAI) for clients who withdrew ($M=5.38$, $SD=.86$) compared with completers ($M=6.24$, $SD=.58$), $F(1, 51)=9.41$, $p<.001$. Results also indicated lower levels of emotional engagement with trauma material (PSQ) for dropouts ($M=17.46$, $SD=6.75$) compared with completers ($M=30.80$, $SD=7.12$), $F(1, 50)=21.60$, $p<.001$.

Treatment Effects

Table III presents pretest, midtreatment test, and posttest data for clients who completed therapy in each treatment condition. Results indicate a steady rate of improvement in both groups on all dependent measures. Results of a pre–post repeated measures multivariate analysis of variance (MANOVA) comparing the IC and EE groups on seven dependent measures indicated a significant effect for time, $F(7,$

$37)=26.32$, $p<.001$, but not for group, $F(7, 37)=1.53$, $p=.19$, and no interaction, $F(7, 37)=1.80$, $p=.12$. Results of separate pre–post univariate analyses shown in Table III indicated significant improvements on all dimensions (all $ps<.001$) in both the IC and EE conditions. This significance level is less than the estimated conservative Bonferroni correction for Type I error (.05/8 measures = .01; Jaccard & Guilamo-Ramos, 2002). Calculations of pre–post effect sizes indicated a small advantage for the IC condition, with overall $\eta^2=.91$ and the average Cohen's $d=1.67$ standard deviations compared with $\eta^2=.81$ and $d=1.24$ for EE. Additionally, three clients (15%) in IC and four in EE (16%) met criteria for a diagnosis of PTSD at posttest. This was a significant pre–post improvement (see Table II) in both conditions, $F(1, 43)=28.84$, $p<.001$, with no difference between the conditions, $F(1, 43)=0.46$, $p=.72$.

Therapist effects. After attrition, in the IC condition, one therapist saw four clients, three therapists saw three clients each, two therapists saw two clients each, and three therapists saw one client each. In the EE condition, one therapist saw four clients, four

Table II. Client Pretreatment Characteristics

Variable	Total (N = 45)		IC (n = 20)		EE (n = 25)	
	N	%	n	%	n	%
Abuse focus						
Emotional	10	22.2	5	25.0	5	10.0
Physical	6	13.3	2	10.0	4	16.0
Sexual	25	55.6	12	60.0	13	52.0
Neglect	4	8.9	1	5.0	3	12.0
PTSD diagnosis (yes)	28	62.2	14	70.0	14	56.0
Axis II pathology (yes)	11	24.4	4	20.0	7	28.0
Antidepressant medication (yes)	11	24.4	5	25.0	6	24.0
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Childhood Trauma Questionnaire						
Total	74.72	17.45	73.85	20.31	75.41	15.18
Emotional abuse	18.40	4.88	18.70	4.96	18.17	4.90
Physical abuse	12.83	5.16	13.35	5.84	12.42	4.62
Sexual abuse	13.21	7.80	12.75	8.40	13.57	7.44
Emotional neglect	18.83	3.79	18.15	3.54	19.38	3.96
Physical neglect	11.14	4.04	10.90	4.64	11.33	3.57
PTSD Symptom Severity Interview						
Total	23.21	11.59	23.15	11.35	23.25	12.00
Reexperiencing	6.09	3.69	6.25	0.42	5.96	3.96
Avoidance	11.46	6.26	10.90	6.24	11.90	6.36
Arousal	6.95	3.94	7.40	0.16	6.60	3.80
Personality Diagnostic Questionnaire-4						
Total	41.33	14.3	39.04	12.90	43.01	15.43

Note. IC, imaginal confrontation; EE, empathic exploration; PTSD, posttraumatic stress disorder.

therapists saw three clients each, three therapists saw two clients each, and three therapists saw one client each. To increase power and because there were no statistically significant differences between the treatment groups, we compared therapists in terms of their clients' outcomes with treatment conditions combined. First, we calculated residual change scores from pre- to posttest on each dependent measure and used a series of one-way analyses of variance to compare the 11 therapists. Results revealed no significant therapist effects, with an overall p of .53.

Attrition. There were no significant differences between the eight dropouts and 45 completers in terms of assessed pretreatment variables and client processes. However, there was a significant difference in terms of treatment condition assigned, $\chi^2(1, N = 53) = 7.34, p = .03$, with a higher dropout rate in IC (20%) compared with EE (7%).

Follow-Up

Fourteen (70%) and 23 (92%) clients completed follow-up questionnaires in the IC and EE conditions, respectively. The average length of the follow-up period was 48.57 weeks ($SD = 25.25$; range, 28–96) in IC and 45.04 weeks ($SD = 20.58$; range, 28–92) in

EE. Thus, the length of the follow-up period was comparable for both conditions. There also were no significant differences between clients who completed follow-up questionnaires and those who did not in terms of demographics, pretreatment characteristics, treatment condition, and assigned therapist. However, fewer clients who completed follow-up assessments, compared with those who did not, met criteria for a diagnosis of PTSD at pretreatment (55% vs. 100%), $\chi^2(1, N = 45) = 5.91, p = .02$. In terms of pre-post outcome, results of a repeated measures MANOVA indicated no significant overall differences between these subgroups on seven dependent measures. There was a significant effect for time, $F(7, 37) = 15.59, p < .001$, no effect for group, $F(7, 37) = 0.81, p = .68$, and no interaction, $F(7, 37) = 0.98, p = .84$.

Table IV presents pretreatment, posttreatment, and follow-up data for clients in each condition. Results of a pre-follow-up repeated measures MANOVA indicated a significant effect for time, $F(14, 22) = 10.00, p < .001$, but not for group, $F(7, 29) = 0.89, p = .19$, and no interaction, $F(14, 22) = 1.77, p = .12$. Results of pairwise comparisons indicated significant improvements from pre- to posttest and pretest to follow-up on all dependent measures but no significant effect for time from posttest to follow-up.

Table III. Pretest, Midtreatment Test, and Posttest Means and Standard Deviations on Dependent Measures in Each Treatment Condition

Measure	Pretest		Midtest		Posttest		<i>F</i> (time) ^a
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Impact of Event Scale							
IC	25.45	8.30	19.55	9.35	11.65	8.09	43.87
EE	25.12	9.18	15.60	8.47	8.51	8.52	56.10
State-Trait Anxiety Scale (State)							
IC	50.75	12.50	47.65	13.57	36.45	11.66	24.40
EE	46.20	13.31	40.58	14.73	35.76	14.73	13.96
Beck Depression Inventory-II							
IC	23.15	9.53	15.70	10.34	7.90	10.05	58.15
EE	21.32	12.47	13.52	10.12	9.88	11.69	16.44
Target Complaints Scale (Discomfort)							
IC	10.49	1.43	8.18	1.81	5.46	2.12	92.97
EE	9.39	2.05	6.94	2.20	4.80	2.26	77.84
Rosenberg Self-Esteem Scale							
IC	24.45	5.5	22.60	6.74	19.10	5.62	18.29
EE	23.81	6.02	22.44	5.81	20.16	8.36	6.54
Inventory of Interpersonal Problems							
IC	1.84	0.43	1.43	0.48	1.05	0.43	59.00
EE	1.84	0.63	1.71	0.81	1.3	0.86	16.98
Resolution Scale							
IC	39.01	5.82	34.53	7.00	25.53	6.71	80.12
EE	39.68	7.38	32.68	8.87	25.66	10.43	52.62
PTSD Symptom Severity Interview							
IC	23.15	11.36	18.15	11.41	10.37	10.28	23.22
EE	23.24	12.01	15.10	8.89	7.96	8.50	9.60

Note. IC, imaginal confrontation; EE, empathic exploration; PTSD, posttraumatic stress disorder. *N* = 45, *IC*_{*n*} = 20, *EE*_{*n*} = 25.

^aPre-post.

Thus, overall, clients who completed follow-up assessments in both conditions maintained treatment gains at approximately 1 year (on average) follow-up. Results of pre-follow-up univariate analyses for each condition, shown in Table IV, indicated that six of seven significance levels in IC were below estimated criteria using conservative corrections for Type I error ($p < .01$). Reductions in anxiety (State) in the IC condition at follow-up were not statistically significant ($p > .05$). In EE, for all analyses shown in Table IV, all $ps < .05$. Calculations of effect sizes indicated a small advantage for the IC condition, with overall $\eta^2 = .95$ and average Cohen's $d = 1.59$ standard deviations compared with $\eta^2 = .88$ and $d = 1.29$ for EE.

Intent-to-Treat Analyses

ITT analyses that account for dropouts were conducted on posttest and follow-up data using the carry-forward method (pretest data for eight dropouts, midtreatment test data for three clients who were excluded because of missing posttest data, posttest data for eight clients who did not complete follow-up assessments). In terms of posttest analyses, results of a repeated measures MANOVA ($n = 28$ for both

completer and dropout groups) indicated a significant effect for time, $F(7, 48) = 17.22$, $p < .001$, a significant effect for group, $F(7, 48) = 2.77$, $p = .02$, and a significant interaction, $F(7, 48) = 2.21$, $p = .05$. Subsequent univariate analyses indicated significant improvements on all dependent measures (all $ps < .001$) and that the significant interaction was due to greater reductions in trauma symptoms (IES) for clients in the EE condition, $F(1, 54) = 3.97$, $p = .05$.

In terms of follow-up ITT analyses, a repeated measures MANOVA yielded a significant effect for time, $F(7, 48) = 15.93$, $p < .001$, no effect for group, $F(7, 48) = 1.28$, $p = .28$, and a significant interaction, $F(7, 48) = 2.33$, $p = .04$. Results of univariate analyses indicated that the interaction was due to greater reductions in trauma symptoms (IES), $F(1, 54) = 4.90$, $p = .03$, and resolution of abuse issues (RS), $F(1, 54) = 6.72$, $p = .01$, in the EE condition.

Clinically Significant Change

Criteria used to calculate clinically significant change are those recommended by Jacobson and Truax (1991). A reliable change index (RCI) refers to pre-post change that is greater than normal

Table IV. Pretest, Posttest, and Follow-Up Means and Standard Deviations on Dependent Measures in Each Treatment Condition

Measure	Pretest		Posttest		Follow-up		<i>F</i> (time)*
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Impact of Event Scale							
IC	24.14	8.63	10.2	7.6	13.30	7.47	25.01
EE	24.61	8.80	9.25	8.48	9.95	7.64	52.85
State-Trait Anxiety Scale (State)							
IC	47.79	12.84	35.29	11.44	39.36	12.19	3.51
EE	48.83	13.22	35.57	15.27	36.09	2.88	15.22
Beck Depression Inventory-II							
IC	21.29	8.00	7.57	11.49	10.41	11.05	9.09
EE	21.09	12.64	10.30	2.02	8.74	10.66	12.88
Target Complaints Scale (Discomfort)							
IC	10.45	1.47	5.46	2.06	4.36	1.81	85.36
EE	9.26	2.04	4.96	2.28	4.81	2.32	61.63
Rosenberg Self-Esteem Scale							
IC	23.71	5.66	18.14	6.26	18.36	6.63	16.68
EE	23.75	6.34	20.74	8.46	19.70	7.64	6.43
Inventory of Interpersonal Problems							
IC	1.82	0.50	1.00	0.43	1.14	0.59	26.30
EE	1.85	0.64	1.38	0.86	1.19	0.78	16.64
Resolution Scale							
IC	38.52	5.14	23.79	4.67	24.34	8.19	26.85
EE	39.37	7.62	26.33	10.60	24.25	8.57	75.81

Note. IC, imaginal confrontation; EE, empathic exploration. $N = 37$, $IC_n = 14$, $EE_n = 23$.

*Pre-follow-up.

fluctuations in the instruments. A recovered index refers to posttest scores that are above clinical cutoffs (C) for distress on each measure and pre-post improvements that met criteria for reliable change (RCI). Proportions recovered are based on the number of clients whose pretest scores were at or below C for distress (80% in IC and 76% in EE, averaging across seven dependent measures). Criteria for RCI and C, respectively, on each outcome dimension are as follows: IES, 18.10 and 2.40; STA, 46.63 and 2.10; BDI, 17.05 and 3.57; TCD, 6.19 and 3.21; RSE, 23.19 and 2.11; IIP, 1.29 and 5.40; RS, 26.40 and 3.11. Averaging across seven dimensions, a larger proportion of IC compared with EE clients were reliably improved (88% vs. 78%) and recovered (64% vs. 52%), and a smaller proportion deteriorated (3% vs. 8%) at posttest. The advantage for IC at follow-up was smaller (79% vs. 77% improved; 67% vs. 64% recovered, 6% vs. 13% deteriorated).

Prognostic Client Variables

Results of two repeated measures MANOVAs indicated no overall pre-post differences between three maltreatment types (sexual abuse, physical abuse, emotional abuse and neglect) and between men and women in either condition (all $ps > .05$). Partial

correlations controlling for pretest scores on each measure were conducted between other client characteristics (CTQ, PSSI, PDQ-4 total) and posttest outcome. Results indicated no effect for severity of childhood trauma (CTQ) in either condition. In the IC condition, the association between severity of personality pathology (PDQ-4) and more discomfort on target complaints (TCD) at posttest approached significance ($r = .482$, $p = .056$). In the EE condition, more severe trauma symptoms (PSSI) at pretreatment were associated with higher self-esteem (RSE), $r = -.445$, $p = .03$, at posttest. There also were significant positive associations in EE between severity of personality pathology (PDQ-4) at pretreatment and more severe trauma symptoms (IES; $r = .552$, $p = .01$), higher depression (BDI; $r = .435$, $p = .03$), and anxiety (State; $r = .412$, $p = .05$) and more discomfort from target complaints (TCD; $r = .533$, $p = .01$) at posttest.

Discussion

In terms of treatment effects, results indicated pre-post effect sizes for therapy completers in both conditions that far exceed the standard for efficacy (0.8 *SDs*) recommended by Cohen (1988). These findings also are comparable to those reported for individual therapies for child abuse trauma (Chard,

2005; Cloitre et al., 2002; Resick et al., 2003). Findings concerning therapist effects, adherence, alliance quality, and levels of emotional engagement during reexperiencing procedures, in both conditions, support the internal validity of the study. Failure to find significant differences between the treatment conditions at posttest is consistent with findings from studies comparing different cognitive-behavioral trauma therapies (e.g., Foa et al., 2005). Present findings could be partly a function of sample size and limited statistical power, especially considering the larger effect sizes and greater number of clients achieving clinically significant change in the IC condition. Nonetheless, it seems that differences between the two versions of EFTT in this sample, if they exist at all, are small. Results more likely reflect different routes to change in different approaches and challenge assumptions and previous research (Paivio et al., 2001) on additional benefits afforded by the IC procedure.

Present findings are consistent with those previously reported for 37 clients who completed EFTT-IC (Paivio & Nieuwenhuis, 2001) and thus increase confidence in this treatment model. Present results also identify EFTT-EE as another effective treatment option for this client group. This is particularly relevant for the substantial proportion of clients (35%; Paivio et al., 2001) who may be unwilling or unable to participate in IC. Importantly, EE is not simply supportive or nondirective therapy. Comparable efficacy of the two treatments likely is attributable to comparable treatment models that maintained a focus on reprocessing trauma material, were based on the same empirically verified model of resolution (Greenberg & Foerster, 1996) that provided session-by-session guidelines for intervention, and used the same intervention principles. Both versions emphasized client experience and expression of feelings and needs concerning particular attachment figures and offenders and particularly emphasized accessing adaptive emotions, such as anger and sadness and their associated meanings. Thus, findings may challenge assumptions regarding the IC technique but not the fundamental intervention principles of EFTT.

In terms of attrition, present findings indicated a dropout rate in IC (20%) comparable to rates reported for other therapies using exposure-based procedures (e.g., Chard, 2005: 18%; Cloitre et al., 2002: 29%; Resick et al., 2003: 26.8%), including EFTT-IC (Paivio & Nieuwenhuis, 2001: 25%). The remarkably low dropout rate in EE (7%) supports the view that EE is a less stressful procedure. Results of ITT analyses also suggested a small advantage for the EE condition when the lower dropout rate is taken into consideration. In terms of the factors

contributing to client withdrawal from therapy, overall, dropouts and completers did not differ on assessed pretreatment variables. However, clinical observation suggested a mismatch with the treatment focus on dredging up painful material, coupled with the push to participate in IC. This appeared to be too uncomfortable and disorganizing for some clients who withdrew and not a priority for others who had more pressing current concerns (e.g., marital distress, financial problems). Weaker alliances (WAI) and lower levels of engagement with trauma material (PSQ) for dropouts support this view. It should be noted that, in these cases, in real-world settings a focus on past trauma or the IC procedure likely would be abandoned.

In terms of follow-up, results indicating maintenance of treatment gains in both conditions are consistent with expectations and previous findings for EFTT-IC (Paivio & Nieuwenhuis, 2001). Of course, there are the usual problems with interpreting this type of longitudinal data because of attrition and limited control over factors during the follow-up period. The lower response rate to follow-up assessments for IC clients and for clients diagnosed with PTSD at pretest is of particular concern. More clients in the IC group who entered therapy with a diagnosis of PTSD may have relapsed during the follow-up period and, therefore, may have been less willing or able to respond to research demands. Nonetheless, the proportion of clients who maintained clinically significant gains (at least 60% in each condition) is remarkable, especially considering the length of the follow-up period (6–18 months) and length and chronicity of disturbance. In terms of differential group effects at follow-up, present findings do not support the study's hypothesis or the superior effect of IC on memory systems. As in other studies (Greenberg & Watson, 1998; Paivio et al., 2001), it is possible that long-term advantages would occur only for clients who were highly engaged in the IC procedure. Future research can test this hypothesis.

Finally, results support the intended applicability of both versions of EFTT to both men and women, to different types of maltreatment, and across maltreatment and trauma symptom severity. These findings are consistent with those previously reported for EFTT-IC (Paivio et al., 2004). Results also indicated that personality pathology had a negative influence on multiple dimensions of change in the EE condition. Despite the small sample, consistency across outcome indexes increases confidence in this finding. It is possible that because EE is less distinct from the therapeutic relationship compared with IC, clients with more severe relational problems, typical of Axis II disturbance, found it more difficult to explore authentic feelings and needs in that context. This, in

turn, interfered with emotional processing and change. Nonetheless, present findings indicate that clients with more severe personality pathology did benefit from both versions of EFTT but suggest, however, that IC could be a better choice for them.

That said, several factors limit conclusions that can be drawn from our findings. Most notably, the absence of a control group makes it impossible to accurately assess treatment effects beyond those of time alone. As well, the small sample limited power to detect small effects and multiple comparisons increased the Type I error rate, especially in results concerning therapist effects, attrition, and client variables. In terms of external validity, therapists in the study likely are representative of those found in many clinics, but they received more supervision than is typical for these settings. Moreover, although inclusion criteria, abuse severity, and level of disturbance were comparable to those reported in other studies (e.g., Chard, 2005; Cloitre et al., 2002; Resick et al., 2003), the sample was not representative of more severely disturbed clients and ethnic and racial minorities. As well, 41% of individuals who contacted our clinic were excluded on the basis of current problems that were considered incompatible with the treatment focus on past trauma. This excludes a substantial proportion of child abuse survivors who seek therapy for current problems. Other psychological treatments may be effective for this group.

Despite limitations, results of the present study are highly relevant to clinical practice. The constellation of disturbances typical of complex PTSD stemming from child abuse trauma is highly prevalent in clinic samples (Van der Kolk, 2003), and there is a need for effective treatment options for this client group. To date, EFTT is the only systematically investigated individual treatment for the effects of different types of abuse among both men and women (Paivio & Greenberg, 1995; Paivio et al., 2001, 2004; Paivio & Nieuwenhuis, 2001; Paivio & Patterson, 1999). Present findings increase confidence in EFTT-IC and identify EFTT-EE as another effective treatment option. Finally, the present study collected valid indexes of client change and generated hypotheses for testing in future process–outcome research. Understanding the processes of change in each treatment condition will have additional important implications for improved clinical practice.

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