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Client Characteristics as Predictors of Best and Worst Outcome in Two Versions of Emotion Focused Therapy for Child Abuse Trauma

Tiziana F. Fulco

A Thesis Submitted to the Faculty of Graduate Studies through the Department of Psychology
In Partial Fulfillment of the Requirements for the
Degree of Master of Arts at the University of Windsor

Windsor, Ontario, Canada
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Abstract

The present study examined client characteristics that differentiate between best and worst outcome in two versions of EFTT. Both versions of EFTT have been shown to be effective for survivors of child abuse (Paivio et al., 2009); however the unique features of the two versions of EFTT may interact with client characteristics, and hence differentially affect outcome. Certain client characteristics have been examined in relation to outcome; however, many relevant client characteristics have been neglected. Results indicated that marital status, personality pathology, and abuse characteristics differentiated clients who did best and worst in EE, whereas personality pathology, alexithymia symptom clusters, and abuse characteristics differentiated best and worst outcome in IC. This comprehensive examination of pre-treatment client characteristics provides a more complete picture of what factors may facilitate or impede improvement in EFTT. Findings can guide future research and inform individual treatment planning and tailoring to improve effectiveness.

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Introduction

Objectives. The purpose of the present study was to examine pre-treatment client characteristics that differentiated between best and worst outcome in two versions of Emotion Focused Trauma Therapy (EFTT; Paivio, Chagigiorgis, Hall, Jarry, & Ralston, 2009). In the Imaginal Confrontation (IC) condition clients imaginally confront the abusive/neglectful other in an empty chair and express their thoughts, feelings, and needs directly to the "imagined" other. In the Empathic Exploration (EE) condition, clients express their thoughts and feelings about the abuse to the therapist as opposed to an imagined other (Paivio et al., 2009). Both versions of EFTT (Paivio et al., 2009; Paivio & Nieuwenhuis, 2001) have been shown to be effective for male and female survivors of different types of child abuse. However, factors that facilitate or impede improvement in therapy are not clearly understood.

Core features of EFTT, including forming a strong therapeutic alliance and the capacity to experience and express feelings related to trauma, require trust and emotion regulation that may be difficult for some abuse survivors. Furthermore, the unique features of the two versions of EFTT may interact with different client variables, and hence differentially affect outcome. Other client characteristics, such as experiencing multiple forms of abuse, adult attachment styles, and particular PTSD symptoms, may affect clients' ability to engage in key therapy processes, and therefore, treatment outcome.

Certain client characteristics, including overall abuse severity, severity of personality pathology and PTSD symptoms, and gender of the abuse victim, have been previously examined in relation to outcome (Paivio et al., 2009; Paivio & Nieuwenhuis, 2001). However, other potentially relevant client characteristics have not been examined. The aim of the present study was to explore the pre-treatment patient characteristics that interact with each version of therapy and effect outcome. A more complete picture of client-by-treatment interactions in this type of trauma therapy could generate hypotheses for testing in future research and ultimately inform individual treatment planning and tailoring to improve effectiveness.

Literature Review

The first part of this thesis will review pertinent literature on the nature, prevalence, and long-term effects of childhood maltreatment, treatments for child abuse trauma, and client variables that potentially affect process and outcome in trauma therapy, in general, and EFTT in particular.

Nature and Long Term Effects of Child Abuse Trauma

The following sections present widely-accepted definitions of different types of childhood maltreatment, and review the literature on prevalence rates for these different types and on the long-term effects of childhood maltreatment.

Definition and Prevalence of Child Abuse and Neglect

First, it is important to define the different types of child abuse experiences that were the focus of EFTT and the present study, and to present data on prevalence rates. These child abuse experiences include sexual, physical, and emotional abuse, as well as emotional neglect.

The Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998) defines sexual abuse as "sexual contact or conduct between a child younger than 18 years of age and an adult or older person." Other sources define sexual abuse as sexual activity which can include oral-genital, genital-genital, genital-rectal, hand-genital, hand-rectal, hand-breast contact, as well as exposure of genitals, or forced viewing of pornography with a child before the legal age of consent (Felzen-Johnson, 2004). Canadian law defines the

legal age of consent as age 14, unless it occurs in a relationship of trust or dependency, in which case sexual activity with a person under 18 years of age constitutes an offense (Pilon, 1999).

Physical abuse is defined as "bodily assaults on a child by an adult or older person that poses a risk of or result in injury" (Bernstein & Fink, 1998). Other definitions of physical abuse include inflicting physical injury upon a child, such as burning, hitting, punching, shaking, kicking, beating, or otherwise harming a child. Although the parent or caretaker may not have intended to hurt the child, the injury is not an accident (Trocmé, MacLaurin, Fallon, Daciuk, Billingsley, Tourigny et al., 2001).

Emotional abuse is defined as, "verbal assaults on a child's sense of worth or well-being or any humiliating or demeaning behaviour directed toward a child by an adult or older person" (Bernstein & Fink, 1998). Emotional abuse also includes acts or the failures to act by parents or caretakers that have caused or could cause serious behavioural, cognitive, emotional, or mental disorders. This can include use of extreme and/or bizarre forms of punishment (i.e. confinement in a closet or dark room, being tied to a chair for long periods of time, threatening or terrorizing a child). Less severe acts, but no less damaging, are belittling or rejecting treatment, using derogatory terms to describe the child, and habitual scapegoating or blaming (Trocmé et al., 2001).

Emotional neglect is defined as, "the failure of caretakers to meet children's basic emotional and psychological needs, including love, belonging, nurturance, and support" (Bernstein & Fink, 1998). It is also defined as parents or caregivers failing to provide the

requisite attention to the child's emotional, psychological, or physical development (Trocmé et al., 2001).

Prevalence rates of all forms of child abuse remain under-reported and therefore likely underestimated (Newton, 2001). Due to the large number of abuse victims requiring treatment, comprehending the factors that contribute to effective treatment has the potential to benefit large numbers of individuals. Prevalence rates are highly relevant to the current study, given that child abuse has been linked with deleterious long-term effects that may be affecting treatment outcome.

In Canada, there were an estimated 21.52 investigations of child abuse and neglect per 1,000 children in 1998. Of these, 9.71 were substantiated (i.e. confirmed or verified). Neglect appears to be the most prevalent motive for referrals to child welfare agencies (40%). Of the 43% of substantiated cases, failure to supervise leading to physical harm represented 48%, followed by physical neglect (19%), permitting criminal behaviour (14%), abandonment (12%), educational neglect (11%), and medical neglect (9%). In 31% of all referrals to child welfare agencies, physical abuse was the primary reason for investigation, with 69% of substantiated cases involving inappropriate punishment. Sexual abuse was the primary reason for referral in 10% of cases, and is more common in female victims. Touching and fondling genitals was the most common form of substantiated child sexual abuse, occurring in 68% of cases. Attempted and completed sexual activity accounted for over one-third (35%) of all substantiated reports (Trocmé et al., 2001). Contrary to popular belief, perpetrators of child maltreatment are frequently identified as parents or caregivers (Cawson, Wattam, Brooker, & Kelly, 2000),

that is, adults that have a trusted relationship with the child. Prevalence estimates for emotional abuse are more imprecise than for sexual and physical abuse. This imprecision is because definitions vary and victims themselves are often unsure of what constitutes "abuse". This results in challenges measuring this form of abuse (Nelms, 2001). Nonetheless estimates of emotional abuse range from 15-42% for females and 12-38% for males (Jack, Munn, Cheng, & MacMillan, 2006; Paivio & Cramer, 2004; Turner & Paivio, 2002).

In terms of adult retrospective self-reports, a community-based survey indicated that 31.2% of males and 21.1% of females reported physical abuse experiences during childhood, with similar proportions of males (10.7%) and females (9.2%) reporting a history of severe physical abuse. Furthermore, 12.8% of females and 4.3% of males reported a history of child sexual abuse. Overall, 33% of males and 27% of females reported experiencing one or more incidents of physical and/or sexual abuse during their childhood (MacMillan, Fleming, Trocme, Boyle, Wong, Racine, et al., 1997). The authors of the CTQ also examined prevalence rates in a variety of populations, including substance abusers, adolescent inpatients, adult outpatients, fibromyalgia and arthritis patients, and college undergraduates. Prevalence rates varied greatly. Between 6-91% of females and 3-41% of males reported emotional abuse, 4-56% of females and 2.9-34% of males reported physical abuse, and 4.3-48% of females and 2.2-23% of males reported sexual abuse (Bernstein & Fink, 1998). More recent studies have reported prevalence rates in Ontario undergraduates. They found that 42% of females and 38% of males reported experiencing emotional abuse, 22% of females and 24% of males reported

histories of physical abuse, and 23% of females and 22% of males reported histories of sexual abuse (Paivio & Cramer, 2004; Turner & Paivio, 2002).

Long-Term Effects of Child Abuse Trauma

Experiencing child abuse is associated with multiple adverse psychosocial and health consequences for the victims, which often persist far beyond the duration of abuse (Landsford, Miller-Johnson, Berlin, Dodge, Bates, & Pettit, 2007; Riggs, Sahl, Greenwald, Atkinson, Paulson, & Ross, 2007). The long-term effects of childhood abuse can be organized into clusters. Specifically, experiencing abuse during childhood increases the risk of chronic symptom distress, emotion regulation difficulties, self and interpersonal difficulties, and associated maladaptive behaviours. Chronic symptom distress includes symptoms related to posttraumaStic stress disorder (PTSD), anxiety, and depression. Emotion regulation difficulties include suicidality, self-harm, chronic anger, aggressive behaviour, and addiction problems. Self-related difficulties include low self-esteem/respect, and feelings of vulnerability and insecurity. Interpersonal difficulties include difficulty trusting, or overdependence on others (Bagley & Mallick, 2000; Briere & Runtz, 1990; Landsford et al., 2007; Riggs et al., 2007). These self-related and interpersonal difficulties also are characteristic of personality disturbance.

Psychopathology. Research indicates that the DSM disturbances associated with a history of childhood maltreatment include symptoms of PTSD, complex PTSD, and Axis II disorders (Allen, Coyne, & Huntoon, 1998; Courtois, 2004; Landsord et al., 2007). PTSD frequently results from enduring physical, sexual, emotional or other forms of

abuse (Landsford et al., 2007; Riggs et al., 2007). According to the Diagnostic and Statistical Manual of Mental Disorders IV –TR (DSM-IV-TR; APA, 2000), PTSD can occur when an individual has been exposed to an extreme traumatic stressor in which two conditions were present: 1) The direct experience or witnessing of an event involving actual or threatened death or serious injury, and/or learning of an unexpected death, serious harm of a family member or close acquaintance; and 2) The response to the event(s) involved intense fear, helplessness or horror. Symptoms of PTSD are organized into three clusters of re-experiencing the traumatic event(s), avoidance (avoiding places, people, or other things that are reminders of the event), and hyper-arousal (hypersensitivity to normal life experiences). Complete DSM-IV-TR criteria for PTSD are presented in Appendix A.

Children exposed to abuse (sexual and physical) may exhibit an extreme disruption in their emotional experience and become threatened by the unpredictable and uncontrollable nature of their own emotions. The intensity with which emotions are experienced in trauma survivors is associated with difficulties in long-term emotion regulation. Specifically, difficulties include reduced self-efficacy for regulating emotional states and a tendency to negatively evaluate emotional experiences (view emotional experiencing as threatening). Consequently, fear of emotions may act as a motivator in attempting to avoid or over control emotions (Tull, Jakupcak, McFadden, & Roemer, 2007). Avoiding emotions is problematic in terms of self-development, interpersonally (Cloitre, Stovall-McClough, Miranda, & Chemtob, 2004; Tull et al., 2007), and in trauma recovery (Paivio et al., 2009). Avoidance or over control of emotions poses problems in

relation to trauma therapy, as it requires the ability to emotionally process trauma material (Cloitre, Koenen, Cohen, & Han, 2002; Paivio, Hall, Holowaty, Jellis, & Tran, 2001).

Although PTSD has been linked to child abuse experiences (Landsford et al., 2007), the effects of child abuse may be better characterized by a condition known as "Complex PTSD". A diagnosis of PTSD frequently is associated with a single traumatic event. Single traumatic events and reactions to them have been argued to differ significantly from the prolonged and repeated trauma suffered by victims of child abuse (Courtois, 2004). Studies of the specific effects of child abuse trauma have indicated that they are more complex than a single diagnosis of PTSD. This is likely due to the fact that experiencing long-term abuse is more complex than exposure to a single traumatic event. Children exposed to long periods of abuse across developmental time frames suffer from many effects that are not included in PTSD criteria, including depression, anxiety, self-hatred, high-risk behaviours, re-victimization, personality pathology, and interpersonal problems. Experts in this line of study view these characteristics as comprising a separate disorder known as Complex PTSD or Disorders of Extreme Stress not Otherwise Specified (DESNOS) (Herman, 1992; Pelcovitz, van der Kolk, Roth, Mendel, Kaplan, & Resick, 1997). This syndrome is included in the Appendix of DSM-IV-TR (APA, 2000). Aside from symptoms related to PTSD, victims of child abuse often experience alterations in self perception (e.g., low self-esteem, identity disturbance) and perceptions of their perpetrator (e.g., malevolent or idealized), as well as interpersonal and affect

regulation difficulties characterized by Complex PTSD (Courtois, 2004). Specific Complex PTSD criteria as highlighted by Courtois (2004) are outlined in Appendix B.

Victims of chronic abuse, particularly during childhood, are often plagued by a sense of hopelessness in regard to finding anyone who is able to comprehend them or the suffering they have endured. They can exhibit a sense of despair regarding ever being able to recover from their emotional anguish (Courtois, 2004). Consequently, many individuals suffering from Complex PTSD have difficulty forming healthy relationships with others; frequently engage in relationships involving further abuse, victimization and loss (Pearlman & Courtois, 2005). Exposure to prolonged trauma increases disruptions in self-concept, identifying and regulating emotions, and maintaining personal safety. Other long-term effects include alterations in consciousness and self-awareness (e.g. dissociation), and cognitive distortions regarding self worth and motivations of others (Pearlman, 2003). For example, victims of chronic abuse can view themselves as being at fault for the abuse resulting in self-hatred, chronic feelings of guilt, and intense shame. Others can be viewed as self serving and untrustworthy. These perceptions interfere with the formation of healthy relationships and emotional intimacy (Courtois, 2004; Pearlman & Courtois, 2005).

Previous literature also has indicated an association between experiencing child abuse and personality disorders (Allen et al., 1998; Grover et al., 2007). Personality disorders are defined by the DSM-IV-TR as enduring patterns of inner experience and behaviour that deviate from an individual's culture, are pervasive and inflexible, have an onset in adolescence or early adulthood, are stable over time, and lead to distress and

impairment (APA, 2000). Personality pathology is also a component of DESNOS, as disruptions in self and interpersonal functioning are features of both groups of disorders. The ten DSM personality disorders are grouped into three clusters based on similar features. Cluster A is characterized by odd/eccentric features and includes Paranoid, Schizoid, and Schizotypal personality disorders. Cluster B is characterized by dramatic, emotional, and erratic features and includes Antisocial, Borderline, Histrionic, and Narcissistic personality disorders. Cluster C includes Avoidant, Dependent, and Obsessive-Compulsive personality disorders, which are characterized by anxious and fearful features (APA, 2000).

Research suggests that all personality disorders are more prevalent in abuse survivors compared to non-abused groups, with the exception of histrionic, schizotypal, and dependant personality disorders (Grover et al., 2007). Personality disorders may be more prevalent in abuse survivors due to dysfunctional family environments prevalent in both groups. Research indicates that abuse survivors report early family experiences as less supportive and organized, and more isolated. They also report low levels of independence and high levels of family control. Individuals with personality disorders similarly report family environments characterized by high control, conflict, and disorganization, and low levels of expressiveness, independence, and cohesion (Riggs et al., 2007). The majority of personality pathology is more prevalent in abuse survivors, however, borderline, avoidant, and narcissistic personality disorders have been found to be most common (Paivio et al., 2009).

Attachment style. Children who have suffered abuse often develop insecure attachment styles, and a belief that the world is dangerous, others cannot be trusted, and that they are unlovable and therefore vulnerable to abandonment (Herman, 1992). Attachments to primary caregivers are established during the formative years of childhood (Bowlby, 1988). Childhood experiences with caregivers are internalized as working models of the self in relation to others, cognitive-affective expectations, and beliefs that have been shown to influence subsequent behaviour and adult relationships (Marmarosh et al., 2006). Individuals with child abuse histories often internalize negative beliefs regarding self worth, which are characterized by a lack of self-respect and autonomy in relation to others. It has been argued that once the view of the self has been damaged, the sense of agency and power to direct one's own life in relationships is also negatively affected (Herman, 1992). Consequently, this negative view of self and others frequently leads to insecure attachment in adulthood (Muller, Lemieux, & Sicoli, 2001), with many displaying Fearful Avoidant attachment styles (Riggs et al., 2007).

Attachment styles are defined in terms of two underlying dimensions: perceptions or experiences of self (positive-negative) and perceptions of others (positive-negative). This two-dimensional model produces four theoretically possible attachment styles: 1) secure (positive views self and others), 2) preoccupied (negative views of self and positive views of others), 3) dismissing (positive views of self and negative views of others), and 4) fearful (negative views of self and negative views of others) (Bartholomew, 1990). Individuals with secure attachment styles have an integrated sense of self-worth and are comfortable forming intimate relationships (Schafer &

Bartholomew, 1994). Preoccupied adult attachment styles are characterized by coping and emotional regulation strategies that are highly anxious (Mikulincer & Shaver, 2003). Those with preoccupied styles seek a sense of safety by gaining the acceptance and approval of others (Schafer & Bartholomew, 1994). They tend to be vigilant and catastophizing in identifying and evaluating what they perceive as threats. This style has been linked to low self-control and tolerance, and interpersonal dependence/reliance (Mikulincer & Shaver, 2007; Onishi, Gjerde, & Block, 2001). Dismissing–avoidant attachment is characterized by deactivating strategies (Mikulincer & Shaver, 2003). Individuals with this style dismiss dependency needs and emphasize independence as a method of maintaining positive self-regard. Fearful individuals avoid intimacy to avoid the pain of rejection or loss (Schafer & Bartholomew, 1994).

Emotional competence. Alexithymia is an affect regulation difficulty related to problems in identifying and describing emotional stimuli (Murthi & Espelage, 2005; Taylor & Bagby, 2004). Specifically, alexithymic individuals exhibit difficulties identifying and distinguishing among feelings and bodily sensations, difficulties labeling and communicating emotional experience, and externally oriented thinking (Taylor, Bagby, & Parker, 1997). An important developmental process is learning to identify and label internal experiences through social-verbal learning. Experiences of abuse during childhood can disrupt this process (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). Specifically, exposure to trauma early in life, such as sexual and physical abuse, has been linked to affect dysregulation. This appears to be a consequence of excessive stimulation of the central nervous system as a result of trauma exposure. The constant stimulation of

the neural circuits connected to affect arousal is difficult to reduce (Krystal, 1988). Conversely, neglect during formative years has also been linked to alexithymia through under-arousal. Insensitivity and emotional unresponsiveness of a caretaker to a child's needs has been shown to contribute to emotion dysregulation. This is attributed to the child not learning how to label emotions with words, to discriminate their emotions with those of others, and to trust their emotional responses as valid interpretations of events (Linehan & Kehrer, 1993).

Supporting evidence has indicated that individuals with histories of child abuse and neglect were more likely to have greater severity of alexithymia (van der Kolk, Pelcovitz, Roth, Mandel, McFarlene, & Herman, 1996; Taylor & Bagby, 2004; Zlotnick, 1997). Research has shown that alexithymia mediates the relationship between child abuse and self-injurious behaviour (Paivio & McCulloch, 2004) and interpersonal difficulties (Turner & Paivio, 2002). Moreover, certain characteristics of trauma are related to the degree of alexithymia. Specifically, victims of repeated rape are generally more alexithymic than victims of a single incidence (Zeitman, McNally, & Cassiday, 1993). Together these findings suggest that both the developmental stage of the victim and repeated victimization might be more detrimental in terms of alexithymia.

Treatments for the Long-term Effects of Child Abuse Trauma

Treatments for child abuse trauma address the above problems. They highlight the importance of the therapeutic relationship and emotional processing of traumatic memories as change processes (Cloitre et al., 2002; Paivio et al., 2001; Paivio & Pascual-Leone, 2009). Most trauma therapies view the therapeutic relationship as pivotal in

improving difficulties forming and maintaining healthy relationships and difficulties with emotion regulation common in abuse survivors. This relationship becomes a "testing ground" for forming healthy attachment relationships and a safe place to experience, explore, understand, and ultimately resolve maladaptive emotions related to traumatic experiences (Paivio et al., 2009; Pearlman & Courtois, 2005). A strong therapeutic alliance established early in treatment predicts therapeutic outcome across treatment modalities, including short-term cognitive behavioural, interpersonal, psychodynamic, emotion-focused, gestalt, and cognitive therapies (Cloitre et al., 2004; Martin, Garske, & Davis, 2000; Paivio et al., 2009; Paivio & Patterson, 1999). This alliance is particularly important for survivors of child abuse, because they otherwise lack a feeling of safety necessary to share traumatic emotional experiences (Paivio & Shimp, 1998).

Forming a strong therapeutic alliance requires the ability to trust and disclose traumatic experiences. This requirement is difficult for many abuse survivors because interpersonal difficulties may contribute to difficulty forming and maintaining a strong alliance with a therapist (Chemtob, Novaco, Hamada, Gross, & Smith, 1997; Cloitre & Koenen, 2001; Jaycox & Foa, 1996). Specifically, some survivors of child abuse have exhibited difficulty trusting another person with their pain (Turner, McFarlane, & van der Kolk, 1996). The ability to form a strong therapeutic alliance appears to be especially important in short-term therapy. This may be due to the brief period of time available to strengthen weak alliances (Gelso & Carter, 1994). This may be particularly problematic for abuse survivors, due to the aforementioned difficulties. Clients who develop weak alliances are characterized by difficulty maintaining social relationships, poor past family

and current relationships, and problems related to hostility and dominance (Kanninen, Salo, & Punamaki 2000). Short-term treatment models, in general, strive to address these client difficulties, and have shown to be effective for trauma survivors (Cloitre et al., 2002; Paivio et al, 2009; Paivio & Nieuwenhuis, 2001). It is argued that the short duration of therapy minimizes client dependence, maximizes commitment to therapeutic work with an emphasis on clients' strengths, and provides structure and boundaries lacking for many trauma survivors (Jong & Gorey, 1996). Furthermore, the collaborative nature and client control over the process of short-term experiential trauma therapy may avoid certain alliance problems. Empathetically attuned therapists that are able to identify and address client characteristics that contribute to weak early alliance can minimize alliance difficulties in short-term trauma therapy (Paivio & Patterson, 1999).

Emotional processing of traumatic material is believed to be another critical component of trauma therapy. Confronting trauma feelings and memories in a safe environment can help abuse survivors learn to tolerate previously overwhelming feelings and memories. This tolerance fosters the development of a new understanding of past traumatic events (Cloitre et al., 2002, Cloitre et al., 2004; Paivio et al., 2001; Paivio & Nieuwenhuis, 2001).

The "gold standard" model of therapy for complex trauma consists of three main stages (Herman, 1992; Courtois, 2004). The first stage is predominantly devoted to the development of the therapeutic alliance, affect regulation, education about trauma, safety, and skill building. This stage is said to be the most important in terms of outcome. In this stage the therapeutic relationship provides an opportunity to modify negative attachment

experiences. The therapist also assists the client in correcting factors that can lead to retraumatization, including self-destructive behaviours, and dangerous interpersonal circumstances. The therapist also collaborates with the client on skill building in various areas, including regulating emotional states, developing adaptive coping and problem solving skills, and self-care strategies. The second stage is generally undertaken when the client has enough life stability and has learned adequate affect modulation and coping skills. This stage is directed toward the processing of traumatic material typically using exposure-based and narrative procedures that allow the client to tell and retell the story of the trauma. Processing of trauma material in sufficient detail and to a degree of completion and resolution allows the individual to function with less posttraumatic impairment. The third and final stage is targeted toward life consolidation and restructuring, that is, life that is less affected by the original trauma and its consequences. This frequently involves fine-tuning and solidifying self-regulatory skills developed in stage 1 (Courtois, 2004). Regardless of theoretical orientation and specific techniques employed, most treatments for child abuse or complex trauma follow the general structure advocated by Herman and Courtois. Although successful treatments for child abuse trauma exist, individual client characteristics have the potential to interact with therapeutic process and outcome.

Client Characteristics that Influence Therapy Processes and Outcome

Kiesler (1966) highlighted the importance of recognizing patient heterogeneity in psychotherapy research. This recognizes that not all patients suffering from a disorder will respond uniformly to a specific treatment. Previous research has indicated that

certain pre-treatment client characteristics can have negative consequences in relation to therapy outcome. Patient characteristics such as motivation and readiness to change, openness, capacity for self-inspection, and psychological mindedness have been linked to psychotherapy treatment outcome (Bihlar & Carlsson, 2001). Many studies examining pre-treatment client characteristics and outcome have focused on the effects of personality disorders, mental health, and interpersonal problems on the process of therapy. For instance, clients with personality disorders, dysthymic disorder, emotional neglect in childhood, and more adaptive defense styles predicted a greater number of sessions, while Obsessive Compulsive Personality Disorder predicted fewer sessions in long-term dynamic psychotherapy (Perry, Bond, & Roy, 2007). Moreover, individuals with borderline or antisocial features have been shown to exhibit difficulty forming a strong working alliance because of pervasive interpersonal difficulties (Frieswyk et al., 1986). Furthermore, it has been found that pre-treatment interpersonal problems and mental health characteristics negatively affect therapeutic outcome.

Symptom severity, duration of symptoms, and co-morbidity of disorders also have been associated with poorer outcome in a variety of psychotherapies, likely due to difficulty in forming a strong therapeutic alliance (Constantino, Arnow, Blasey, & Agras, 2005; Dew & Bickman, 2005; Paivio & Patterson, 1999). In terms of symptom severity, Marttunen and colleagues (2008) found that increased symptom severity on SCL-90 predicted non-remission of depression in short-term psychodynamic psychotherapy (Marttunen, Valikoski, Lindfors, Laaksonen, & Knekt, 2008). Although there is considerable support for the influence of client variables on therapy processes and

outcome in general, there is less information on the client characteristics that may affect therapy for child abuse trauma in particular.

Client Variables That Could Interact with Trauma Therapy

The long-term effects of child abuse trauma presented above can interact with features of psychological treatments designed to address these effects. These potential client-by-treatment interactions are reviewed in the followings sections. Categories of client variables that interact with features of trauma therapy considered in the present investigation (because of available data) include DSM psychopathology, attachment style, emotional competence, and characteristics of the abuse.

Psychopathology

Literature has suggested that client characteristics such as symptoms of PTSD, complex PTSD, and Axis II pathology have the potential to interact with features of trauma therapy (Courtois, 2004; Dimaggio & Norcross, 2008). In terms of symptoms of *PTSD and complex PTSD*, these may interact with a number of therapeutic aspects. First, some experts believe that individuals suffering from complex PTSD with the associated relational difficulties have difficulty remaining connected in therapeutic relationships. Second, it has been cautioned that exposing these patients too directly to trauma memories in the absence of safety in the therapeutic relationship and the ability to maintain safety in their lives can lead to re-traumatization. Additionally, therapy research has indicated that it is not unusual to have new issues emerge once others have been resolved (Courtois, 2004). For this reason, it has been suggested that treatment for

Complex PTSD may need to be longer in duration, due to self-identity, self-regulatory, and relational deficits.

In terms of *personality pathology*, treating patients suffering from personality disorders can be particularly challenging. Long-standing relational difficulties characteristic of Axis II disturbance can have a negative effect on building a strong therapeutic alliance, cooperating in problem solving, and reasoning in psychological terms (Dimaggio & Norcross, 2008). Furthermore, high dropout rates (35%) (Thormählen, Weinryb, Norén, Vinnars, Bågedahl-Strindlund, & Barber, 2003), and high rates of co-morbidity of personality disorders in abuse victims present further challenges (McGlashan et al., 2000). This does not suggest that therapy is necessarily ineffective for abuse survivors also suffering from personality disorders. For example, dialectical behavioural therapy (DBT), which is a long-term therapy, has proven effective for clients with borderline personality disorder. Following DBT, clients have demonstrated more improvement, lower dropout rates, and fewer days in psychiatric hospitals when compared to psychopharmacological treatment and intermittent supportive psychotherapy (Linehan, 1993).

Attachment and Emotional Competence

Insecure attachment style and difficulties in the area of emotional competence have the potential to negatively interact with features of trauma therapy (Martinez, 2006; McCallum, Piper, Ogrodniczuk, & Joyce, 2003). In terms of *attachment style,* developing the therapeutic relationship has been considered a specialized form of adult attachment,

which is highly influenced by clients' childhood attachment experiences (Bowlby 1988). Research indicates that individuals with "detached avoidant" attachment styles require extensive preliminary work in order to establish the trust essential to develop a strong working alliance with a therapist (Martinez, 2006). Clients with "avoidant fearful" attachment styles exhibited distrust in their therapist, feared rejection, were reluctant to engage in self disclosure tasks, tended to feel humiliated and ashamed during sessions, and reported the poorest working alliance (Mallinckrodt, Gantt, & Coble, 1995). Although the literature on attachment style and child abuse is extensive, there is little research on the link between attachment style and outcome in therapy for child abuse trauma. Because of the high prevalence of insecure attachment styles among abuse survivors (Riggs et al., 2007), and the difficulties that insecure attachment poses to alliance formation (Mallinckrodt et al., 1995), it is possible that insecure attachment styles may be associated with less favourable outcome in this type of therapy. Avoidant attachment styles may be particularly problematic in terms of accessing trauma feelings and memories necessary for effective exposure and emotional processing.

In terms of *emotional competence*, people suffering from high levels of alexithymia have demonstrated less favourable outcomes in both group and individual psychotherapy, particularly in interpretive and supportive therapies (McCallum et al., 2003; Ogrodnikzuk, Piper, & Joyce, 2005). Specifically, difficulties identifying feelings predicted residual symptom severity of depression over and above initial depression and anxiety, medication use, and form of psychotherapy received (Ogrodnikzuk, Piper, & Joyce, 2004). Furthermore, therapist interpretations, specifically those that involve

negative reactions to patients with high levels of alexithymia, have been found to mediate the relationship with outcome (Ogrodnikzuk et al., 2005). Patients with high levels of alexithymia can demonstrate aloofness and indifference towards the therapist and present as dull, frustrating, and boring, due to an inability of emotional interaction. This in turn can elicit negative feelings in the therapist, resulting in behaviour that communicates dislike, frustration, and contempt towards the client (Krsytal, 1979; Ogrodnikzuk et al., 2005). Moreover, alexithymic patients' repetitive and monotonous communications about external events can generate boredom in therapists, which can cause distractibility, and difficulty in concentrating and remaining empathetically attuned to the client (Ogrodnikzuk et al., 2005). Considering the importance of working with emotional experiences in trauma focused psychotherapy and the difficulty that alexithymic patients have processing emotional information, research suggests that treatment requiring emotional experiencing and expression would likely be only partially successful (Ogrodnikzuk et al., 2004).

Characteristics of the Abuse

There are a number of features of childhood abuse, including experiencing multiple types, severity of the abuse, and relationship to the perpetrator, that also could interact with features of trauma therapies and affect treatment outcome. In terms of experiencing *multiple forms of abuse,* research indicates that children in abusive environments are more likely to experience multiple forms of maltreatment (i.e. physical and sexual abuse; sexual and emotional abuse) rather than a single type. Rates of co-occurring physical and sexual abuse range from 17% in community samples, 30% in

outpatient and university samples, and 71% in inpatient adolescent females (Clemmons, Walsh, DiLillo, & Messman-Moor, 2007). Furthermore, emotional abuse in addition to physical and sexual abuse has been shown to have a co-occurrence rate ranging from 35-45% (Mullen, Martin, Anderson, Romans, & Herbison, 1995). Literature also suggests that experiencing multiple forms of abuse predicts poorer mental health outcomes (Bagley & Mallick, 2000). Exposure to multiple forms of abuse is related to an increase in health risk behaviour (e.g. sexual risk behaviour, increased levels of STI's and HIV, alcoholism, and intravenous drug use) (Felitti et al., 1998) and more detrimental psychological effects (e.g. increased depression, more severe PTSD symptoms, lower self-esteem, and higher suicidality) (Lange, De Beurs, Dolan, Lachnit, Sjollema, & Hanewald, 1999). Specifically, experiencing multiple victimization predicted greater internalizing problems (e.g. depression, more severe PTSD, lower social competence, and lower self-esteem) and externalizing problems (e.g. heightened anger) when compared to victims who experienced one type of abuse (Clemmons et al., 2007).

One possible explanation is that experiencing multiple forms of abuse, as opposed to a single form, may be more traumatic and stressful for the child (Rossman & Rosenberg, 1998). Experiencing multiple forms of maltreatment thus increases the severity of trauma symptomatology (Clemmons et al., 2007). More severe trauma symptomatology has been associated with poorer outcome due to difficulty in forming strong therapeutic alliances and difficulties confronting trauma memories in a variety of psychotherapies (Constantino et al., 2005; Dew & Bickman, 2005; Jaycox, Foa & Morral, 1997). Therefore, it stands to reason that clients with histories of multiple forms of abuse

may not demonstrate the same level of improvement in therapy compared to survivors of one form of abuse. To date, the specific additive affect of experiencing multiple forms of abuse, as opposed to one form of abuse, on therapeutic outcome has not been empirically examined.

In terms of *severity of abuse,* research has shown that, at least in terms of child sexual abuse, the severity of the abuse impacts long-term mental health consequences. Specifically, long-term outcomes of sexual abuse are related to the types of sexual acts and violence experienced during the abuse. There tends to be an increase in depressive symptomatology and destructive behaviours as the frequency of contact sexual abuse experiences increase (Clemmons et al., 2007). Severity of physical and emotional abuse also have been associated with more depressive symptoms, and decreased intimacy in relationships (Davis, Petretic-Jackson, & Ting, 2001). Increased severity of sexual, physical, and emotional abuse has been associated with more hallucinations and delusions in adults with schizophrenia spectrum disorders (Clemmons et al., 2007). Furthermore, research indicates that women who experienced more severe sexual abuse demonstrated less improvement in group therapy (Follette, Alexander, & Follette, 1991). To date, only one study has examined the influence of severity of specific types of abuse on treatment outcome in individual therapy. Paivio and Patterson (1999) found that severity of particular types of child abuse and neglect negatively influenced early alliance quality in EFTT but this effect disappeared by the end of therapy and did not influence treatment outcome.

In terms of *perpetrator status,* some research suggests that being abused by a family member may be more traumatic than abuse at the hands of an offender who is not a family member, however, evidence remains mixed. Mother and father figures are generally the offenders in cases of emotional and physical abuse; however, perpetrators of child sexual abuse often do not occupy these parental roles. One line of thought is that the psychological impact may be related to the amount of betrayal involved in the abuse, not necessarily the family relation. For example, abuse perpetrated by a trusted priest may be more detrimental than that perpetrated by a relative due to the amount of betrayal experienced (Browne & Finkelhor, 1986; Russell, 1986). In terms of sexual abuse, experts suggest that incest perpetrated by a father or father figure is more traumatic than sexual abuse at the hands of any other perpetrator (Browne & Finkelhor, 1986; Russell, 1986). One study of outcome in group therapy did not support this hypothesis (Morgan & Cummings, 1999), but, in that study, only father figures versus non father figures were contrasted. Another study noted that although non-parental family members, babysitters, and clergy were also identified as perpetrators, the focus of therapy was often the client's distress concerning non-protective mothers, that is, that mothers did not protect them from the abuse and/or perpetrator (Paivio et al., 2009). The strength and perceived quality of the relationship and the amount of trust, thereby the amount of betrayal involved, was not examined specifically. The relationship between perpetrator status and abuse survivor therapy outcome has not been examined in individual therapy. The amount of betrayal and trust violation may pose specific difficulties in therapy where trust is key in forming a strong therapeutic alliance.

Client by Treatment Interactions

It has been shown that client characteristics can affect treatment outcome (e.g. Barker & Neimeyer, 2003; Bihlar & Carlsson, 2001), however, an important question is *why*. Research has indicated that different client characteristics interact with unique features of different treatment to produce outcome. Critics have argued that some aspects of therapy that lead to change are common to all therapies (Garfield, 1990); however, it has been shown that positive outcomes can be produced by different mechanisms and benefit clients with different characteristics (Stiles, Shapiro, & Elliott, 1986). For example, a 16-week study with hundreds of patients conducted across multiples sites by the National Institute of Mental Health revealed no difference in effectiveness among four different therapies when initial depression severity was disregarded. However, differences did emerge when initial severity of depression was considered. That is, therapies differed in terms of efficacy in treating severely depressed clients, whereas, for clients with lower levels of depression all three therapies appeared equivalent to one another and to the placebo group (Elkin et al., 1989; Shoham-Soloman & Hannah, 1991).

Another study found that clients higher in externalizing behaviours (i.e. acting out, projection) showed more improvement in treatment oriented towards behavioural change (as opposed to insight oriented therapy), whereas, clients higher on reactance (i.e. dominance, control, defensiveness) showed more improvement with nondirective treatment (Beutler, et al., 1991). In another study, client personality style was shown to interact with different career counseling interventions. Specifically, those classified as social and enterprising preferred counseling with little structure and unlimited sessions,

whereas more realistic types preferred structured sessions focused on problem solving (Boyd & Cramer, 1995).

Supportive psychotherapies have been shown to have a lower dropout rate (Verheul & Herbrink, 2007). Therefore, insight-oriented techniques may be contraindicated for patients who lack frustration and anxiety tolerance, impulse control, and are less capable of reality testing (Gabbard, 2000). On the other hand, among those who do possess these capacities, insight-oriented techniques might lead to a break-through in treatment and increase its effectiveness (Verheul & Herbrink, 2007).

Affect regulation difficulties common in survivors of child abuse can interfere with client engagement in exposure-based procedures due to difficulty tolerating distress, managing feelings of anger and anxiety, and vulnerability to dissociation under stress. Increased trauma severity may be linked with increased difficulty in confronting trauma material (Zlotnick et al., 1997), resulting in symptom exacerbation, higher dropout rates, and compliance problems (Cloitre et al., 2002). However, for those who are able to remain in therapy, individual treatments that use techniques of exposure to trauma memories have been shown to have superior long-term outcomes than other therapies (e.g. present-centered, supportive counseling, symptom-focused cognitive behavioural treatment) in reducing affect regulations problems, interpersonal skills deficits, and PTSD symptoms (Cloitre et al., 2002; Cloitre et al., 2004).

Although research supports the existence of client by treatment interactions, little research has systematically examined which client characteristics interact with which

treatments to effect therapy outcome (Baker & Neimeyer 2003), particularly in trauma therapies. This is the question of "What treatment for what client with what particular disorder" (Shoham-Soloman & Hannah, 1991). This is the focus of the present study.

Emotion-Focused Therapy for Trauma

The following section describes the treatment approach that is the focus of the present study. To date, emotion-focused therapy for trauma (EFTT; Paivio et al., 2009) is the only evidence-based individual therapy for men and women who are dealing with different types of childhood abuse experiences (emotional, physical, and sexual). EFTT is grounded in current experiential therapy theory and research, and draws on emotion theory and research, as well as the literatures on attachment and trauma (e.g., Damasio, 1999; Greenberg & Paivio, 1997; Solomon & Seigel, 2002). This type of therapy targets the core affective disturbances, described earlier, that are common across different forms of child abuse. The treatment model posits the therapeutic relationship and "emotional processing" of trauma memories as the primary mechanisms of change.

The therapeutic relationship in EFTT consists of 3 components defined by the working alliance (Horvath & Greenberg, 1989). These are: 1) Client and therapist agreement on goals of treatment, 2) Client and therapist agreement on how to achieve the goals (Task agreement), and 3) Development of a personal bond between the therapist and client. A strong therapeutic alliance is said to be key in ameliorating difficulties forming and maintaining healthy relationships and difficulties with emotion regulation common in abuse survivors. This relationship becomes a "testing ground" for forming

healthy relationships and a safe place to explore painful feelings and memories related to abuse (Paivio et al., 2009; Paivio & Patterson, 1999). As presented earlier, survivors of child abuse often have insecure attachment styles as a result of early attachment experiences (Herman, 1992). Negative representations of the self and others serve as models that influence expectations and behaviour in adult intimate relationships (Paivio & Patterson, 1999). The therapeutic relationship has the potential to counteract the effects of these negative attachment experiences (Mitchell, 1988; Paivio & Patterson, 1999). Research on EFTT found that a strong therapeutic alliance early in therapy was associated with a reduction of trauma symptoms, increased self-acceptance and self-esteem, and resolution of child abuse issues in survivors of child abuse (Paivio et al., 2001; Paivio & Patterson, 1999).

Another a key component of EFTT is emotional processing which involves accessing trauma feelings and memories so they are available for modification through the admission of new information (Paivio et al., 2009). Clients learn to tolerate previously overwhelming experiences and construct a more adaptive view of the self, others, and traumatic events. An imaginal confrontation (IC) intervention is the primary re-experiencing procedure used in EFTT to facilitate emotional processing. During IC, clients imaginally confront the abusive/neglectful other in empty chair and express their thoughts, feelings, and needs directly to the "imagined other". This process is designed to evoke memories of the abuse and facilitate arousal and expression of emotion (Paivio et al., 2009). This technique is based on an empirically verified model that identified steps in the process of resolving interpersonal issues from the past (Greenberg & Foerster,

1998; Greenberg & Malcolm, 2002). One key step in the process involves accessing inhibited adaptive emotions that aid in adaptive functioning (e.g. anger, sadness). This is thought to help modify maladaptive emotions (e.g., fear, shame) and meanings. Appropriate expression of anger at feelings of violation resulting from the abuse is thought to promote assertiveness, self-empowerment, and interpersonal boundary definition. Expression of sadness at loss promotes grieving, acceptance of loss, and accesses self-soothing resources (Paivio et al., 2009). Thus change is facilitated by emotional arousal and the evocation of memories and beliefs about traumatic experiences and the relationship with the other that are then available for exploration and modification. In the imaginal confrontation process, the client develops a more self-affirming and self-empowered stance, as well as a more differentiated perspective of the other, holds the imagined other accountable for perpetrated harm, and may forgive the other (Greenberg & Malcolm, 2002). Research supports both the efficacy (Paivio & Nieuwenhuis, 2001; Paivio et al., 2009) and the posited mechanisms of change (i.e., alliance quality and engagement with trauma material during IC) in EFTT (Paivio et al., 2001).

The construct of experiencing is crucial to emotional processing in EFTT (Paivio et al., 2009). Experiencing refers to how deeply clients are involved in exploring their internal experience, particularly their feelings and the meanings connected to them (Andrusyna, Tang, DeRubeis, & Luborsky, 2001). Depth of experiencing refers to the amount of effort invested by the client in symbolizing, reflecting on, reframing, and incorporating the internal information associated with emotion structures that are

activated through emotional arousal. Experiencing has been associated with positive outcome (Goldman & Greenberg, 1997; Wiser & Goldfried, 1998). However, as previously stated, child abuse experiences are associated with affect regulation difficulties (Zlotnick et al., 1997), including PTSD symptoms (e.g. avoidance) and alexithymia (Murthi & Espelage, 2005; Riggs et al., 2007) that can interfere with client capacity for experiencing.

In order to experience and process trauma, clients must emotionally engage with abuse experiences. Emotional engagement with trauma memories during imaginal confrontation (IC) independently contributed to client change (Paivio et al., 2001). This technique requires the client to express thoughts and feelings about the abuse directly to the "imagined other" in an empty chair. However, research indicated that not all clients substantially participated in IC over the course of therapy (Paivio et al., 2001). Paivio and colleagues (2001) found that 22% of clients did not substantially participate in IC after session four, possibly because of distress, non-assertiveness, and/or social anxiety related to the enactment requirement inherent in the process. This is consistent with low compliance rates reported for other exposure-based procedures (Cloitre et al., 2004; Jaycox, Foa, & Morral; 1998; Scott & Stradling, 1997).

Two versions of EFTT. Because engaging in the IC procedure was observed to be too stressful for some trauma survivors (Paivio et al., 2001), a less evocative and less stressful Empathic Exploration (EE) procedure was developed and its efficacy assessed (Paivio et al., 2009). As noted earlier, the present study uses data from the Paivio et al study evaluating both versions of EFTT. The IC procedure in which clients confront

imagined perpetrators of abuse and neglect in an empty chair was described above. The EE version of EFTT is based on the same model of resolution and intervention as IC. The main difference between the IC and EE procedures is that, in EE, clients express their thoughts and feelings to the therapist as opposed to the imagined abusive/neglectful other. EFTT with EE was found to be equally effective when compared to EFT with IC (Paivio et al., 2009). As well, research supported EE as a less evocative and stressful procedure in that there were lower levels of emotional arousal during EE compared to IC (Ralston, 2007), and a lower dropout rate in EE compared to IC (7% versus 20%) (Paivio et al., 2009).

Research on Client Variables in EFTT

In terms of *demographic characteristics,* research consistently indicates no effects for gender on process and outcome in either version of EFTT thus supporting the intended applicability of EFTT with IC to both men and women (Paivio & Nieuwenhuis, 2001; Paivio et al., 2001; Paivio et al., 2009). Additionally, one study reported no effect for gender in EFTT with EE (Paivio et al., 2009). To date, no studies have examined the effects of other demographic and client variables on outcome in either version of EFTT.

The following section highlights existing research on client variables in EFTT. In terms of *psychopathology*, studies have not found a link between total PTSD symptom severity and outcome (Paivio & Nieuwenhuis, 2001; Paivio et al., 2009). Although Paivio & Nieuwenhuis (2001) reported that clients in EFTT were more avoidant compared to clients in CBT for rape (Foa, Rothbaum, Riggs, & Murdock, 1991), who were higher on

the arousal dimension of PTSD, no studies to date have examined the effects of different symptom clusters.

In terms of personality pathology in EFTT, results are mixed. For example, in one study, presence of Axis II pathology was a significant predictor of alliance difficulties early and late in therapy but this did not negatively affect outcome (Paivio & Patterson, 1999). In another study, presence of an Axis II diagnosis and fewer sessions were associated with limited reductions in global interpersonal problems that tend to be relatively enduring (Paivio & Nieuwenhuis, 2001). This is consistent with previous literature highlighting challenges working with clients with personality disorders (e.g. Dimaggio & Norcross, 2008). Results further indicated that client problems related to anxious over-control of experience did not significantly improve over the course of EFTT with IC (Paivio & Nieuwenhuis, 2001).

In term of *emotional competence*, research on EFTT has shown that alexithymia may influence therapy processes and outcome. Alexithymia was found to interfere with client processes, in that clients reporting more severe alexithymia tended to exhibit lower levels of experiencing (Ralston, 2007). Another study of trauma narratives among undergraduates found that alexithymia was associated with lower depth of experiencing, but not emotion word vocabulary, per se. This suggests that alexithymic clients may exhibit reduced experiencing capacity, which is a core process in EFTT. To date, the effects of attachment style on treatment outcome in EFTT has not been examined.

In terms of *abuse characteristics*, research on EFTT has examined the effects of gender, abuse type, and total severity of maltreatment on treatment outcome (Paivio et al., 2009; Paivio & Nieuwenhuis, 2001; Paivio & Patterson, 1999). Paivio and Patterson (1999) found that severity of particular types of abuse and neglect negatively influenced alliance quality early in EFTT but this effect disappeared by the end of therapy and did not affect outcome. Another study found that total abuse severity was associated with less improvement in self-esteem (Paivio et al., 2001).

Client by treatment interactions in EFTT. Research suggests some differential client-by-treatment interactions in the two versions of EFTT. For example, personality pathology negatively affected outcome in both conditions. In the IC condition more severe personality pathology was associated with more discomfort at post-test. Although this effect was also noted in the EE condition, severity of personality pathology in this condition was also associated with more severe trauma symptoms and higher depression and anxiety. Paivio et al (2009) speculated that one possible explanation is that clients with severe personality pathology show greater improvement in response to more evocative therapy such as the IC condition. Additionally, in the EE condition, more severe trauma symptoms at pre-treatment were associated with higher self-esteem at post-test. To clarify, in the condition where the therapeutic relationship was the main vehicle for change, clients who were highly distressed at pre-treatment reported feeling better about themselves at the end of treatment. This effect was not found in the IC condition.

These aforementioned differences in the two conditions provide support for the aim of the current study, that is, to explore and identify pre-treatment client

characteristics that interact with treatment modality and differentiate good and poor outcome in the two different version of EFTT.

The Present Study

Essential features of EFTT, including forming a strong therapeutic alliance and the capacity to experience and express feelings related to traumatic events, require trust and emotion regulation capacities. Research has highlighted the potential negative impact of particular client variables on therapeutic outcome due to difficulties with alliance formation and confronting and experiencing trauma material (Cloitre et al., 2002; Dew & Bickman, 2005; Paivio et al., 2009). Client demographic characteristics, as well as particular PTSD symptom clusters, attachment styles, and features of the abuse may affect clients' ability to engage in these key therapy processes and therefore benefit from therapy, regardless of the re-experiencing procedure (i.e., IC or EE). Furthermore, previous research (Paivio et al., 2009) suggests that unique features of the two versions of EFTT (with IC or EE) may differentially interact with different client variables, and hence affect outcome.

The present study identified the client variables that characterize best and worst outcome cases in two versions of EFTT employing either the IC or EE re-experiencing procedure. Because the study made secondary use of data already collected, the client variables examined were those assessed in the original study (Paivio & Jarry, 2003) and the sample is small – a subset of the already small total sample of 45 clients who completed one version or the other of EFTT. The present study therefore is exploratory in nature. Nonetheless, examining best and worst outcome cases in two versions of EFTT

can contribute to understanding potentially important client-by-treatment interactions in this type of trauma therapy and generate hypotheses for testing in future research. Specific research questions addressed in the present study are as follows.

1. Do client demographic characteristics differentiate between best and worst outcome in (a) the EE condition, (b) the IC condition, and (c) across the IC and EE conditions?

The present study is the first to examine client age, marital status, education, and employment status in two versions of EFTT. Previous research on EFTT found no effect for gender (Paivio & Nieuwenhuis, 2001; Paivio et al., 2001; Paivio et al., 2009). However, it is possible that clients with a better education, for example, did better is this type of insight-oriented therapy. Another client variable examined for the first time in the present study was anti-depressant medication status (i.e., presence or absence). Anti-depressants are commonly prescribed for this client group (Friedman, Davidson, Mellman, & Southwick, 2000) and could interact with the demands of trauma exploration, either because of co-morbid depressive symptoms or the affective blunting effect of the medication.

2. Does psychopathology differentiate between best and worst outcome in (a) the EE condition, (b) the IC condition, and (c) across the EE and IC conditions?

The present study is the first to examine the effects of specific PTSD symptom clusters and different personality disorders. EFTT has been shown to be effective in reducing total PTSD symptom distress (Paivio et al., 2009; Paivio et al., 2001). However, it is possible that specific PTSD symptoms (i.e., arousal, avoidance, and re-experiencing)

have an influence that is not detected when using global scores. For example, clients experiencing severe arousal symptoms may not do as well in either version of EFTT because of the re-experiencing demands of therapy. Additionally, experiencing predominantly one cluster of symptoms may interact differently with the IC and EE therapeutic conditions. For example, clients experiencing extreme arousal symptoms may benefit least from the more evocative IC condition but this variable may not be a factor in the gentler EE that also provides maximum therapist support.

Severity of personality pathology also has been associated with less improvement in both versions of EFTT, but this was more pronounced in the EE condition (Paivio et al., 2009). However, the effects of different personality profiles have not been examined. It is possible that different clusters of personality disturbance may interact with the different demands of the two conditions. For instance, the anxious/fearful features typical of Cluster C personality disorders may interact negatively with the performance demands of the IC procedure but have no effect in the EE condition.

3. Do attachment style and emotional competence differentiate between best and worst outcome in (a) the EE condition, (b) the IC condition, and (c) across the EE and IC conditions?

The present study is the first to examine the link between different attachment styles and therapy outcome. Adults who have experienced childhood abuse frequently report insecure attachments in their current intimate relationships; particularly avoidant fearful styles (Riggs et al., 2007). As a result, these individuals also can have difficulties forming a strong therapeutic alliance (Martinez, 2006). Research supports the importance

of a strong therapeutic alliance to positive therapeutic outcome in general and EFTT in particular (e.g. Paivio et al., 2001). It is possible that particular styles of attachment (e.g., preoccupied and needy, dismissing and aloof) negatively influence the capacity for alliance formation and thereby influence outcome more than others. Different attachment styles also may interact differently with the two versions of EFTT. For example, clients who are predominantly fearful/avoidant in close relationships may take longer to establish trust, need more support from the therapist, and therefore do less well in the IC condition that demands interacting with imagined others as well as the therapist.

In terms of emotional competence, the present study is the first to examine whether certain aspects of alexithymia affected outcome in the two versions of EFTT. Previous research on EFTT has shown that more severe alexithymia (total score) was associated with lower levels of experiencing which is a key process in EFTT (Ralston, 2006). However, the construct of alexithymia consists of three clusters: difficulty identifying feelings, difficulty describing feelings, and externally oriented thinking (Bagby et al., 1994). Another study found that difficulties identifying feelings, in particular, was associated with lower levels of experiencing in trauma narratives (Le, 2005). This suggests that different features of alexithymia, such as the capacity to identify and label feelings, may interact with the experiencing demands of EFTT.

4. Do abuse characteristics differentiate between best and worst outcome in (a) the EE condition, (b) the IC condition, and (c) across the EE and IC conditions?

The present study is the first to examine the effects of abuse type severity, multiple types of abuse, and perpetrator status in two versions of EFTT. Results

concerning the effects of abuse severity are mixed. Some studies failed to find a link between overall severity of abuse (as measured by a total score on the Childhood Trauma Questionnaire) and overall treatment outcome in either version of EFTT (Paivio & Nieuwenhuis, 2001; Paivio et al., 2009). However, one study found a link between overall abuse severity and less improvement in self-esteem in EFTT with IC (Paivio et al., 2001). Another study of EFTT with IC found that severity of different types of abuse and neglect was associated with early alliance quality (Paivio & Patterson, 1999) but not outcome. However, it is possible that clients experiencing sexual abuse, for example, may do worse in IC which requires confronting imagined perpetrators, but may find the support of the therapeutic relationship in EE particularly helpful.

The present study also is the first to examine the effects of other relevant features of abuse in both versions of EFTT. Features such as experiencing multiple forms of maltreatment and perpetrator status have been associated with increased trauma symptoms, interpersonal problems, and emotion regulation difficulties (e.g. Riggs et al., 2007). Previous research found that severity of trauma, and interpersonal and emotion regulation problems were associated with less favourable outcome due to alliance difficulties (e.g. Constantino et al., 2005; Paivio & Patterson, 1999). It is possible, therefore, that experiencing multiple forms of abuse or abuse at the hands of a primary attachment figure (i.e., a mother), for example, will negatively influence outcome in EFTT. On the other hand, it is possible that directly confronting abusive or neglectful attachment figures in IC, for example, is particularly beneficial.

The following section describes the data used in the present study and the methods used to examine the above questions.

Method

The current study used a subset of archival data from a process-outcome study evaluating EFTT (Paivio & Jarry, 2003). Therefore, the methodology is presented in two sections. Section A presents information regarding procedures, demographics, and measures from the original Paivio & Jarry (2003) study. Results concerning treatment outcome and some client variables have previously been reported (Paivio et al., 2009). Section B presents information regarding measures and procedures used in the current study.

Section A: Methods for Original EFTT Process-Outcome Study

Recruitment

Participants were recruited during the fall of 2002, 2003, and 2004 through newspaper features and advertisements, posters in community clinics, and referrals from local mental health agencies. The study was described as offering individual psychotherapy for men and women who wished to resolve issues related to childhood abuse (emotional, physical, and sexual), and therapy was offered free in exchange for research participation. Written consent was obtained for completion of assessment questionnaires, taping and monitoring of therapy sessions and retention of tapes until completion of adherence checks. The Research Ethics Board of the University of Windsor approved the study.

Exclusion criteria. According to Paivio et al (2009), participants were included on the basis of accepted criteria for short-term insight-oriented therapy (Beutler & Clarkin, 1990). Motivation, capacity to form a therapeutic relationship, and the ability to focus on past child abuse were among the necessary inclusion criteria. Participants were excluded if they were experiencing concurrent problems incompatible with emotion intensification and focus on past child abuse issues, or had a primary issue of emotion dysregulation with risk of harm to self or others. Furthermore, participants were excluded if they had 1) a history of substance abuse or involvement in a violent relationship within the past year, 2) incompatible diagnosis (e.g., bipolar, psychosis), 3) a Global Assessment of Functioning (GAF; DSM-IV-TR; APA, 2000) score less than 50, 4) were under 18 years of age, 5) were receiving an alternate psycho-social treatment, 6) were on unstabilized anxiolitic/antidepressant medication (e.g., dose change within the past two months), or 6) had no conscious memories of child abuse.

Screening and Assessment. Graduate students in clinical psychology who were trained in clinical assessment conducted screening and selection interviews. These individuals also were specifically trained (by Dr. Paivio) in conducting screening and selection interviews for the Paivio and Jarry (2003) study and in administering the *PTSD Symptom Severity Interview* (PSSI; Foa, Riggs, Dancu, & Rothbaum, 1993). Participants who approached the clinic (n = 163) were contacted via telephone, and exclusion criteria were assessed through a standardized script (see Appendix C). The most frequent reason for exclusion was participation in another psychosocial treatment. For those not excluded by initial contact (n = 87), a 90-minute, semi-structured selection interview was

administered, which included questions assessing compatibility with the therapy; mental health, interpersonal, and abuse history; as well as current symptoms, level of functioning, and diagnoses assigned by professionals in the community (see Appendix D). The PSSI (Foa et al., 1993), described in the measures section below, also was administered as part of the selection interview. Following selection interviews, 75 individuals were invited to participate in the study; 19 declined participation due to scheduling difficulties and no longer being interested in participation. The remaining 56 participants immediately began therapy. Of clients that began therapy, 11 withdrew before completion of therapy, resulting in 45 clients who completed therapy -- 20 clients in the IC condition and 25 in the EE condition.

Demographics

The majority of participants were of European origin (88.9%; $n = 40$). About half of participants were female (53.4%; $n = 24$), married or common law (48.9%; $n = 22$), and were employed full time (53.3%; $n = 24$). The majority of participants were in their mid forties ($M = 45.62$, $SD = 12.99$) and more than half had completed some form of post-secondary education (60%; $n = 27$).

Although many participants reported histories of multiple maltreatment experiences (66.7 %; $n = 30$), the majority (55.6%; $n = 25$) identified sexual abuse as the primary focus of therapy. Emotional abuse was identified as the primary focus by 22.2% ($n = 10$) of participants, followed by physical abuse (13.3%; $n = 6$), and emotional neglect (8.9%; $n = 4$). Experiences of sexual abuse ranged from a single episode of molestation by an uncle, to repeated paternal rape and incest, to recurring victimization

by several perpetrators. Experiences of emotional abuse included verbal derogation by a caregiver, threats of harm, and being witness to extreme family violence. Physical abuse experiences ranged from harsh physical discipline to beatings that resulted in injury and required medical attention. Emotional neglect involved failure to provide basic needs for attention, protection, and support. Fathers or father figures were identified as primary perpetrators of abuse in almost half of all cases (44.4%; $n = 20$), followed by mothers (31.1%; $n = 14$), babysitters and clergy (13.3%; $n = 6$), relatives (6.7%; $n = 3$), and brothers (4.4%; $n = 2$). All participants identified unresolved issues with attachment figures (parents) as the focus of therapy, regardless of who was identified as the abuse perpetrator (Paivio et al., 2009).

The following information was previously reported in Paivio et al. (2009). Scores on the *Childhood Trauma Questionnaire* abuse subscales (CTQ; Bernstein & Fink, 1993), described in the measures section below, were all above thresholds for severe abuse (Bernstein & Fink, 1993; Paivio et al., 2009). More than half of participants met PTSD criteria (62.2%; $n = 28$), with most experiencing moderate symptom distress on the PSSI (Foa et al., 1993). Furthermore, approximately one third of participants (31.1%; $n = 14$) met criteria for personality pathology on the *Personality Diagnostic Questionnaire – Fourth Edition* (PDQ4; Hyler, 1994) including Avoidant (68 %; $n = 31$), Borderline (36 %; $n = 16$), and Narcissistic personality disorders (20 %; $n = 9$). The majority of participants (87%; $n = 39$) previously had received some form of psychosocial treatment, and 24.4% ($n = 11$) were stabilized on a course of antidepressant medication. Furthermore, there were no significant differences between the IC and EE groups in

terms of age, numbers of children, gender, ethnicity, marital status, income, education, employment status, type of abuse focus, presence of Axis II pathology, and PTSD diagnosis.

Dependent Measures

The following section outlines the dependent measures administered to clients in the original process-outcome study (Paivio & Jarry, 2003).

The *Symptom Checklist-90-Revised* (SCL; Derogatis, 1983) is a 90 item self-report measure that assesses distress experienced over the past 7 days. The 9 subscales are 1) somatization, 2) obsessive compulsive, 3) interpersonal sensitivity, 4) depression, 5) anxiety, 6) hostility, 7) phobic anxiety, 8) paranoid ideation, and 9) psychoticism. In addition, 3 global scores are also produced: 1) global severity index (GSI), 2) positive symptom distress index (PSDI), and 3) positive symptom total (PST). Clients rate items on a 5-point Likert scale (0 = *not at all*, 4 = *extremely*). Derogatis (1983) reported subscale internal consistencies ranging from .77 for psychoticism to .90 for depression, and test–retest reliabilities over one week between .80 and .90.

The *State-Trait Anxiety Inventory* (Speilberger, Gorsuch, & Lushene, 1970) consists of two twenty-item subscales: one measuring state anxiety (anxiety that is experienced by a person at the moment) and the other measuring trait anxiety (anxiety generally experienced by the person). Clients rate items in the state anxiety subscale (e.g., "I feel calm") on a 4-point Likert scale ranging from 1 (*not at all*) to 4 (*very much so*) and rate items in the trait anxiety subscale (e.g., "I feel nervous and restless") on a 4-point Likert scale ranging from 1 (*almost never*) to 4 (*almost always*). Both scales of the STAI

have good internal consistency, with alphas ranging from .83 to .92 and from .86 to .92 respectively (Speilberger et al., 1970), and adequate 30-day test-retest reliability in high school students (rs > .71; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983).

The *Beck Depression Inventory-II* (BDI; Beck, Brown, & Steer, 1996) consists of 21 items that assess depression symptoms over the past 2 weeks based on DSM-IV-TR. Clients rate each item on a 4-point scale (0 to 3 increasing severity). Alpha coefficients of .92 for an outpatient population have been reported, as well as one-week test-retest reliability as .93 (Beck et al., 1996).

The *Rosenberg Self Esteem Scale* (RSE; Rosenberg, 1989) consists of 10 items that assess self-worth on a 4-point Likert scale (0 = *strongly disagree*, 3 = *strongly agree*). It has test-retest reliability ranging from .82 to .88 and alphas ranging from .77 to .88 (Rosenberg, 1989). Internal reliability has also been reported as 0.75 (Kugu, Akyuz, Dogan, Ersan, & Izgic, 2006).

The *Inventory of Interpersonal Problems* (IIP: Horowitz, Rosenberg, Baer, Ureno, & Villesenor, 1988) consists of 127 items that assess distress from interpersonal sources during the past 7 days. Clients rate, on a 5-point Likert scale (0 = *not at all*, 4 = *extremely*), the degree of distress experienced. The IIP has a test-retest reliability of .98 and internal consistency of .94 for the total scale, and agreement with other measures of improvement. Specifically, it was found to have a correlation of .74 with the Global Outcome Rating Scale, the Symptom Checklist Revised, and the Global Assessment Scale (Horowitz et al., 1988). Furthermore, alphas for the 8 subscales have also been reported (domineering/controlling = .77, vindictive/self-centered = .80, cold/distant = .81,

socially avoidant = .85, nonassertive = .85, exploitable/overly accommodating = .82, overly nurturant/self-sacrificing = .76, intrusive/needy = .72) (Alden, Wiggins, & Pincus, 1990).

The *Resolution Scale* (RS; Singh, 1994) consists of 11 items that assess the degree to which clients feel troubled by negative feelings and unmet needs, 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*). It has test-retest reliabilities (over one month) of .81 with a clinical sample. Paivio (2001) reported alpha reliability with an EFTT sample (n = 51) as .82. The majority of clients (92 %; n = 41) 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 concerned a secondary other that was typically identified as a non-protective or neglectful mother. Means of the two RS scores, indicating resolution of childhood maltreatment issues, were used.

The *Target Complaints (Discomfort) Scale* (TCD; Battle et al., 1966) identifies the 3 problems clients wish to focus on in therapy. Clients rate on a 13-point scale (1 = *none* to 13 = *couldn't be worse*) the degree of discomfort on each problem. The TCD has a test-retest reliability of .68 and high correlations with other outcome measures provided validity evidence. The types of problems identified by clients in the present study included unresolved feelings about childhood abuse, negative self-esteem, interpersonal difficulties, emotion regulation problems, and symptom distress.

The *Impact of Event Scale* (IES; Horowitz, 1986) consists of 15 items that assess intrusion and avoidance symptoms in relation to a specific trauma. The frequency of each

symptom experienced during the past week is rated on a 4-point Likert scale (0 = *not at all*, 3 = *often experienced*). Alpha coefficients range from .86 to .89 for the intrusion subscale and .88 to .90 for the avoidance subscale (Zilberg, Weiss, & Horowitz, 1982), and a factor analysis (Weiss & Marmar, 1997) supported the construct validity of the measure.

Client Predictor Measures

The following section describes the client predictor measures that were administered to clients in the original process-outcome study (Paivio & Jarry, 2003).

The *PTSD Symptom Severity Interview* (PSSI; Foa, Riggs, Dancu, & Rothbaum, 1993) consists of 17 items that correspond to DSM-IV criteria PTSD. Severity of symptoms over the preceding two 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, and scores on symptom clusters of avoidance, arousal, and re-experiencing. Internal consistencies for the subscales range from .65 (avoidance), .69 (re-experiencing), to .71 (arousal). Test-retest reliabilities for the total score, after a one-month interval, were .80. The test-retest correlations for the subscales ranged from .66 (re-experiencing), .76 (avoidance), .77 (arousal). The PSSI has an inter-rater reliability of 95%, intraclass correlations ranging from .93 to .95 for the cluster scores and .97 for the total severity score. It also has significant correlations with other measures of psychological distress, including the Beck Depression Inventory (.72), Impact of Events intrusion subscale (.69), and avoidance (.56) (Foa et al., 1993).

The *Personality Diagnostic Questionnaire–Fourth Edition (*PDQ4; Hyler, 1994) consists of 99 items (True/False) that correspond to DSM-IV criteria for twelve personality disorders. It is a screening tool for the presence of Axis II pathology, which allows for screening of multiple disorders (Hyler, Skodol, Kellman, Oldham, & Rosnick, 1990). It has internal consistencies ranging from .46 to .74, and correlations with semi-structured interviews ranging from .20 to .40 (Fossati et al., 1998). Internal consistency in the current sample is .83. Total scores greater than 50 on the PDQ-4 indicate the presence of personality pathology.

The *Childhood Trauma Questionnaire* (CTQ; Bernstein & Fink, 1993) is a 28-item retrospective measure that assesses the frequency and severity of different types of abuse (sexual, physical, emotional) and two types of neglect (emotional and physical). 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 as well as subscale scores for individual forms of abuse. It has internal consistency ranging from .84 to .96, test-retest reliability, after 3.6 months, ranging between .80 and .88, and associations between the CTQ and measures of distress (Bernstein et al., 2003). It also has discriminant validity with measures of social desirability.

The *Attachment Style Questionnaire* (ASQ; Feeney, Noller, & Hanrahan, 1994) is a 40 item self-report questionnaire. The five subscales are rated on a 6 point scale (1= totally disagree/6=totally agree), which assess 1) Confidence (secure), 2) Discomfort with Closeness (Avoidant), 3) Relationships as Secondary (dismissing), 4) Need for Approval

(anxious/ambivalent), 5) Preoccupation with Relationships (Fearful/preoccupied). It has adequate internal consistency (a = .76 -.84), with test-retest reliability of the scales ranging from .67-.78 (Feeney, 1994). It also has shown good discriminant validity with measures of parental bonding (Fossati et al., 2003).

The *Toronto Alexithymia Scale* (TAS-20; Bagby, Parker, & Taylor; 1994) is a 20-item questionnaire assessing three factors on a 5-point scale (1=never true; 5=very often true). The three factors are 1) Difficulties identifying and distinguishing among feelings, 2) Difficulties describing or communicating feelings, and 3) Externally oriented thinking. The TAS has good internal consistency (.81), and test-retest reliability (r= .77).

Therapists and Treatment Conditions

Therapists (7 women and 4 men) were one masters level and six doctoral level students in Clinical Psychology, and four post-doctoral psychologists who ranged in age from 25 to 57 years. All therapists had previous clinical experience with this client group. Therapists participated in approximately 39 hours of training over a 26-week period conducted by the principle investigator. This included reviewing the treatment manual (Paivio & Pascual-Leone, 2009), discussing videotaped therapy segments from expert therapists, and role-playing.

Procedure

Self-report questionnaires were administered at pre-, mid- (after session 8), post-treatment, and follow-up in the original process-outcome study (Paivio & Jarry, 2003). The PSSI was conducted at pre, mid, and post-test. Predictor measures were administered

at pre-treatment. Clients were assured, verbally and in writing, that information on self-report questionnaires would be kept confidential from each client's respective therapist.

Clients were assigned to therapists based on scheduling compatibility. Clients were randomly assigned to the IC or EE treatment condition (coin toss by the supervisor) after session three and before the introduction of the IC and EE procedures in session four. Therapists also were assigned to equal numbers of clients in both treatment 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. Therapists participated in weekly individual and group supervision, including reviewing videotaped therapy sessions and team meetings. All therapies were monitored for adherence by the principle investigator who also saw four clients and conducted weekly supervision of 71% of the cases. Weekly supervision of the remaining 29% of cases was carried out by one of the co-authors. Both supervisors were registered psychologists with more than 20 years each of clinical experience.

Section B: Method for the Current Study

The following section describes the measures and procedures used in the current study, including measures used to classify best and worst outcome groups, and the data analysis plan.

Measures Used to Assess Best and Worst Outcome

The following dependent outcome measures used in original process-outcome study (Paivio & Jarry, 2003) and described above were used in the current study to identify best and worst outcome groups in the two treatment conditions (see Appendix E). The GSI on the *Symptom Checklist-90-Revised* (SCL: Derogatis, 1983), as well as total scores on the *Beck Depression Inventory* (BDI; Beck et al., 1996), the *State-Trait Anxiety Inventory* (Speilberger et al., 1970), the *Impact of Event Scale* (IES; Horowitz, 1986), the *Target Complaints (Discomfort) Scale* (TCD; Battle et al., 1966), the *Rosenberg Self Esteem Scale* (RSE; Rosenberg, 1989), the *Inventory of Interpersonal Problems* (IIP; Horowitz et al., 1988), and the *Resolution Scale* (RS; Singh, 1994).

Client Predictor Measures

The following client predictor measures (see Appendix F) administered in the original process-outcome study (Paivio & Jarry 2003) were used in the present study to differentiate between best and worst outcome. Measures are organized according to particular client variable dimensions.

Demographics. The present study will report all demographic information for clients in the sample (gender, age, marital status, number of children, education, and family income).

Psychopathology. The *PTSD Symptom Severity Interview* (PSSI; Foa et al., 1993), described above, yields a total severity score, and scores on symptom clusters of avoidance, arousal, and re-experiencing. Paivio et al (2009) found no effect for the total severity of PTSD. The present study is the first to examine specific symptom clusters that differentiated the best and worst outcome groups.

The *Personality Diagnostic Questionnaire*–Fourth Edition (PDQ4; Hyler, 1994) consists of a total score and scores on 12 personality disorders. Paivio et al (2009) found that total severity on the PDQ-4 negatively effected outcome, particularly in the EE condition. The present study is the first to examine whether particular personality disorders differentiated between best and worst outcome in the two versions of EFTT.

Attachment and Emotional Competence. The *Attachment Style Questionnaire* (ASQ; Feeney et al., 1994) was used in the present study to examine whether particular attachment styles differentiated between best and worst outcome in the two treatment conditions. Specifically, the subscales of confidence (secure), discomfort with closeness (avoidant), relationships as secondary (dismissing), need for approval (anxious/ambivalent), preoccupation with relationships (fearful/preoccupied) were used.

The *Toronto Alexithymia Scale* (TAS-20; Bagby et al., 1994) was used to assess whether specific aspects of alexithymia, highlighted by the three TAS subscales (difficulties identifying and distinguishing among feelings, difficulties describing or communicating feelings, and externally oriented thinking), interacted with treatment modality to affect outcome.

Abuse characteristics. The *Childhood Trauma Questionnaire* (CTQ; Bernstein et al., 2003) yields a total severity score as well as scores on three different types of abuse

(emotional, physical, sexual) and two types of neglect (emotional, physical). Paivio et al. (2009 reported no effect for total severity. The present study is the first to examine severity by type of abuse (sexual, physical, emotional).

The present study also examined the effects of experiencing multiple forms of maltreatment and the clients' relationship to the perpetrator. These data were obtained from assessment and screening interviews.

Procedures

As previously stated, the current study used archival data from a large process-outcome study examining two versions of EFTT (Paivio & Jarry, 2003). Best and worst outcome groups in each of the treatment conditions (EFTT with IC and EFTT with EE) were created based on client scores on the eight dependent measures described earlier.

First, effect size estimates were calculated for each dependent measure. For seven measures the lower post-treatment scores (indicating lower disturbance) were subtracted from the higher pre-treatment scores (indicating higher levels of disturbance). On the other hand, for the *Rosenberg Self-Esteem Scale* (Rosenberg, 1989), the lower pre-treatment score (indicating low self-esteem) was subtracted from the higher post-treatment score (indicating higher self-esteem). For all measures, the resultant difference score was divided by the pooled (average of pre and post) standard deviation for each measure.

Second, all of the effect sizes for each client were added to create an overall effect size to indicate the total amount of change.

Third, the distribution of the total overall effect sizes for all clients was graphed (see Appendix G) and visually examined to determine best and worst outcome groups for

both treatment conditions. Research on extreme group comparison has suggested using the top and bottom third of the distribution (Preacher, Rucker, MacCallum, & Nicewander, 2005). Therefore, in the present study the best and worst outcome groups for the IC condition (n = 20) consisted of 7 clients, each. In the EE condition (n = 25), the best and worst outcome groups consisted of 9 clients, each.

Data Analytic Strategy

Design

The current study used an extreme groups design to examine pre-treatment client characteristics that differentiate between best and worst outcome groups in a sample of trauma survivors who received two versions of EFTT. Generally, the use of the extreme group method is recommended for exploratory research in which the focus is to assist with detecting trends and guiding future studies (Preacher et al., 2005). Extreme group designs were developed to reduce the sample size necessary to observe an effect without compromising statistical power (Abrahams & Alf, 1978; Alf & Abrahams, 1975; Feldt, 1961; Peters, 1941). This design enables the examination of large amounts of descriptive data to arrive at a detailed picture of each group and to compare the groups in terms of variables of interest. Since the present study was descriptive and exploratory in nature, had a small sample size and a large number of variables, an extreme group comparison design was thought to be appropriate. The two stages in this method are (1) measures on a first variable (outcome measures in the current study) for subjects in the sample are obtained and on the basis of those scores, high and low outcome subgroups are isolated, and (2) scores for a second variable (pre-treatment client characteristics in the present study) are obtained for members of the high and low subgroups (Abrahams & Alf, 1978;

Garg, 1983). If a relationship exists between outcome status and the pre-treatment client characteristics, this relationship will be reflected in differences between the high and low subgroups on assessed client variables (Abrahams & Alf, 1978). Advantages and disadvantages of this approach have been highlighted in the literature, and are presented below.

Advantages

One of the benefits of extreme group comparisons, as opposed to other analyses such as multiple correlations, is the potential to examine a large number of variables in a small sample. In order to use correlational analyses, multiple correlations would have to be examined, therefore, the risk of potential Type I error would be increased. By using a group comparison strategy, increase in the error rate is reduced.

As stated earlier, extreme group designs also reduce the sample size necessary to observe an effect without compromising statistical power (Abrahams & Alf, 1978; Alf & Abrahams, 1975; Feldt, 1961; Peters, 1941). Because the scores in the best and worst groups are now more extreme, the power of subsequent tests is maximized (Preacher et al., 2005). Research shows that statistical power is generally enhanced after extreme group analysis relative to no extreme group selection (Preacher et al., 2005). This is of particular importance for detecting effects in the current study in light of the small sample size.

Limitations

The use of extreme groups does have limitations. First, group comparisons do not provide as much information as correlations, such as the direction and strength of a relationship among variables. No inferences can be drawn in regards to the strength of

these relationships (Feldt, 1961; Pitts, 1993). However, once the characteristics of interest are examined, additional analyses can be run on variables of interest.

Second, extreme-groups designs may use non-representative levels of continuous variables, which can result in the overestimation of the importance of the predictors, in this case, the client characteristics (McClelland & Judd, 1993). That being said, the purpose of the current study was to detect trends in pre-treatment client characteristics of abuse survivors that have not previously been examined. Findings are meant to guide future studies.

Third, extreme group designs involve the assumption that the relationship between the outcome and predictors (client characteristics) across the range of values of the outcome variable(s) is the same as that in the extreme groups (Preacher et al., 2005). However, the true function relating the predictor variables to the outcome variables could be nonlinear in a variety of ways (McNemar, 1960). When the possibility of a nonlinear relationship cannot be dismissed, extreme group analysis should not be used (Feldt, 1961). Violations of linearity were not a concern in the present study given its exploratory and descriptive nature.

Fourth, assigning individual scores to arbitrary groups can be problematic due to the fact that it involves making possibly unwarranted assumptions about the accuracy of group assignment, group size, and the stability of group membership (Preacher et al., 2005). It should be noted that the present study attempted to protect against arbitrary group assignment. Specifically, extreme groups were created by computing effect size estimates from change scores on eight different measures of symptom distress. This

procedure, which is described in a later section, can increase confidence in the accuracy of individual group assignment.

Finally, extreme group designs assume that extreme scores in the sample represent the extreme values in the population (Campbell & Kenny, 1999). It is possible, however, that the cases in the extreme groups in one instance may not be in the extremes if sampled at another time. Therefore, statistically significant findings may be the result, at least in part, of regression to the mean (Preacher et al., 2005). As previously stated, findings of the current study are meant to provide directions for future research on the effect of pre-treatment client variables on therapeutic outcome.

Analyses

Differences between best and worst outcome groups, both within and across conditions, were assessed based on three criteria. First, for each predictor variable, the number and percentage of clients in the best and worst outcome groups was calculated. Second, if the difference between the best and worst groups was at least double in terms of number or percentage, *t* tests or chi squares analyses were conducted to compare the groups. Third, *p* values ranging from .06 to .1 were considered to be trends, whereas *p* values less than or equal to .05 were considered to be statistically significant. Due to the nature of the study being exploratory, no adjustments for error were made.

Results

The first set of research questions concerned whether client characteristics (demographics, psychopathology, attachment style and emotional competence, and abuse characteristics) differentiated between best and worst outcome groups in each treatment condition. Results concerning this set of questions are presented in the following sections, beginning with the EE condition

The Evocative Empathy Condition

The first research question was "Do demographic characteristics differentiate between clients who did best and worst in each treatment condition?" Results concerning demographic characteristics for clients in the EE condition are presented in the section below.

Demographic Characteristics of Clients in the EE Best versus EE Worst Outcome Groups

Table 1 presents demographic information for clients in the best and worst outcome groups in the EE condition.

Table 1
Demographics of EE Best and Worst Outcome Groups

Variable	Best Outcome		Worst Outcome	
	N	Mean (*SD*) % Yes	N	Mean (SD) % Yes
Gender				
Male*	3	33.3 %	7	77.8 %
Female*	6	66.7 %	2	22.2 %
Age		41.56 (10.38)		44.78 (4.59)
Ethnicity				
Anglo	7	77.8 %	8	88.9 %
Other	2	22.2 %	1	11.1 %
Marital Status				
Single**	0	0	4	44.4 %
Common Law	2	22.2 %	0	0
Married	4	44.4 %	4	44.4 %
Separated/Divorced	3	33.3%	1	11.1 %
Widowed	0	0	0	0
Children	8	88.9 %	5	55.6 %
Education				
High School	4	44.4 %	2	22.2 %
Undergraduate	5	55.6 %	4	44.4 %
Graduate	0	0	3	33.3 %

Table 1 (Continued)
Demographics of EE Best and Worst Outcome Groups

Variable	Best Outcome		Worst Outcome	
	N	Mean (*SD*) % Yes	N	Mean (SD) % Yes
Employed	8	88.9 %	7	77.8 %
Income				
<$20,000	4	44.4 %	1	11.1 %
$20-39,000	0	0	2	22.2 %
$40-59,000	2	22.2 %	1	11.1 %
>$60,000	3	33.3 %	5	55.6 %

Note: n *EE = 18,* n *EE best = 9,* n *EE worst = 9; ** p<. 05; *p < .10.*

Overall, as indicated in Table 1, the best and worst outcome groups in the EE condition were not vastly different in regards to demographics. The average age range for both good and poor outcome clients was early to mid forties. The majority of clients in both groups identified as being of European decent, reported having one or more children, being employed full time, and having some education beyond high school. Although reported income for the two client groups varied, there were no obvious differences in the distribution for the groups on this dimension.

In terms of gender, there was a trend for the *best outcome group* to be comprised mainly of females, x^2 (1, N = 18) = 3.600, p = .058. Although not significant, there also was a trend for gender in the *worst outcome group*, which was comprised mainly of males, x^2 (1, N = 18) = 3.600, p = .058.

In terms of marital status, clients in the *worst outcome group* were significantly more likely to be single, x^2 (1, N = 18) = 5.143, p = .023 compared to clients in the best outcome group.

Psychopathology for Clients in EE Best versus EE Worst Outcome Groups

The second question in the current study was "Does psychopathology differentiate between clients who did best and worst?" Results regarding PTSD symptom clusters, specific personality disorders, and medication status of clients who did best and worst in EE are presented below and in Table 2.

Table 2
Psychopathology Measures for Clients in the EE Best versus the EE Worst Outcome Groups

Variable Name	Best Outcome		Worst Outcome	
	N	Mean *(SD)* % Yes	N	Mean *(SD)* % Yes
PTSD[1]				
Diagnosis	6	66.7 %	4	44.4 %
PSSI Total		27.92 (9.32)		18.78 (15.36)
Re-experiencing		7.47 (3.77)		4.44 (4.48)
Avoidance		13.95 (4.79)		8.89 (7.61)
Arousal		7.88 (2.43)		6.22 (5.38)
Personality Pathology[2]				
Axis II Diagnosis (score > 50 on PDQ-4)	4	44.4 %	4	44.4 %
Paranoid	7	77.8 %	5	55.6 %
Histrionic	1	11.1 %	0	0
Antisocial	0		2	22.2%
Obsessive	7	77.8 %	7	77.8 %
Negativistic	2	22.2%	5	55.6 %
Schizoid**	1	11.1 %	5	55.6 %
Narcissistic	1	11.1 %	3	33.3 %
Avoidant	8	88.9 %	8	88.9 %
Depressive	6	66.7 %	7	77.8 %

Table 2 (Continued)
Psychopathology Measures for Clients in the EE Best versus the EE Worst Outcome Groups

Variable Name	Best Outcome		Worst Outcome	
	N	Mean *(SD)* % Yes	N	Mean *(SD)* % Yes
Schizotypal	4	44.4 %	6	66.7 %
Borderline	3	33.3 %	5	55.6 %
Dependent*	0	0	3	33.3 %
Medication Status	1	11.1 %	4	44.4 %

Note: n *EE = 18,* n *EE best = 9,* n *EE worst = 9;* [1]*PTSD = PTSD Symptom Severity Interview (PSSI);* [2]*PDQ-4 = Personality Diagnostic Questionnaire; ** p<. 05; * p<.1.*

PTSD. Table 2 indicates that clients in the EE best and worst outcome groups did not differ in regards to PTSD symptom clusters.

Personality disorders. Table 2 indicates differences between clients who did best and worst in regards to specific personality disorders. Specifically more than double the number of clients in the *EE worst outcome group*, compared to the best outcome group, met screening criteria on the PDQ – 4 (Hyler, 1994) for antisocial ($n = 2$ versus $n = 0$), negativistic ($n = 5$ versus $n = 2$), and narcissistic ($n = 3$ versus $n = 1$) personality disorders. However, these differences were not statistically significant.

However, clients in the *EE worst outcome group* were significantly more likely than clients who did best in this condition to meet PDQ-4 criteria for schizoid personality disorder, x^2 (1, N =18) = 4.000, p = .046. There also was a trend for more clients in the *worst outcome group* to meet PDQ-4 criteria for dependent personality disorder, x^2 (1, N =18) = 3.600, p = .058.

Medication status. In terms of medication status, although the majority of clients in both EE outcome groups reported not being on psychotropic medication, Table 2 indicates that more clients in the *worst outcome group*, compared to clients in the best outcome group ($n = 4$ versus $n = 1$) reported a positive status on this dimension.

Attachment Style and Emotional Competence for Clients in EE Best versus EE Worst Outcome Groups

The third research question was "Does attachment style or emotional competence differentiate between clients who did best and worst?" Table 3 presents mean scores on the attachment style and alexithymia subscales for clients in EE.

Table 3
Attachment Style and Emotional Competence for Clients in the EE Best versus EE Worst Outcome Groups

Variable	Best Outcome Mean *(SD)*	Worst Outcome Mean *(SD)*
Attachment Style		
Confidence	27.32 (4.14)	29.11 (5.06)
Discomfort with Closeness	42.56 (3.17)	42.33 (3.20)
Need for Approval	29.0 (4.61)	29.11 (6.99)
Preoccupied with Relationships	34.0 (4.53)	34.0 (5.98)
Relationships as Secondary	18.0 (4.21)	22.33 (6.21)
Total Insecure	123.56 (10.89)	127.78 (16.28)
Alexithymia		
Difficulty Identifying Feelings	23.56 (5.59)	20.78 (5.12)
Difficulty Describing Feelings	17.89 (4.59)	17.33 (4.85)
Externally Oriented Thinking	21.78 (2.73)	22.56 (4.36)

Note: n *EE = 18,* n *EE best = 9,* n *EE worst = 9*

As shown in Table 3, no differences were observed between clients in the EE best and worst outcome groups in terms of either attachment style, as measured by the ASQ (Feeney et al., 1994), or the alexithymia subscales on the TAS-20 (Bagby et al., 1994).

Characteristics of Abuse for Clients in EE Best versus EE Worst Outcome

The fourth question asked by the current study was "Do abuse characteristics differentiate between clients who did best and worst?" Table 4 presents abuse characteristics of clients who did best and worst in EE.

Table 4
Abuse Characteristics for Clients in the EE Best versus EE Worst Outcome Groups

Variable	Best Outcome		Worst Outcome	
	N	% Yes	N	% Yes
Perpetrator				
Parent	8	88.9 %	7	77.8 %
Father	3	33.3 %	6	66.7 %
Mother**	5	55.6 %	1	11.1 %
Brother	0		1	11.1 %
Other	1	11.1 %	1	11.1 %
Severity on the CTQ[1]				
Sexual Abuse**	7	77.8 %	2	22.2 %
Physical Abuse	6	66.7 %	6	66.7 %
Emotional Abuse	6	66.7 %	5	55.6 %
Neglect	6	66.7 %	5	55.6 %
Multiple Abuse Types	7	77.8 %	5	55.6 %

Note: n EE = 18, n EE best = 9, n EE worst = 9; [1] *CTQ = Childhood Trauma Questionnaire; ** p<. 05.*

As indicated in Table 4, some aspects of abuse characteristics did differentiate between best and worst outcome in EE. Specifically, clients in the EE *best outcome group* were significantly more likely than clients in the worst outcome group to report having experienced severe sexual abuse, x^2 (1, N =18) = 5.56, p = .018. Clients in the EE *best outcome group* also were significantly more likely to identify their mother as the perpetrator of abuse, x^2 (1, N =18) = 4.00, p = .046, compared to clients who did worst in the EE condition. However, as shown in Table 4, experiencing multiple forms of abuse did not differentiate between clients who did best and worst in EE.

The Imaginal Confrontation Condition

The second set of research questions concerned client characteristics that differentiated best and worst outcome in the IC condition. Those results are presented in the following sections.

Demographic Characteristics of Clients in the IC Best versus IC Worst Outcome Groups

Table 5 presents demographic information for clients who did best and worst in IC.

Table 5
Demographic Characteristics for Clients in the IC Best and Worst Outcome Groups

Variable	Best Outcome		Worst Outcome	
	N	Mean *(SD)* % Yes	N	Mean *(SD)* % Yes
Gender				
Male	3	42.9 %	4	57.1 %
Female	4	57.1 %	3	42.9 %
Age		46.43 (14.52)		45.57 (12.69)
Ethnicity				
European	7	100 %	7	100 %
Marital Status				
Single	3	42.9 %	1	14.3 %
Common Law	0	0	1	14.3 %
Married*	3	42.9 %	0	0
Separated/Divorced	1	14.3 %	4	57.1 %
Widowed	0	0	1	14.3 %
Children	5	71.4 %	5	71.4 %
Education				
High School	1	14.3 %	0	0
Undergraduate	5	71.4 %	6	85.7 %
Graduate	1	14.3 %	1	14.3 %
Employed	5	71.4 %	5	71.4 %

Table 5 (Continued)

Demographic Characteristics for Clients in the IC Best and Worst Outcome Groups

Variable	Best Outcome		Worst Outcome	
	N	Mean *(SD)* % Yes	N	Mean *(SD)* % Yes
Income				
<$20,000	2	28.6 %	2	28.6 %
$20-39,000	2	28.6 %	2	28.6 %
$40-59,000	1	14.3 %	0	0
>$60,000	2	28.6 %	3	42.9 %

Note: n *IC= 14,* n *IC best = 7,* n *IC worst = 7*; * *p<.1.*

As shown in Table 5, clients in the best and worst outcome groups in the IC condition did not vastly differ on most of the examined demographics. More than half, 57.1% ($n = 4$), of women were classified in the best outcome group, compared to 42.9 % ($n = 3$) in the worst outcome group. Both groups had an average age range in the mid forties. In regards to ethnicity, all participants identified as white. The majority of those in each group reported having children, at least an undergraduate education, being employed, and similar income levels. However, more clients in the *best outcome group* were married, $x^2 (1, N = 14) = 3.82, p = .051$.

Psychopathology for Clients in IC Best versus IC Worst Outcome Groups

Results regarding psychopathology (PTSD symptom clusters, specific personality disorders, and medication status) of clients who did best and worst in IC are presented below and in Table 6.

Table 6
Psychopathology Measures for Clients in the IC Best versus the IC Worst Outcome Groups

Variable	Best Outcome		Worst Outcome	
	N	Mean *(SD)* % Yes	N	Mean *(SD)* or % Yes
PTSD[1]				
Diagnosis	6	85.7 %	4	57.1 %
PSSI Total		29.14 (8.47)		21.43 (11.37)
Re-experiencing		6.29 (2.81)		6.57 (3.10)
Avoidance		14.29 (5.28)		10.00 (6.90)
Arousal		9.57 (3.74)		6.57 (3.95)
Personality				
Pathology[2]				
Axis II Diagnosis	3	42.9 %	1	14.3 %
(score > 50 on PDQ-4)				
Paranoid	4	57.1 %	3	42.9 %
Histrionic	1	14.3 %	0	0
Antisocial	1	14.3 %	2	28.6 %
Obsessive	3	42.9 %	4	57.1 %
Negativistic	1	14.3 %	2	28.6 %
Schizoid	2	28.6 %	2	28.6 %
Narcissistic	2	28.6 %	0	0
Avoidant**	7	100 %	3	42.9 %

Table 6 (Continued)
Psychopathology Measures for Clients in the IC Best versus the IC Worst Outcome Groups

Variable	Best Outcome		Worst Outcome	
	N	Mean *(SD)* % Yes	N	Mean *(SD)* % Yes
Depressive	3	42.9 %	4	57.1 %
Schizotypal	2	28.6 %	3	42.9 %
Borderline	3	42.9 %	2	28.6 %
Dependent	0	0	1	14.3 %
Medication Status	1	14.3 %	3	42.9 %

Note: n *IC= 14,* n *IC best = 7,* n *IC worst = 7; PTSD = Posttraumatic Stress Disorder; PDQ = Personality Diagnostic Questionnaire.* ** $p < .05$.

PTSD. Table 6 indicates no observed differences between the best and worst outcome groups in terms of PTSD symptomatology on the PSSI (Foa et a., 1993).

Personality disorders. As indicated in Table 6, clients who did *best* in IC were significantly more likely than those in the worst outcome group to meet screening criteria for avoidant personality disorder on the PDQ –4 (Hyler, 1994), x^2 (1, N =14) = 5.600, p = .018.

Medication status. Table 6 indicates no difference between clients in the best and worse IC outcome groups -- the majority of clients in both groups reported not being on psychotropic medication.

Attachment Style and Emotional Competence for Clients in IC Best versus Worst Outcome

Table 7 presents mean scores for the attachment style and alexithymia subscales for clients in the best and worst IC outcome groups.

Table 7
Attachment Style and Emotional Competence of Clients in IC Best and IC Worst Outcome

Variable	Best Outcome Mean *(SD)*	Worst Outcome Mean *(SD)*
Attachment Style		
Confidence	29.27 (4.94)	29.57 (5.65)
Discomfort with Closeness	39.43 (3.41)	39.43 (5.50)
Need for Approval	26.13 (8.78)	26.71 (6.26)
Preoccupied with Relationships	33.43 (8.62)	35.47 (4.55)
Relationships as Secondary	17.14 (6.44)	22.43 (6.21)
Total Insecure	116.16 (21.61)	124.04 (19.77)
Alexithymia		
Difficulty Identifying Feelings	25.57 (2.64)	22.29 (7.87)
Difficulty Describing** Feelings	18.86 (2.91)	14.57 (3.59)
Externally Oriented Thinking	21.86 (4.14)	23.29 (4.54)

Note: n *IC= 14,* n *IC best = 7,* n *IC worst = 7.* ** $p < .05$.

Table 7 indicates that the best and worst outcome groups in the IC condition did not differ in terms of attachment style dimensions on the ASQ (Feeney et al., 1994).

In terms of specific clusters of alexithymia on the TAS-20 (Bagby et al. 1994), shown in Table 7, clients in the *best outcome group*, compared to those in the worst outcome group, were significantly more likely to report difficulty describing feelings, t $(12) = 2.45$, $p = .031$.

Characteristics of Abuse Experienced by Clients in IC Best versus IC Worst Outcome

The fourth question in the present study concerned whether abuse characteristics differentiate between best and worst outcome. Table 8 presents abuse characteristics of clients who did best and worst in the IC condition.

Table 8
Abuse Characteristics for Clients in the IC Best versus IC Worst Outcome Groups

Variable	Best Outcome		Worst Outcome	
	N	% Yes	N	% Yes
Perpetrator				
Parent*	7	100 %	4	57.1 %
Father	4	57.1 %	2	28.6 %
Mother	3	42.9 %	2	28.6 %
Brother	0	0	1	14.3 %
Relative	0	0	1	14.3 %
Other	0	0	1	14.3 %
Severity on the CTQ[1]				
Sexual Abuse	3	42.9 %	2	28.6 %
Physical Abuse	3	42.9 %	4	57.1 %
Emotional Abuse	6	85.7 %	3	42.9 %
Neglect	6	85.7 %	3	42.9 %
Multiple Abuse Types	3	42.9 %	4	57.1 %

Note: n *IC= 14,* n *IC best = 7,* n *IC worst = 7;* [1] *CTQ = Childhood Trauma Questionnaire;* * *p <.1.*

As indicated in Table 8, some differences in abuse characteristics were observed between clients who did best and worst in IC. Specifically, results on the CTQ (Bernstein et al., 2003) indicated that more than three times as many clients in the *best outcome group*, compared to the worst outcome group, reported experiencing severe emotional abuse and neglect (85.7 % versus 28.6 %). However, differences were not statistically significant. Table 8 also shows that twice as many clients in the *best outcome group*, compared to the worst outcome group, reported being abused by their father (57.1 % versus 28.6 %). Again, these differences were not statistically significant. However, there was a trend for clients in the *best outcome group* to report their parent as the perpetrator x^2 (1, N =14) = 3.82, p = .051, compared to clients in the worst IC outcome group. Finally, as shown in Table 8, experiencing multiple forms of abuse did not differentiate between clients who did best and worst in the IC condition.

Characteristics of Clients in EE versus IC Best Outcome Groups

The third set of research questions in the present study concerned the client characteristics (demographics, psychopathology, attachment style and emotional competence, abuse characteristics) that differentiated clients who did best in the two treatment conditions. Results of those comparisons across conditions are presented in the following sections.

Demographic Characteristics of Clients in the EE versus IC Best Outcome Groups

Table 9 presents demographic information for clients in the best outcome groups in the EE and IC conditions.

Table 9
Demographic Characteristics for Clients in the EE and IC Best Outcome Groups

Variable	IC Best Outcome		EE Best Outcome	
	N	Mean *(SD)* % Yes	N	Mean *(SD)* % Yes
Gender				
Male	3	42.9 %	3	33.3 %
Female	4	57.1 %	6	66.7 %
Age		46.43 (14.52)		41.56 (10.38)
Ethnicity				
European	7	100 %	7	77.8 %
Other	0	0	2	22.2 %
Marital Status				
Single**	3	42.9 %	0	0
Common Law	0	0	2	22.2 %
Married	3	42.9 %	4	44.4 %
Separated/Divorced	1	14.3 %	3	33.3%
Children	5	71.4 %	8	88.9 %
Education				
High School	1	14.3 %	4	44.4 %
Undergraduate	5	71.4 %	5	55.6 %
Graduate	1	14.3 %	0	0
Employed	5	71.4 %	8	88.9 %

Table 9 (Continued)
Demographic Characteristics for Clients in the EE and IC Best Outcome Groups

Variable	IC Best Outcome		EE Best Outcome	
	N	Mean *(SD)* % Yes	N	Mean *(SD)* % Yes
Income				
<$20,000	2	28.6 %	4	44.4 %
$20-39,000	2	28.6 %	0	0
$40-59,000	1	14.3 %	2	22.2 %
>$60,000	2	28.6 %	3	33.3%

Note: n *IC best = 7,* n *EE best = 9; ** p<. 05.*

Table 9 indicates that clients in the *EE best outcome* group, compared to those in the IC best outcome group, were more likely to report having a high school diploma as their highest completed education (44.4 % versus 14.3 %). However this difference between treatment conditions was not statistically significant.

On the other hand, clients in the *IC best outcome group* were significantly more likely to be single compared to those in the EE best outcome group, x^2 (1, N =16) = 4.75, p = .029.

Psychopathology Measures for Clients in EE versus IC Best Outcome Groups

Results regarding psychopathology (PTSD symptom clusters, specific personality disorders, and medication status) for clients who did best in EE and IC are presented in Table 10.

Table 10
Psychopathology Measures for Clients in EE versus IC Best Outcome Groups

Variable	IC Best		EE Best	
	N	Mean *(SD)* % Yes	N	Mean *(SD)* % Yes
PTSD[1]				
Diagnosis	6	85.7 %	6	66.7 %
PSSI Total		29.14 (8.47)		27.92 (9.32)
Re-experiencing		6.29 (2.81)		7.47 (3.77)
Avoidance		14.29 (5.28)		13.95 (4.79)
Arousal		9.57 (3.74)		7.88 (2.43)
Personality Pathology[2]				
Axis II Diagnosis (score > 50 on PDQ-4)	3	42.9 %	4	44.4 %
Paranoid	4	57.1 %	7	77.8 %
Histrionic	1	14.3 %	1	11.1 %
Antisocial	1	14.3 %	0	0
Obsessive	3	42.9 %	7	77.8 %
Negativistic	1	14.3 %	2	22.2 %
Schizoid	2	28.6 %	1	11.1 %
Narcissistic	2	28.6 %	1	11.1 %
Avoidant	7	100 %	8	88.9 %
Depressive	3	42.9 %	6	66.7 %
Schizotypal	2	28.6 %	4	44.4 %

Table 10 (Continued)
Psychopathology Measures for Clients in the EE versus the IC Best Outcome Groups

Variable	IC Best		EE Best	
	N	Mean *(SD)* % Yes	N	Mean *(SD)* % Yes
Borderline	3	42.9 %	3	33.3 %
Dependent	0	0	0	0
Medication Status	1	14.3 %	1	11.1 %

Note: n *IC best = 7,* n *EE best = 9; PTSD = Posttraumatic Stress Disorder; PDQ = Personality Diagnostic Questionnaire.*

PTSD. Table 10 indicates no difference between clients in the EE and IC best outcome groups in terms of PTSD symptom clusters.

Personality disorders. Table 10 indicates that more that twice as many clients in the EE compared to the IC best outcome group met screening criteria for obsessive-compulsive ($n = 7$ versus $n = 3$), negativistic ($n = 2$ versus $n = 1$), depressive ($n = 6$ versus $n = 3$), and schizotypal ($n = 4$ versus $n = 2$) personality disorders. However, these differences were not statistically significant.

In terms of *medication status*, clients in the IC and EE best outcome groups did not differ. Specifically, the majority of clients in the best outcome groups reported not being on psychotropic medication.

Attachment Style and Emotional Competence for Clients in EE versus IC Best Outcome

Table 11 presents mean scores on the attachment style and alexithymia subscales for clients in the EE and IC best outcome groups.

Table 11
Attachment Style and Emotional Competence for Clients in IC versus EE Best Outcome

Variable	IC Best Mean *(SD)*	EE Best Mean *(SD)*
Attachment Style		
Confidence	29.27 (4.94)	27.32 (4.14)
Discomfort with Closeness	39.43 (3.41)	42.56 (3.17)
Need for Approval	26.13 (8.78)	29.00 (4.61)
Preoccupied with Relationships	33.43 (8.62)	34.00 (4.53)
Relationships as Secondary	17.14 (6.44)	18.00 (4.21)
Total Insecure	116.16 (21.61)	123.56 (10.89)
Alexithymia		
Difficulty Identifying Feelings	25.57 (2.64)	23.56 (5.59)
Difficulty Describing Feelings	18.86 (2.91)	17.89 (4.59)
Externally Oriented Thinking	21.86 (4.14)	21.78 (2.73)

Note: n *IC best = 7,* n *EE best = 9*

As shown in Table 11, no differences were observed between clients in the EE and IC best outcome groups in terms of either attachment style, as measured by the ASQ (Feeney et al., 1994), or the alexithymia subscales on the TAS-20 (Bagby et al., 1994).

Characteristics of Abuse for Clients in EE versus IC Best Outcome

Table 12 presents abuse characteristics reported by clients on the CTQ (Bernstein et al., 2003) and in screening and selection interviews.

Table 12
Characteristics of Abuse Experienced by Clients in IC versus EE Best Outcome

Variable	IC Best		EE Best	
	N	Mean *(SD)* % Yes	N	Mean *(SD)* % Yes
Perpetrator				
Parent	7	100 %	8	88.9 %
Father	4	57.1 %	3	33.3 %
Mother	3	42.9 %	5	55.6 %
Other	0	0	1	11.1%
Severity on the CTQ[1]				
Sexual Abuse	3	42.9 %	7	77.8 %
Physical Abuse	3	42.9 %	6	66.7 %
Emotional Abuse	6	85.7 %	6	66.7 %
Neglect	6	85.7 %	6	66.7 %
Multiple Abuse Types	3	42.9 %	7	77.8 %

Note: n *IC best = 7,* n *EE best = 9;* [1]*CTQ = Childhood Trauma Questionnaire*

Table 12 indicates that more than twice as many (n = 7 versus n = 3) clients in the *EE best outcome group* reported experiencing multiple forms of abuse. However, this was not a statistically significant difference. Table 12 also indicates that at least twice the number of clients in the EE best outcome group, compared to IC, reported experiencing severe sexual abuse (n = 7 versus n = 3) and physical abuse (n = 6 versus n = 3). Again, this was not a statistically significant difference.

Characteristics of Clients in EE Worst versus IC Worst Outcome Groups

The fourth set of research questions in the present study concerned the characteristics (demographics, psychopathology, attachment style and emotional competence, and abuse characteristics) of clients who did worst in the EE and IC conditions. These results are presented in the following sections.

Demographic Characteristics of Clients in the IC versus EE Worst Outcome Groups

Table 13 presents demographic information for clients in the EE and IC worst outcome groups.

Table 13
Demographic Characteristics for Clients in the EE and IC Worst Outcome Groups

Variable	IC Worst		EE Worst	
	N	Mean (*SD*) % Yes	N	Mean (*SD*) % Yes
Gender				
Male	4	57.1 %	7	77.8 %
Female	3	42.9 %	2	22.2 %
Age		45.57 (12.69)		44.78 (4.59)
Ethnicity				
European	7	100 %	8	88.9 %
Other	0	0	1	11.1 %
Marital Status				
Single	1	14.3 %	4	44.4 %
Common Law	1	14.3 %	0	0
Married**	0	0	4	44.4 %
Separated/ Divorced**	4	57.1 %	1	11.1 %
Widowed	1	14.3 %	0	0
Children	5	71.4 %	5	55.6 %
Education				
High School	0	0	2	22.2 %
Undergraduate	6	85.7 %	4	44.4 %
Graduate	1	14.3 %	3	33.3 %

Table 13 (Continued)

Demographic Characteristics for Clients in the EE and IC Worst Outcome Groups

Variable	IC Worst		EE Worst	
	N	Mean (*SD*) % Yes	N	Mean (*SD*) % Yes
Employed	5	71.4%	7	77.8 %
Income				
<$20,000	2	28.6 %	1	11.1 %
$20-39,000	2	28.6 %	2	22.2 %
$40-59,000	0	0	1	11.1 %
>$60,000	3	42.9 %	5	55.6 %

Note: n *IC worst = 7,* n *EE worst = 9; ** p <. 05*

Clients in the *EE worst outcome group*, shown in Table 13, were significantly more likely than those in the IC worst outcome group to report being married, x^2 (1, N =16) = 4.15, p = .042. Additionally, although not statistically significant, more than twice the number of clients in the EE worst outcome group, compared to those in the IC worst outcome group, reported being single (n = 4 versus n = 1), and employed full-time (n = 7 versus n = 3).

Clients in the *IC worst outcome group* were significantly more likely to report their marital status as separated or divorced, x^2 (1, N =16) = 3.88, p = .049.

Psychopathology for Clients in the IC versus EE Worst Outcome Groups

Table 14 presents results regarding psychopathology (PTSD symptom clusters, specific personality disorders, and medication status) of clients who did worst in EE and IC.

Table 14
Psychopathology Measures for Clients in IC versus EE Worst Outcome Groups

Variable	IC Worst		EE Worst	
	N	Mean *(SD)* % Yes	N	Mean *(SD)* % Yes
PTSD[1]				
Diagnosis	4	57.1 %	4	44.4 %
PSSI Total		21.43 (11.37)		18.78 (15.36)
Re-experiencing		6.57 (3.10)		4.44 (4.48)
Avoidance		10.00 (6.90)		8.89 (7.61)
Arousal		6.57 (3.95)		6.22 (5.38)
PDQ[2]				
Axis II Diagnosis (score > 50 on PDQ-4)	1	14.3 %	4	44.4 %
Paranoid	3	42.9%	5	55.6%
Histrionic	0	0	0	0
Antisocial	2	28.6 %	2	22.2%
Obsessive	4	57.1 %	7	77.8 %
Negativistic	2	28.6 %	5	55.6%
Schizoid	2	28.6 %	5	55.6%
Narcissistic	0	0	3	33.3 %
Avoidant**	3	42.9%	8	88.9 %
Depressive	4	57.1 %	7	77.8 %
Schizotypal	3	42.9%	6	66.7 %

Table 14 (Continued)
Psychopathology Measures for Clients in IC versus EE Worst Outcome Groups

Variable	IC Worst		EE Worst	
	N	Mean *(SD)* % Yes	N	Mean *(SD)* % Yes
Borderline	2	28.6 %	5	55.6%
Dependent	1	14.3 %	3	33.3 %
Medication	3	42.9%	4	44.4 %

Note: n *IC worst = 7,* n *EE worst = 9; PTSD = Posttraumatic Stress Disorder; PDQ = Personality Diagnostic Questionnaire.* ** $p < .05$

PTSD. Table 14 shows that clients in the IC worst outcome group were not vastly different from clients in the EE worst outcome group on the PSSI (Foa et al., 1993).

Personality disorders. Table 14 indicates that clients in the *EE worst outcome* group were significantly more likely than those in the IC worst outcome group to meet screening criteria for avoidant personality disorder on the PDQ – 4 (Hyler, 1994), x^2 (1, N =16) = 3.88, p = .049. Additionally, more than twice the number of clients in the EE worst outcome group, compared to IC, met initial screening criteria for an Axis II diagnosis (n = 4 versus n = 1), as well as negativistic (n = 5 versus n = 2), schizoid (n = 5versus n = 2), narcissistic (n = 3 versus 0), schizotypal (n = 6 versus n = 3), borderline (n = 5 versus n = 2), and dependent (n = 3 versus n = 1) personality disorders on the PDQ –4 (Hyler, 1994). These differences did not reach statistical significance.

In terms of *medication status* shown in Table 14, clients in the worst outcome groups in the IC and EE conditions did not differ. Specifically, over half of clients in both the IC and EE worst outcome group reported not being on psychotropic medication.

Attachment Style and Emotional Competence for Clients in IC versus EE Worst Outcome

Table 15 presents mean scores for the attachment style and alexithymia subscales for clients in the IC and EE worst outcome groups.

Table 15
Attachment Style and Emotional Competence for Clients in IC versus Worst Outcome

Variable	IC Worst Mean *(SD)*	EE Worst Mean *(SD)*
Attachment Style		
Confidence	29.57 (5.65)	29.11 (5.06)
Discomfort with Closeness	39.43 (5.50)	42.33 (3.20)
Need for Approval	26.71 (6.26)	29.11 (6.99)
Preoccupied with Relationships	35.47 (4.55)	34.0 (5.98)
Relationships as Secondary	22.43 (6.21)	22.33 (6.21)
Total Insecure	124.04 (19.77)	127.78 (16.28)
Alexithymia		
Difficulty Identifying Feelings	22.29 (7.87)	20.78 (5.12)
Difficulty Describing Feelings	14.57 (3.59)	17.33 (4.85)
Externally Oriented Thinking	23.29 (4.54)	22.56 (4.36)

Note: n *IC worst = 7,* n *EE worst = 9*

As indicated in Table 15, clients who did worst in both the IC and EE treatment conditions did not differ in terms of attachment style, on the ASQ (Feeney et al., 1994) or symptoms of alexithymia on the TAS –20 (Bagby et al., 1994).

Characteristics of Abuse Experienced by Clients in IC versus EE Worst Outcome

Table 16 presents abuse characteristics of clients who did worst in the IC and EE treatment conditions.

Table 16
Characteristics of Abuse Experienced by Clients in IC versus EE Worst Outcome

Variable	IC Worst		EE Worst	
	N	Mean *(SD)* % Yes	N	Mean *(SD)* % Yes
Perpetrator				
Parent	4	57.1 %	7	77.8 %
Father	2	28.6 %	6	66.7 %
Mother	2	28.6 %	1	11.1 %
Brother	1	14.3 %	1	11.1 %
Relative	1	14.3 %	0	0
Other	1	14.3 %	1	11.1 %
Severity on the CTQ[1]				
Sexual Abuse	2	28.6 %	2	22.2 %
Physical Abuse	4	57.1 %	6	66.7 %
Emotional Abuse	3	42.9 %	5	55.6 %
Neglect	3	42.9 %	5	55.6 %
Multiple Abuse Types	4	57.1 %	5	55.6 %

Note: n *IC worst = 7,* n *EE worst = 9;* [1]*CTQ = Childhood Trauma Questionnaire*

As indicted in Table 16, more clients in the *EE worst outcome group* reported their father as the perpetrator compared to those in the IC worst outcome group (66.7 % versus 28.6 %). However, this was not a statistically significant difference.

Summary of Results

The following summarizes pre-treatment client characteristics that differentiated between the best and worst outcome groups in the EE and IC conditions. First, in terms of the Evocative Empathy (EE) condition, clients in the EE *best* outcome group were significantly more likely to report having experienced severe sexual abuse, as well as report their mother as the perpetrator of the abuse compared to clients in the EE poor outcome group. There also was to be a trend for the best outcome group to be comprised mainly of females.

In terms of *worst* outcome in the EE condition, these clients were significantly more likely compared to clients in the best outcome EE group to identify as single. Those in the EE poor outcome group also were significantly more likely to meet diagnostic criteria for schizoid personality disorder. Although differences did not reach statistical significance, there was a trend for clients in the EE worst outcome group to be comprised mainly of males, and to meet screening criteria for dependent personality disorder. Furthermore, clients who met screening criteria for antisocial personality disorder were exclusively in the worst outcome group,

In terms of the Imaginal Confrontation (IC) condition, clients who did *best* in the IC condition were significantly more likely than those who did worst in this condition to meet diagnostic criteria for avoidant personality disorder. Furthermore, in terms of alexithymia symptom clusters, clients who did best in the IC condition were significantly

more likely to report more difficulties describing feelings than those in the IC worst outcome group. There also was a trend for clients in the *best* outcome group to be married, and to report their parent as the perpetrator of abuse.

In regards to the *best* outcome groups *across treatment conditions*, clients in the *IC best outcome* group were significantly more likely to identify as single compared to those in the EE best outcome group. Furthermore, although not statistically significant, clients in the *EE best outcome* group, compared to those in the IC best outcome group, were more likely to report having a high school diploma as their highest completed education, to meet screening criteria for obsessive-compulsive, depressive, and schizotypal personality disorders, to report experiencing severe sexual and physical abuse, and having experienced multiple forms of abuse.

In terms of the *worst* outcome groups, clients in the *IC worst outcome* group were significantly more likely to identify as separated or divorced compared to clients in the EE worst outcome group. Furthermore, clients in the *EE worst outcome* group were significantly more likely to be married, and meet criteria for avoidant personality disorder than those in the IC condition. Although not statistically significant, some trends were present in the worst outcome groups across treatment conditions. Specifically, clients in the EE worst outcome group were more likely to report being single, and employed full-time.

Discussion

The present study was conducted to examine pre-treatment client characteristics that differentiate between best and worst outcome and between two versions of EFTT. Both versions of EFTT have been shown to be effective for survivors of different types of child abuse (Paivio et al., 2009; Paivio & Nieuwenhuis, 2001), however, factors that facilitate or impede improvement in therapy are not clearly understood. One goal of the present study was to examine potential client characteristics, in terms of demographics, psychopathology, attachment style, emotional competence, and characteristics of the childhood abuse, which may affect clients' ability to engage in key therapy processes, and therefore, benefit from treatment. Furthermore, different client variables may interact differently with the unique features of the two versions of EFTT, and hence differentially affect outcome. Therefore, a second aim of the present study was to explore the pre-treatment client characteristics that interact with aspects of each version of therapy.

The following section will discuss client characteristics found to differentiate between those who did the best and worst in each conditions (IC and EE), followed by pre-treatment client characteristics that differed between best and worst outcomes across the IC and EE treatment conditions. The discussion will focus exclusively on positive findings because these have implications for future research. Strengths and limitations of the current study, as well as future research and treatment implications will also be discussed.

The Evocative Empathy Condition

In terms of demographic characteristics of clients who did best and worst in the EE condition, there was a trend for clients who did *best* in EE to be female and for those

who did *worst* to be male. Previous studies of EFTT have reported no significant effects ($p < .05$) for gender in either the IC or EE conditions (Paivio & Nieuwenhuis, 2001; Paivio et al., 2009). The Paivio et al (2009) study included the complete sample of EFTT-EE completers that included the subgroups of clients in the present study. This suggests that present findings either may be a function of the extreme group design that does not reflect the complete distribution or that the trend was not reported by Paivio et al (2009). Existing research on the interaction between gender and psychotherapy outcome, in general, is mixed. For instance, studies have indicated that female clients may benefit from therapy more than male clients, whereas others have found that both genders benefit more from treatment provided by female therapists (Ogrodniczuk, Piper, Joyce, & McCallum, 2001; Zlotnick, Shea, Pilkonis, Elkin, & Ryan, 1996). Research comparing supportive and interpretive therapies has found that male and female clients improved in both therapies, however, male clients showed larger gains in interpretive therapy while females showed larger gains in supportive psychotherapy (Ogrodniczuk et al., 2001). This may partially explain why female clients may have shown greater improvement in EE, given the emphasis on the relationship with the therapist. On the other hand, this finding suggests that male clients may not respond as well to the relational emphasis in EE and may do better in a more structured or directive approach to trauma exploration.

Furthermore, significantly more clients who identified as single were in the EE *worst* outcome group. Previous research has suggested that clients who are in marital or common-law relationships show more improvement in therapy, perhaps because they may receive more support outside of therapy and possess better interpersonal skills (Van, Schoevers, & Dekker, 2008). One of the well-documented long-term effects of child

abuse trauma is a diminished capacity for interpersonal relatedness in adulthood (Courtois & Ford, 2009). Given the relational emphasis of the EE condition, it is possible that clients who were single did worse in EE partly because of lower capacities for interpersonal relatedness, which may have influenced their ability to form or maintain a strong relationship with the therapist. If this were true, clinicians would be well-advised to assess the relational capacities of single clients and pay particular attention to cultivating the alliance with these individuals.

In terms of psychopathology, the present study is the first to examine the impact of different clusters of personality pathology on treatment outcome in EFTT. Results indicated that clients in the EE *worst* outcome group were more likely to meet screening criteria for schizoid and dependent personality disorders. Recent research on EFTT found that overall severity of personality pathology, in general, was associated with less improvement in both IC and EE conditions; however, this effect was more pronounced in the EE condition (Paivio et al., 2009). Specifically, severity of personality pathology was found to be associated with more discomfort at post-test in both conditions, however, in the EE condition, severity of personality disturbance also was associated with more severe trauma symptoms, and higher depression and anxiety at post-test (Paivio et al., 2009). This is in accordance with psychotherapy research on other treatment approaches that has highlighted difficulties working with clients with personality disorders and that the presence of Axis II pathology, in general, has a negative influence on treatment outcome, particularly in short-term modalities (e.g. Dimaggio & Norcross, 2008).

In terms of specific findings concerning schizoid personality disorder in EE, schizoid personality disorder is characterized by relational distance and the absence of

emotional expressiveness (Sperry, 2003). Therefore, it stands to reason that these clients may have had poorer outcomes in EE since this condition requires expressing feelings about painful traumatic experiences to the therapist. This is consistent with literature indicating that clients with schizoid personality disorder often find therapy challenging due to the fact that their functioning is nonrelational, and they typically respond with emotional distancing (Sperry, 2003). Clinical literature suggests that long-term treatment averaging twice per week may be better suited for clients with schizoid personality disorder (Sperry, 2003).

Furthermore, although not statistically significant, there was a trend for clients in the EE *worst* outcome group to meet initial screening criteria for dependent personality disorder. This is consistent with literature indicating clients with these personality features do not do as well in psychotherapy. Specifically, clients with dependent personality disorder are often apprehensive about becoming competent and autonomous due to a fear of abandonment, and cannot tolerate confrontation and interpretation of their extreme dependency, and therefore, may not demonstrate treatment gains (Othmer & Othmer, 2002). Although EFTT with EE does not rely on confrontation or interpretation as interventions, extreme client dependence on the therapist would interfere with the client's capacity to rely on their own internal experience (thoughts, feelings, values) as the primary source of new information – the hallmark of EFTT -- and thus would limit therapy success. Again, it is likely that clients with dependent personality disorder would do better in a more long term approach. Such an approach could include a focus on gradually reducing abandonment fears and increasing autonomy in the therapeutic relationship, rather than an exclusive focus on resolving past trauma.

In terms of characteristics of abuse, clients in the *best* EE outcome group were significantly more likely than those in the worst outcome group to report having experienced severe sexual abuse. Feelings of self-blame, shame, and low self-esteem are common to victims of sexual abuse (Brown, Lourie, Zlotnick, & Cohn, 2000; Greenberg et al., 1999; Loeb, 2002). These feelings often stem from actively participating in the sexual behaviour, failing to seek help, avoid or control the abuse (Celano, 1992). These feelings may contribute to difficulty with disclosure. The EE condition has been shown to be less evocative and stressful for clients (Paivio et al., 2009; Ralston, 2006), likely because it does not involve imaginary confrontations of abusive others and trauma exploration takes place solely in the context of interaction with a supportive therapist. The support and guidance of the therapist in the EE condition may be particularly important in reducing shame and enabling sexual abuse survivors to disclose their abuse experiences, emotionally engage with abuse experiences in order to process trauma, and thereby, benefit from therapy.

The present study is the first study to examine the relationship between perpetrator status and outcome in individual therapy, and in EFTT specifically. Results indicated that clients in the EE *best* outcome group were significantly more likely to report their mother as the primary perpetrator of harm. This may be related to previous research findings suggesting that perpetrator status has been associated with increased trauma, interpersonal problems, and emotion regulation difficulties (e.g. Riggs et al., 2007). Because mothers are typically primary attachment figures for children, when mothers are the primary perpetrators of harm, this may be more painful for abuse survivors. Survivors of child abuse often have relational difficulties in adulthood as a result of

negative early attachment experiences, which influence expectations and behaviour in adult relationships (Courtois & Ford, 2009; Herman, 1992). EFTT, in general, has a strong focus on an empathic and supportive therapeutic relationship, which is designed to counteract the effects of these negative early attachment experiences (Mitchell, 1988; Paivio & Pascual-Leone, 2009; Paivio & Patterson, 1999). The EE treatment condition may have been particularly helpful for clients whose mothers were the primary perpetrators of harm because change in this condition is even more a function of a corrective interpersonal experience with an empathically responsive and supportive therapist. Future research could determine whether having a female therapist in EE would be additionally helpful for clients whose mothers were the primary perpetrators of harm.

The Imaginal Confrontation Condition

In terms of the demographic characteristics of clients who did best and worst in the IC condition, there was a trend for more clients in the *best* outcome group to identify as married. This is consistent with the literature described in the above section on EE suggesting that clients who are married show greater treatment gains perhaps because they receive more support outside of therapy and possess better social skills enabling them to participate in and maximally benefit from the therapeutic relationship (Van et al., 2008). These external and internal resources may have been particularly helpful to clients in IC which additionally required them to interact and resolve issues with imagined offenders. This finding suggests that assessing and capitalizing on clients' current relational resources could contribute to maximizing change in IC.

In terms of psychopathology, clients in the IC *best* outcome group were significantly more likely to meet initial screening criteria for avoidant personality disorder than clients in the worst outcome group. Avoidant personality disorder is characterized by social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation. Those with avoidant personality disorder often act with restraint, display difficulty talking about themselves, and withhold intimate feelings for fear of being ridiculed or shamed (DSM-IV-TR; APA, 2000). Research on EFTT with IC has shown that, although clients diagnosed with Axis II pathology, in general, benefited from therapy, the presence or severity of Axis II pathology, in general, negatively influenced engagement in IC and some dimensions of outcome (Paivio & Nieuwenhuis, 2001; Paivio et al., 2001; Paivio et al., 2009). Psychotherapy research on other treatment models has found that clients with avoidant personality disorder, in particular, often have difficulty expressing themselves directly to others (including the therapist), but have shown improvements with exposure-based therapies (Alden & Capreol, 1993). This suggests that highly evocative procedures may be powerful enough to activate core material that avoidant clients otherwise would inhibit. IC is an evocative exposure-based procedure in which clients imaginally confront the abusive/neglectful other and express their thoughts, feelings, and needs to this "imagined other". The IC procedure may be particularly beneficial for avoidant clients because, in addition to its evocative nature, confronting imagined others is easier than expressing intimate thoughts and feelings to the therapist, thus allowing them to maximally benefit from therapy.

In regards to emotional competence, this is the first study to examine the impact of different dimensions of alexithymia in EFTT. The construct of alexithymia consists of

three clusters: difficulty identifying and distinguishing feelings from bodily sensations, difficulty describing feelings, and externally oriented thinking (Bagby et al., 1994). Clients in the IC *best* outcome group reported more difficulty on the dimension of describing feelings compared to clients who did worst. This is inconsistent with research findings for other therapy approaches indicating that clients suffering from high levels of alexithymia, in general, have demonstrated less favourable outcomes in both group and individual psychotherapy, particularly in interpretive and supportive therapies (McCallum et al., 2003; Ogrodnikzuk et al., 2005). Similarly, the capacity to verbally describe and explore the meaning of affective experience is an essential part of the capacity for experiencing which, in turn, is crucial to emotional processing in EFTT. However, it is possible that clients with difficulties in this area were particularly helped by the IC procedure. The evocative nature of the IC procedure is designed to quickly activate episodic memories of abuse experiences, allowing the associated emotional experiences to enter into awareness. Once in experiential awareness, the explicit "coaching" or guidance provided by the therapist during IC helps clients to accurately label and describe feelings and explore their meaning. This, in turn, would help clients who have difficulties in this area to benefit from therapy.

In terms of characteristics of abuse, the present study was the first to examine the impact of perpetrator status on outcome in individual therapy with child abuse survivors. Results indicated that clients who did *best* in IC were more likely to report their parent (rather than sibling or non-family members, for example) as the perpetrator of abuse. Although evidence is mixed, some research suggests that abuse by a family member may be more traumatic than abuse at the hands of another offender, particularly if that family

member is an attachment figure (Browne & Finkelhor, 1986; Russell, 1986). This may be because of the enormous influence that attachment figures have on development and the amount of betrayal involved. The present finding suggests that the IC procedure, in which clients imaginally confront offenders and express thoughts and feelings about the abuse directly to them, may be particularly beneficial for helping clients resolve attachment injuries.

Characteristics of Clients Who Did Best and Worst Across Conditions

Present analyses yielded few meaningful findings when best and worst outcome groups were compared across conditions. For example, significantly more clients in the IC best outcome group identified as single compared to clients who did best in EE. However, this was because most single clients in EE were in the worst outcome group. Similarly, more clients who did worst in IC were married compared to clients who did worst in EE. Overall, marital status was not a distinguishing feature of either good or poor outcome in the IC condition. Likewise, in terms of psychopathology, clients in the EE worst outcome group were significantly more likely to meet criteria for avoidant personality disorder compared to clients who did worst in IC. However, this was because most clients in IC with avoidant personality were in the best outcome group. Avoidant personality was not a distinguishing feature of either good or poor outcome in EE. Overall, potentially important client-by-treatment interactions were identified in the present study by the client variables that distinguished good and poor outcome in the individual treatment conditions rather than across conditions.

Strengths and Limitations

One of the strengths of the present study is its clinical relevance. Prevalence rates of all forms of child abuse range from 22% to 42%; however, due to the fact that many instances of abuse go unreported, this is likely an underestimation (Newton, 2001; Paivio & Cramer, 2004; Turner & Paivio, 2002). Moreover, the long-term adverse psychosocial and health effects associated with child abuse experiences have been well documented in the literature (e.g. Landsford et al., 2007; Riggs et al., 2007). These include chronic symptom distress (i.e. PTSD, anxiety, depression), emotion regulation difficulties (i.e. suicidality, self-harm, addiction problems), self-related difficulties (i.e. low self-esteem, vulnerability and insecurity), and interpersonal difficulties (i.e. difficulty trusting, or overdependence on others) (Bagley & Mallick, 2000; Briere & Runtz, 1990; Landsford et al., 2007; Riggs et al., 2007). Thus large numbers of individuals seek therapy for these difficulties. Understanding the factors that contribute to effective therapy for the effects of child abuse trauma has the potential to benefit large numbers of individuals.

The present study also contributes to the trauma treatment literature by examining the influence of a large number of client characteristics on outcome in EFTT that previously had not been studied. Previous research in EFTT had predominantly looked at the influence of global factors, such as overall abuse severity, presence and severity of personality pathology, and total PTSD symptoms (Paivio et al., 2009; Paivio & Nieuwenhuis, 2001), whereas the present study examined these and other factors in more detail. Particular PTSD symptom clusters, specific personality disorders, severity of different types of abuse, different attachment styles, different dimensions of alexithymia, and features of abuse (multiple abuse experiences, perpetrator status) have the potential

to differentially influence treatment outcome in EFTT via their differential influence on alliance formation and the capacity to confront and re-experience trauma material (e.g. Paivio & Pascual-Leone, 2009). The current study's comprehensive examination of a large number of pre-treatment client characteristics provides a more complete picture of what factors might facilitate or impede improvement in EFTT. These findings are useful in formulating hypotheses about prognostic client variables for testing in future research.

The present study also contributes to the literature on client-by-treatment interactions. Although there is evidence supporting the existence of client-by-treatment interactions, there has been little systematic research examining which client characteristics interact with which treatments to effect therapy outcome (Baker & Neimeyer 2003), and no such studies of trauma therapy. Previous research on EFTT has indicated that both the IC and EE versions are effective in resolving child abuse trauma (Paivio et al., 2009) but, as with all treatments, some clients did better than others. The present study's examination of the aforementioned pre-treatment client variables and the interaction of these variables with two controlled treatment conditions begin to tease apart the particular client variables that might interact with the particular demands of each treatment. This is an important first step in generating hypotheses about which clients might be more suitable for which version of EFTT.

Finally, the extreme group design used in the current study allowed for a preliminary examination of a large number of variables in a small sample without inflating the Type I error rate to the same degree as would occur with multiple correlational analyses. This examination of a large number of variables provided a more

complete picture of clients who did best and worst in each condition and isolated those client characteristics that merit further investigation.

In terms of limitations, the disadvantages of the extreme group design used in the present study were presented earlier in the Methods section. To review briefly, one methodological concern is arbitrary group assignment that, in this case, does not represent the extent to which any client benefited from therapy. The present study minimized this limitation by creating groups based on effect size estimates from change scores on eight different dependent measures. Another limitation of extreme group designs is the possibility of using non-representative levels of continuous variables. Consequently, the importance of the pre-treatment client characteristics found to differentiate between best and worst outcome might be overestimated (McClelland & Judd, 1993). However, the purpose of the current study was to detect trends in pre-treatment client characteristics that could be investigated further in future studies.

Other limitations of the present study are a function of using archival data that restricted the variables that could be examined and the size of the sample. The use of the extreme group methodology further restricted sample size. The small sample decreased the power of analyses to detect effects so that potentially important client-by-treatment interactions may have gone undetected. However, in light of the limited power, the fact that client-by-treatment interactions were detected supports the validity of findings that merit investigation in future research. That being said, the chance of significant findings being due to Type I error cannot be dismissed due to the number of multiple comparisons conducted. For example, analyses of personality disorders were conducted for each of the 10 disorders. Findings concerning the influence of personality pathology also need to be

interpreted with caution, given the criticism that the PDQ-4 tends to over diagnose (Fossati et al., 1998), and the outdated personality disorder categories that do not correspond to the current DSM taxonomy.

Another limitation of the present study concerns generalizability of findings. This was a moderately distressed sample of clients of European decent. Although clients reported a constellation of disturbances typical of this client group (Paivio et al., 2009; Scoboria et al., 2006), the sample was not representative of more severely disturbed clients and ethnic and racial minorities. Results cannot be generalized to these individuals, nor can results be generalized to different treatments. Features, such as promoting client experiencing, the model of resolution (Greenberg & Foerster, 1996), and specific interventions such as IC are unique to EFTT. Therefore, client characteristics associated with best and worst outcome cannot necessarily be generalized to other treatment modalities. Finally, the current study was exploratory in nature. It is not possible to draw firm conclusions and make specific treatment recommendations based on current findings. Results can, however, guide future investigations on client-by-treatment interactions in EFTT and other trauma therapies.

Future Research

Research has indicated that psychological treatments are effective for survivors of child abuse (e.g. Chard, 2005; Cloitre et al., 2002; Paivio et al., 2009; Paivio & Nieuwenhuis, 2001). Trauma therapy research therefore needs to move beyond questions of efficacy to the examination of the factors that contribute to efficacy, including client characteristics. Further investigation of the interactions between specific client variables and outcome found in the present study may be particularly promising. In EE, this

includes the effects of gender, being single, personality disorders characterized in interpersonal and emotional distance, a treatment focus on sexual abuse and mothers as perpetrators. In IC, this includes being married, personality disorders characterized by experiential avoidance, severe difficulties describing feelings, and a treatment focus on perpetrators who are attachment figures.

Several other client variables were not examined in the present study but also can potentially influence outcome in trauma therapy and are worthy of future investigation. One such variable is client resiliency in the face of trauma. Factors highlighted in the literature that may influence resiliency include cognitive abilities, self-esteem, locus of control, attributing blame to perpetrators, and social support (Campbell, Ahrens, Sefl, Wasco, & Barnes, 2001; Cicchetti, Rogosch, Lynch, & Holt, 1993; Heller, Larrieu, D'Imperio, & Boris, 1999).

Research has suggested that higher intelligence may contribute to adaptive coping thereby increasing resiliency. Moreover, intellect may also be associated with academic success, which may in turn foster a sense of competence and increase self-esteem (Cicchetti et al., 1993). High self-esteem has also been found to positively impact resiliency, because it is thought to be a protective factor against depression in survivors of child abuse and neglect (Moran & Eckenrode, 1992). One explanation that has been suggested is that higher self-esteem may act as a buffer against negative messages inflicted upon children during abusive experiences (Cicchetti et al., 1993).

Survivors of abuse who possess an internal locus of control and external attributions of blame for the abuse have also been found to be more resilient (Heller et al., 1999). Likewise, research indicates that the availability of social support increases

resiliency in child abuse survivors (Campbell et al., 2001). However, perceived social support, which refers to the victims perception that support will be available when needed, may be a stronger predictor of resiliency that actual available social support (Norris & Kaniasty, 1996; Schumm et al., 2006). Specifically, experiencing child abuse, coupled with a lack of perceived social support, have been found to increase the risk of depression and PTSD (Schumm et al., 2006). On the other hand, among survivors of child sexual abuse, use of social support and positive coping styles, defined as disclosing and discussing abuse experiences, positive reframing, and not dwelling on previous abuse, have been associated with decreased risk of psychological maladjustment (Arata, 2000). This connection between social support and resilience seems relevant to present findings, discussed earlier, concerning the negative effects of being single in EE and positive effects of being married in IC.

Conclusion

Psychological treatments differ at the level of underlying theories of functioning, dysfunction and change, and at the level of intervention. In the area of therapies for complex child abuse trauma, there are recognized change factors that are common across treatment modalities. These include emotional processing of trauma material and provision of a safe therapeutic relationship that facilitates exploration of trauma feelings and memories, that is, emotional processing. Different clients respond differently to the relational and re-experiencing demands of trauma therapy. In addition, particular treatment modalities have distinct features that, again, clients respond differently to.

In the case of EFTT, one version is highly evocative and requires that clients imaginally confront perpetrators of abuse and neglect in an empty chair. This procedure

obviously is quite distinct from the normal context of therapy. The other version is gentler, less evocative, and trauma exploration is less distinct from the normal therapeutic relational context. Understanding the client characteristics that interact with the features of different treatment modalities can improve efficacy through treatment planning and tailoring to meet individual client needs. Research on client-by-treatment interactions in the area of trauma therapy is in its infancy. Although the present study was purely exploratory, it generated hypotheses for testing in future research which indirectly has the potential to benefit large numbers of clients seeking therapy for the painful long-term effects of child abuse trauma.

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Appendix A

DSM-IV-TR PTSD Criteria

Criteria A: Stressor:

The person has been exposed to a traumatic event in which both of the following have been present:

1. The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.
2. The person's response involved intense fear, helplessness, or horror. *Note:* in children, it may be expressed instead by disorganized or agitated behavior.

Criteria B: Intrusive Recollection

The traumatic event is persistently re-experienced in at least **one** of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. *Note*: in young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
2. Recurrent distressing dreams of the event. *Note:* in children, there may be frightening dreams without recognizable content.
3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). *Note*: in children, trauma-specific reenactment may occur.
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

Criteria C: Avoidant/Numbing

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least **three** of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma

2. Efforts to avoid activities, places, or people that arouse recollections of the trauma
3. Inability to recall an important aspect of the trauma
4. Markedly diminished interest or participation in significant activities
5. Feeling of detachment or estrangement from others
6. Restricted range of affect (e.g., unable to have loving feelings)
7. Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

Criteria D: Hyper-arousal

Persistent symptoms of increasing arousal (not present before the trauma), indicated by at least **two** of the following:

1. Difficulty falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hyper-vigilance
5. Exaggerated startle response

Criteria E: Duration

Duration of the disturbance (symptoms in B, C, and D) is more than one month.

Criteria F: Functional Significance

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Appendix B
Complex PTSD/DESNOS Criteria

1. Alterations in the regulation of affective impulses, including difficulty with modulation of anger and self-destructiveness.
2. Alterations in attention and consciousness leading to amnesias and dissociative episodes and depersonalization.
   - Dissociation tends to be related to prolonged and severe interpersonal abuse occurring during childhood
3. Alterations in self perception, such as a chronic sense of guilt and responsibility, and ongoing feelings of intense shame.
   - Chronically abused individuals often incorporate the lessons of abuse into their sense of self and self-worth.
4. Alterations in perception of the perpetrator, including incorporation of his or her belief system.
   - Addresses the complex relationships and belief systems that ensue following repetitive and premeditated abuse by primary caretakers;
5. Alterations in relationship to others, such as not being able to trust and not being able to feel intimate with others.
   - Belief internalized by victim/survivors that people are venal and self-serving, out to get what they can by whatever means including using/abusing others
6. Somatization and/or medical problems.
   - May relate directly to the type of abuse suffered and any physical damage that was caused or they may be more diffuse.
7. Alterations in systems of meaning.

Appendix C: Phone Script

PHONE SCREEN PROCEDURES

Basic Information for Callers

We are conducting research on a particular psychotherapy approach for resolving issues related to childhood abuse (emotional, physical, sexual). We are offering approximately 16 to 20 sessions of free individual therapy in exchange for participation in the research. Participation involves completion of questionnaires before and after therapy completion and following therapy sessions.

Because of the research component and the short-term nature of therapy, there are certain requirements for participation. I will need to ask you questions over the phone that are personal and may be difficult to talk about, but your answers will help me decide if we can meet your needs. I also will be able to suggest alternatives if we cannot. The phone interview could take about 30 minutes.

If, after this phone interview, our program seems like a good fit for you and you wish to continue, I will schedule you for a more in-depth personal interview. At that time, we also will ask you to complete brief questionnaires and can give you more information about the program. At that time we can both decide whether this program indeed can meet your needs. You will be notified of our decision within a few days.

Do you have any questions? Would you like to proceed with the telephone interview?

Questions Regarding Suitability

Note: When caller does not meet a criterion, immediately terminate the interview, tell caller another service would be more helpful and ask if he/she would like the number of an alternate service. Refer to resource list for appropriate referral.

1. How did you find out about the program?

2. How old are you? (Minimum, 18 years)

3. Are you currently receiving another therapy or counseling, or taking medication for psychological problems? (If yes, not suitable because of research criteria, continue with current treatment)

4. Do you currently have problems with alcohol or drug use? Have you had these problems in the past? (Minimum, clean/sober for 1 year. Otherwise not suitable, these issues take precedence over a focus on issues from the past.)

5. Are you currently involved in an abusive or violent adult relationship? If past, when did the abuse end and under what circumstances? (Minimum 1 year,

otherwise not suitable, these issues take precedence over a focus on issues from the past.)

6. Have you ever been diagnosed with having a psychiatric or emotional disorder? What was the diagnosis, who diagnosed the disorder and when? (Incompatible diagnoses include: schizophrenia, bipolar disorder, anorexia nervosa, obsessive-compulsive disorder, dissociative disorders. Interviewer may need to consult with supervisor to assess suitability. Provide referral.)

7. Are you currently in crisis (need to see someone immediately)? (If yes, not suitable due to wait-list condition. Refer to Crisis Services.)

8. Have you ever felt so bad you wanted to hurt yourself or commit suicide? If yes, what happened? When was the last time you felt like that or actually hurt yourself? (Not suitable if current risk of self-harm or suicide. Provide referral – self-harm group at Hotel Dieu or Crisis)

9. Tell me something about the child abuse experiences you want to focus on in therapy? (Criteria: conscious memories of abuse, can identify a specific relationship to focus on in therapy –i.e., abusive and/or neglectful other. Global marital, relationship or adjustment problems, or inferences about abuse are not suitable.)

Disposition of Call

Does NOT meet criteria. Why? _____
Specify referral _____

Meets Criteria

APPOINTMENT FOR INTERVIEW

NAME _____ PHONE (H) _____(W)_____

DATE_____ TIME _____ INTERVIEWER_____

GIVE DIRECTINOS TO THE PSYCHOLOGICAL SERVICES CENTRE OR PSYCHOLOGY DEPARTMENT & PARKING

INFORM THAT INTERVIEW WILL TAKE APPROXIMATELY 90 MINUTES

Appendix D: Screening Criteria

CLIENT NO _____ DATE _____
RATER _____ ASSESSMENT TIME____

SCREENING AND SELECTION INTERVIEW GUIDELINES

Information in the following areas should be obtained:

1.PRESENTING PROBLEM
What are the main things the person wants help with in therapy? How can therapy help? Feelings toward past abusive and/or neglectful others?

2. HISTORY OF CHILD ABUSE
Includes perpetrator(s), age of onset, duration, severity, coping strategies, external resources at the time, disclosure to others.

3. QUALITY OF PAST RELATIONSHIPS
Includes relationships with family members, peers, teachers.

4. QUALITY OF CURRENT RELATIONSHIPS
Includes spouse, children, peers, other resources of social support.

5. PHYSICAL AND MENTAL HEALTH HISTORY
Includes serious illnesses, hospitalizations, diagnoses, medications, previous therapy experiences.

6. PAST AND PRESENT FUNCTIONING
Includes occupational, educational, and interpersonal functioning; current stressors, coping strategies. DSM-IV GAF score (see attached scale): _____

7. PTSD SYMPTOM SEVERITY
See attached interview schedule.

Screening Criteria

Ask client to elaborate on endorsement of any of the following problems.

1. Anger Control Problems
   - -history of physical fights or other aggressive behaviour
   - -difficulty controlling temper
   - -considered "hot tempered" by others

2. Self-harm Behaviour
   - -attempts to hurt or kill self
   - -done things on impulse that got you into trouble (e.g., sex with strangers, drinking too much, binge eating)

3. Dissociation in Response to Stress
   - -"black out" or loss of consciousness
   - -recurrent feelings of detachment from yourself or body
   - -feeling like you're in a trance or dream

Appendix E

Dependent Measures

Symptom Checklist-90-Revised (SCL; Derogatis, 1983)
90 Items assessing distress over the preceding seven days on a 5 point scale (0=not at all, 4= extremely)

How much were you distressed by:

1. headaches.....
2. nervousness or shakiness.....
3. repeated unpleasant thoughts that won't leave your mind.....
4. faintness or dizziness.....
5. loss of sexual interest or pleasure.....
6. feeling critical of others.....
7. the idea that someone else can control your thoughts.....
8. feeling others are to blame for most of your troubles.....
9. trouble remembering things.....
10. worried about sloppiness or carelessness....
11. feeling easily annoyed or irritated.....
12. pains in heart or chest.....
13. feeling afraid in open spaces or on the street.....
14. feeling low in energy or slowed down.....
15. thoughts of ending your life.....
16. hearing voices that other people do not hear.....
17. trembling.....
18. feeling that most people cannot be trusted..
19. poor appetite.....
20. crying easily.....
21. feeling shy or uneasy with the opposite sex.....
22. feelings of being trapped or caught.....
23. suddenly scared for no reason.....
24. temper outbursts that you could not control.....

25. feeling afraid to go out of your house alone.....
26. blaming yourself for things.....
27. pains in lower back.....
28. feeling blocked in getting things done.....
29. feeling lonely.....
30. feeling blue.....
31. worrying too much about things.....
32. feeling no interest in things.....
33. feeling fearful.....
34. your feelings being easily hurt.....
35. other people being aware of your private thoughts.....
36. feeling others do not understand you or are unsympathetic.....
37. feeling that people are unfriendly or dislike you.....
38. having to do things very slowly to insure correctness.....
39. heart pounding or racing.....
40. nausea or upset stomach.....
41. feeling inferior to others.....
42. soreness of your muscles.....
43. feeling that you are watched or talked about by others.....
44. trouble falling asleep.....
45. having to check and double-check what you do.....
46. difficulty making decisions.....
47. feeling afraid to travel on buses, subways, or trains.....
48. trouble getting your breath.....
49. hot or cold spells.....
50. having to avoid certain things, places, or activities because they frighten you.....
51. your mind going blank.....
52. numbness or tingling in parts of your body.
53. a lump in your throat.....
54. feeling hopeless about the future.....
55. trouble concentrating.....
56. feeling weak in parts of your body.....
57. feeling tense or keyed up.....
58. heavy feelings in your arms or legs.....
59. thoughts of death or dying.....
60. overeating.....
61. feeling uneasy when people are watching or talking about you.....

62. having thoughts that are not your own.....
63. having urges to beat, injure, or harm someone.....
64. awakening in the early morning.....
65. having to repeat the same actions such as touching, counting, or washing.....
66. sleep that is restless or disturbed.....
67. having urges to break or smash things.....
68. having ideas or beliefs that others do not share.....
69. feeling very self-conscious with others.....
70. feeling uneasy in crowds, such as shopping or at a movie.....
71. feeling everything is an effort.....
72. spells of terror or panic.....
73. feeling uncomfortable about eating or drinking in public.....
74. getting into frequent arguments.....
75. feeling nervous when you are left alone.....
76. others not giving your proper credit for your achievements.....
77. feeling lonely even when you are with people.....
78. feeling so restless you couldn't sit still..
79. feelings of worthlessness.....
80. the feeling that something bad is going to happen to you.....
81. shouting or throwing things.....
82. feeling afraid you will faint in public.....
83. feeling that people will take advantage of you if you let them.....
84. having thoughts about sex that bother you a lot.....
85. the idea that you should be punished for your sins.....
86. thoughts and images of a frightening nature.
87. the idea that something serious is wrong with your body.....
88. never feeling close to another person.....
89. feelings of guilt.....
90. the idea that something is wrong with your mind.....

The *Beck Depression Inventory* (BDI; Beck, Brown, & Steer, 1996)

1. Sadness 0 I do not feel sad 1 I feel sad much of the time 2 I am sad all the time 3 I am so sad or unhappy that I can't stand it	12. Loss of Interest 0 I have not lost interest in other people or activities 1 I am less interested in other people or things than before 2 I have lost most of my interest in other people or things 3 It's hard to get interested in anything
2. Pessimism 0 I am not discouraged about my future 1 I fell more discouraged about my future than I used to be 2 I do not expect things to work out for me 3 I feel my future is hopeless and will only get worse	13. Indecisiveness 0 I make decisions about as well as ever 1 I find it more difficult to make decisions than usual 2 I have much greater difficulty in making decisions than I used to 3 I have trouble making any decisions
3.Past failure 0 I do not feel like a failure 1 I have failed more than I should have 2 As I look back, I see a lot of failures 3 I feel I am a total failure as a person	14. Worthlessness 0 I do not feel I am worthless 1 I don't consider myself as worthwhile and useful as I used to 2 I feel more worthless as compared to other people 3 I feel utterly worthless
4. Loss of Pleasure 0 I get as much pleasure as I ever did from the things I enjoy 1 I don't enjoy things as much as I used to 2 I get very little pleasure from the things I used to enjoy 3 I can't get any pleasure from the things I used to enjoy	15. Loss of Energy 0 I have as much energy as ever 1a I sleep somewhat more than usual 1b I sleep somewhat less than usual 2a I sleep a lot more than usual 2b I sleep a lot less than usual 3a I sleep most of the day 3b I wake up 1-2 hours early and can't get back to sleep
5. Guilty Feelings 0 I don't feel particularly guilty 1 I feel guilty over many things I have done or should have done 2 I feel quite guilty most of the time 3 I feel guilty all of the time	17. Irritability 0 I am no more irritable than usual 1 I am more irritable than usual 2 I am much more irritable than usual 3 I am irritable all the time

6 Punishment Feelings 0 I don't feel I am being punished 1 I feel i may be punished 2 I expect to be punished 3 I feel I am being punished	18. Changes in Appetite 0 I have not experienced any changes in my appetite 1a My appetite is somewhat less than usual 1b My appetite is somewhat greater than usual 2a My appetite is much less than before 2b My appetite is much greater than before 3a I have no appetite at all 3b I crave food all the time
7 Self-Dislike 0 I feel the same about myself as ever 1 I have lost confidence in myself 2 I am disappointed in myself 3 I dislike myself	19. Concentration Difficulty 0 I can concentrate as well as ever 1 I can't concentrate as well as usual 2 It's hard to keep my mind on anything for very long 3 I find I can't concentrate on anything
8. Self-Criticalness 0 I don't criticize or blame myself more than usual 1 I am more critical of myself than I used to be 2 I criticize myself for all of my faults 3 I blame myself for everything bad that happens	20. Tiredness or Fatigue 0 I am no more tired or fatigued than usual 1 I get more tired or fatigued more easily than usual 2 I am too tired or fatigued to do a lot of the things I used to do 3 I am too tired or fatigued to do most of the things I used to do
9. Suicidal Thoughts or Wishes 0 I don't have any thoughts of killing myself 1 I have thoughts of killing myself, but I would not carry them out 2 I would like to kill myself 3 I would kill myself if I had the chance	21. Loss of Interest in Sex 0 I have not noticed any recent change in my interest in sex 1 I am less interested in sex than I used to be 2 I am much less interested in sex now 3 I have lost interest in sex completely
10. Crying 0 I don't cry anymore than I sued to 1 I cry more than I used to 2 I cry over every little thing 3 I feel like crying, but I can't	
11. Agitation 0 I am no more restless or wound up than usual 1 I feel more restless or wound up than usual 2 I am so restless or agitated that it's hard to stay still	

3 I am so restless or agitated that I have to keep moving or doing something	

The *State-Trait Anxiety Inventory* (Speilberger, Gorsuch, & Lushene, 1970)
State Items: 0 = not at all, 4 = very much
Trait Items: 0 = almost never, 4 = almost always

State Items:	Trait Items
1. I feel calm	1. I feel pleasant
2. I feel secure	2. I tire quickly
3. I am tense	3. I feel like crying
4. I am regretful	4. I wish I could be as happy as others seem to be
5. I am at ease	5. I am losing out on things because i can't make up my mind soon enough
6. I feel upset	6. I feel rested
7. I am presently worrying over possible misfortunes	7. I am calm, cool, and collected
8. I feel rested	8. I feel that difficulties are piling up so that I cannot overcome them
9. I feel anxious	9. I worry too much over something that really doesn't matter
10. I feel comfortable	10. I am happy
11. I feel self confident	11. I am inclined to take things hard
12. I feel nervous	12. I lack self confidence
13. I am jittery	13. I feel secure
14. I feel "high strung"	14. I try to avoid facing a crisis or difficulty
15. I am relaxed	15. I feel blue
16. I feel content	16. I am content
17. I am worried	17. Some unimportant thought runs through my mind and bothers me
18. I feel over-excited and "rattled"	18. I take disappointments so keenly that I
19. I feel joyful	
20. I feel pleasant	

	can't put them out of my mind 19. I am a steady person 20. I become tense and upset when i think about my present concerns

The *Rosenberg Self Esteem Scale* (RSE; Rosenberg, 1989)

0= strongly disagree, 3 = strongly agree

1. On the whole, I am satisfied with myself.
2. At times I think I am no good at all.
3. I feel that I have a number of good qualities.
4. I am able to do things as well as most other people.
5. I feel I do not have much to be proud of.
6. I certainly feel useless at times.
7. I feel that I am a person of worth, at least on an equal plane with others
8. I wish I could have more respect for myself.
9. All in all, I am inclined to think that I am a failure.
10. I take a positive attitude towards myself.

Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureno, & Villesenor, 1988)

It is hard for me to:

1. trust other people.....0 1 2 3 4
2. say "no" to other people.....0 1 2 3 4
3. join in on groups.....0 1 2 3 4
4. keep things private from other people.....0 1 2 3 4
5. let other people know what I want.....0 1 2 3 4
6. tell a person to stop bothering me.....0 1 2 3 4
7. introduce myself to new people.....0 1 2 3 4
8. confront people with problems that come up.....0 1 2 3 4
9. be assertive with another person.....0 1 2 3 4
10. make friends.....0 1 2 3 4
11. express my admiration for another person.....0 1 2 3 4
12. have someone dependent on me.....0 1 2 3 4
13. disagree with other people.....0 1 2 3 4
14. let other people know when I am angry.....0 1 2 3 4
15. make a long-term commitment to another person.....0 1 2 3 4
16. stick to my own point of view and not be swayed by other people.....0 1 2 3 4
17. be another person's boss.....0 1 2 3 4
18. do what another person wants me to do.....0 1 2 3 4
19. get along with people who have authority over me.....0 1 2 3 4
20. be aggressive towards other people when the situation calls for it.....0 1 2 3 4
21. compete against other people.....0 1 2 3 4
22. make reasonable demands of other people.....0 1 2 3 4
23. socialize with other people.....0 1 2 3 4
24. get out of a relationship that I don't want to be in.....0 1 2 3 4
25. take charge of my own affairs without help from other people.....0 1 2 3 4

26. show affection around other people.....0 1 2 3 4
27. feel comfortable around other people.....0 1 2 3 4
28. get along with other people.....0 1 2 3 4
29. understand another person's point of view.....0 1 2 3 4
30. tell personal things to other people.....0 1 2 3 4
31. believe that I am lovable to other people.....0 1 2 3 4
32. express my feelings to other people directly.....0 1 2 3 4
33. be firm when I need to be.....0 1 2 3 4
34. experience a feeling of love for another person.....0 1 2 3 4
35. be competitive when the situation calls for it.....0 1 2 3 4
36. set limits on other people.....0 1 2 3 4
37. be honest with other people.....0 1 2 3 4
38. be supportive of another person's goals in life.....0 1 2 3 4
39. feel close to other people.....0 1 2 3 4
40. really care about other people's problems.....0 1 2 3 4
41. argue with another person.....0 1 2 3 4
42. relax and enjoy myself when I go out with other people.....0 1 2 3 4
43. feel superior to another person.....0 1 2 3 4
44. become sexually aroused toward the person I really care about.....0 1 2 3 4
45. feel that I deserve another person's affection.....0 1 2 3 4
46. keep up my side of a friendship.....0 1 2 3 4
47. spend time alone.....0 1 2 3 4
48. give a gift to another person.....0 1 2 3 4
49. have loving and angry feelings towards the same person.....0 1 2 3 4
50. maintain a working relationship with someone I don't like.....0 1 2 3 4
51. set goals for myself without other people's advice.....0 1 2 3 4
52. accept another person's authority over me.....0 1 2 3 4
53. feel good about winning.....0 1 2 3 4
54. ignore criticism from other people.....0 1 2 3 4

It is hard for me to:

55. feel like a separate person when I am in a relationship.....0 1 2 3 4
56. allow myself to be more successful than other people.....0 1 2 3 4
57. feel or act competent in my role as parent.....0 1 2 3 4
58. let myself feel angry at somebody I like.....0 1 2 3 4
59. respond sexually to another person.....0 1 2 3 4
60. accept praise from another person.....0 1 2 3 4
61. put somebody else's needs before my own.....0 1 2 3 4
62. give credit to another person for doing something well.....0 1 2 3 4
63. stay out of other people's business.....0 1 2 3 4
64. take instructions from people who have authority over me.....0 1 2 3 4
65. feel good about another person's happiness.....0 1 2 3 4
66. get over the feeling of loss after a relationship has ended.....0 1 2 3 4
67. ask other people to get together socially with me.....0 1 2 3 4
68. feel angry at other people.....0 1 2 3 4
69. give constructive criticism to another person.....0 1 2 3 4
70. experience sexual satisfaction.....0 1 2 3 4
71. open up and tell my feelings to another person.....0 1 2 3 4
72. forgive another person after I've been angry.....0 1 2 3 4
73. attend to my own welfare when somebody else is needy.....0 1 2 3 4
74. be assertive without worrying about hurting the other person's feelings....0 1 2 3 4
75. be involved with another person without feeling trapped.....0 1 2 3 4
76. do work for my own sake instead of for someone else's approval.....0 1 2 3 4
77. be close to somebody without feeling that I'm betraying somebody else.....0 1 2 3 4
78. be self-confident when I am with other people.....0 1 2 3 4

Part II. The following are things that you do too much.

79. I fight with other people too much.....0 1 2 3 4
80. I am too sensitive to criticism.....0 1 2 3 4
81. I feel to responsible for solving other people's problems.....0 1 2 3 4
82. I get irritated or annoyed too easily.....0 1 2 3 4
83. I am too easily persuaded by other people.....0 1 2 3 4

84. I want people to admire me too much.....0 1 2 3 4
85. I act like a child too much.....0 1 2 3 4
86. I am too dependent on other people.....0 1 2 3 4
87. I am too sensitive to rejection.....0 1 2 3 4
88. I open up to people too much.....0 1 2 3 4
89. I am too independent.....0 1 2 3 4
90. I am too aggressive towards other people.....0 1 2 3 4
91. I try to please other people too much.....0 1 2 3 4
92. I feel attacked by other people too much.....0 1 2 3 4
93. I feel too guilty for what I have done.....0 1 2 3 4
94. I clown around too much.....0 1 2 3 4
95. I want to be noticed too much.....0 1 2 3 4
96. I criticize other people too much.....0 1 2 3 4
97. I trust other people too much.....0 1 2 3 4
98. I try to control other people too much.....0 1 2 3 4
99. I avoid other people too much.....0 1 2 3 4
100. I am affected by another person's moods too much.....0 1 2 3 4
101. I put other people's needs before my own too much.....0 1 2 3 4
102. I try to change other people too much.....0 1 2 3 4
103. I am too gullible.....0 1 2 3 4
104. I am overly generous to other people.....0 1 2 3 4
105. I am too afraid of other people.....0 1 2 3 4
106. I worry too much about other people's reactions to me.....0 1 2 3 4
107. I am too suspicious of other people.....0 1 2 3 4
108. I am influenced too much by another person's thoughts and feelings.....0 1 2 3 4
109. I compliment other people too much.....0 1 2 3 4
110. I worry to much about disappointing other people.....0 1 2 3 4
111. I manipulate other people too much to get what I want.....0 1 2 3 4
112. I lose my temper too easily.....0 1 2 3 4
113. I tell personal things to other people too much.....0 1 2 3 4
114. I blame myself too much for causing other people's problems.....0 1 2 3 4
115. I am too easily bothered by other people making demands of me.....0 1 2 3 4

116. I argue with other people too much
117. I am too envious and jealous of other people
118. I keep other people at a distance too much
119. I worry too much about my family's reaction to me
120. I let other people take advantage of me too much

121. I too easily lose a sense of myself when I am around a strong-minded person
122. I feel too guilty for what I have failed to do
123. I feel competitive even when the situation does not call for it
124. I feel embarrassed in front of other people too much
125. I feel too anxious when I am involved with another person
126. I am affected by another person's misery too much
127. I want to get revenge against people too much

The *Resolution Scale* (RS; Singh, 1994)
6-point Likert scale (0 = not at all, 5 = very much).

CLIENT NO. _____ ASSESSMENT TIME _____
SIGNIFICANT OTHER _____ DATE _____

RS

Instructions: The following questions ask you how you feel now in terms of your unfinished business with the significant other person whom you specified at the beginning of therapy. Please circle the number on the scale that best represents how you currently feel.

---

1. I feel troubled by my persisting unresolved feelings (such as anger, grief, sadness, hurt, resentment) in relation to this person.

1 2 3 4 5
Not at all Very much

2. I feel frustrated about not having my needs met by this person.

1 2 3 4 5
Not at all Very much

3. I feel worthwhile in relation to this person.

1 2 3 4 5
Not at all Very much

4. I see this person negatively.

1 2 3 4 5
Not at all Very much

5. I feel comfortable about my feelings in relation to this person.

1 2 3 4 5
Not at all Very much

6. This person's negative view or treatment of me has made me feel badly about myself.

1 2 3 4 5
Not at all Very much

7. I feel okay about not having received what I needed from this person.

1 2 3 4 5
Not at all Very much

CLIENT NO._____ ASSESSMENT TIME_____
SIGNIFICANT OTHER_____ DATE_____

8. I feel unable to let go of my unresolved feelings in relation to this person.

1 2 3 4 5
Not at all Very much

9. I have a real appreciation of this person's own personal difficulties.

1 2 3 4 5
Not at all Very much

10. I have come to terms with not getting what I want or need from this person.

1 2 3 4 5
Not at all Very much

11. I view myself as being unable to stand up for myself in relation to this person.

1 2 3 4 5
Not at all Very much

12. I feel accepting toward this person.

1 2 3 4 5
Not at all Very much

The *Impact of Event Scale* (IES; Horowitz, 1986)
(0 = *not at all*, 3 = *often experienced*).

---

1. I thought about it when I didn't mean to.
2. I avoided letting myself get upset when I thought about it or was reminded of it.
3. I tried to remove it from memory.
4. I had trouble falling asleep or staying asleep.
5. I had waves of strong feelings about it.
6. I had dreams about it.
7. I stayed away from reminders of it.
8. I felt as if it hadn't happened or it wasn't real.
9. I tried not to talk about it.
10. Pictures about it popped into my mind.
11. Other things kept making me think about it.
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.
13. I tried not to think about it.
14. Any reminder brought back feelings about it.
15. My feelings about it were kind of numb.

The *Target Complaints (Discomfort) Scale* (TCD; Battle et al., 1966)
Clients rate on a 13-point scale (1 = none to 13 = couldn't be worse) the degree of discomfort on each problem.

CLIENT NO _____ DATE _____
RATER _____ ASSESSMENT TIME pre-tx

TC

This form is to be filled out by the research assistant based on the client's report.

WHAT PROBLEMS OR DIFFICULTIES DO YOU WANT HELP WITH IN YOUR THERAPY?

1. Problem 1: _____

_____

_____

2. In what situations does this problem occur or become most severe?

_____

_____

_____

3. In what ways would therapy help this problem? (Be as specific as possible.)

_____

_____

_____

4. The boxes below are numbered from 01 to 13 to indicate how much this problem is bothering you now. Please enter, in the blank to the far right, the number that best describes how much this problem is bothering you now..... _____

13	Couldn't be worse
12	
11	
10	Very much
09	
08	
07	Moderately
06	
05	
04	A little
03	
02	
01	Not at all

Client No:_____

5. Problem 2: _____

6. In what situations does this problem occur or become most severe?

7. In what ways would therapy help this problem? (Be as specific as possible.)

8. The boxes below are numbered from 01 to 13 to indicate how much this problem is bothering you now. Please enter, in the blank to the far right, the number that best describes how much this problem is bothering you now..... _____

13	Couldn't be worse
12	
11	
10	Very much
09	
08	
07	Moderately
06	
05	
04	A little
03	
02	
01	Not at all

Client No:_____

9. Problem 3: _____

10. In what situations does this problem occur or become most severe?

11. In what ways would therapy help this problem? (Be as specific as possible.)

12. The boxes below are numbered from 01 to 13 to indicate how much this problem is bothering you now. Please enter, in the blank to the far right, the number that best describes how much this problem is bothering you now..... _____

13	Couldn't be worse
12	
11	
10	Very much
09	
08	
07	Moderately
06	
05	
04	A little
03	
02	
01	Not at all

Appendix F
Client Predictor Measures

The *PTSD Symptom Severity Interview* (PSSI; Foa, Riggs, Dancu, & Rothbaum, 1993)
4-point Likert scale (0 = not at all, 3 = very much).

PTSD Symptom Severity Interview

Cl #_____ DATE_____

ASSESSMENT TIME_____

TRAUMATIC STRESS SYMPTOMS

Note: current effects of childhood abuse experiences, motivation for seeking therapy—ie., why now; significant distress or impaired functioning.

IV

Describe briefly the stressful event(s) reported by the client.
interpersonal - actual or threatened death or injury, threat to phys integrity
A2 - fear, helplessness, horror

For each item listed below, ascertain whether the individual experienced th4e symptoms during the past two weeks. Probe all positive responses in order to determine the severity of the symptoms (e.g., in the past two weeks, how often have you had bad dreams or nightmares), then rate the severity on the scale presented below.

Rating Scale (ratings made over the last two weeks)

0 = not at all
1 = Once per week or less/a little bit/once in a while/a few
2 = 2-4 times per week/somewhat/half the time/some
3 = 5 or more times per week/very much/almost always/many

Reexperiencing Symptoms (need one)

___ 1. Have you had recurrent or intrusive distressing thought or recollections about the childhood truamatic/abusive experiences (e.g., find self thinking about or remembering when you dont want to)?

___ 2. Have you been having recurrent bad dreams about the childhood trauma/abuse?

___ 3. Have you had the experience of suddenly reliving the early traumatic/abusive experiences, flashbacks of being in the situation, acting or feeling as if it were re-occurring?

___ 4. Have you been intensely emotionally upset when reminded of the early traumatic/abusive situations (includes anniversary reactions, television shows, talking about it in current interview)?

___ 5. Have you been having intense physical reactions when reminded of these early abusive experiences (e.g., stomach ache, tension, numbing, feeling panicky)?

Avoidance Symptoms (need three)

___ 6. Have you persistently been making efforts to avoid thoughts or feelings associated with the early abuse (e.g., shut it out of your mind, shut down, numb out, is this happening now)?

OVER →

7. Have you persistently been making efforts to avoid activities, situations, or places that remind you of the early abusive situations?
8. Are there any important aspects of those early traumatic/abusive experiences that you still cannot remember?
9. Have you markedly lost interest in free time activities since those early abusive experiences? Chronic? Frequency within the last two weeks?
10. Have you felt detached or cut off from others around you since these early experiences? Chronic? Within the last two weeks?
11. Have you felt that your ability to experience emotions is somehow diminished?
12. Have you felt that any future plans or hopes have changed because of those early abusive experiences?

Arousal Symptoms (Need two)
13. Have you been having persistent difficulty falling or staying asleep?
14. Have you been continuously irritable or having outbursts of anger?
15. Have you been having persistent difficulty concentrating?
16. Are you overly alert since those early abusive experiences? Chronic? Frequency within the past two weeks?
17. Have you been jumpier, more easily startled, since those early experiences? Chronic? Frequency within the past two weeks?

Re-experiencing cluster
Intrusive thoughts
Nightmares
Flashbacks
Emotionally upset

Avoidance Cluster
Avoid thoughts and feelings
Avoid places, activities
Psychogenic amnesia
Loss of interest
Detached from others
Restricted *affect*
Foreshortened sense of future

Arousal cluster
Sleep disturbance
Irritability
Difficulty concentrating
Hyper-alertness
Increased startle
Physical reactivity

The *Toronto Alexithymia Scale* (TAS-20; Bagby, Parker, & Taylor; 1994)
5-point scale (1=never true; 5=very often true).

Difficulty Identifying and Distinguishing Among Feelings

1. I am often confused about what emotion I am feeling
3. I have physical sensations that even doctors don't understand
6 .When I am upset, I don't know if I am sad, frightened, or angry
7 . I am often puzzled by sensations in my body
9. I have feelings that I can't quite identify
13. I don't know what's going on inside me
14. I often don't know why I am angry

Difficulty Describing Feelings

2. It is difficult for me to find the right words for my feelings
4. I am able to describe my feelings easily
11. I find it hard to describe how I feel about people
12. People tell me to describe my feelings more
17. It is difficult for me to reveal my innermost feelings, even to close friends

Externally Oriented Thinking

5. I prefer to analyze problems rather than just describe them
8. I prefer just to let things happen rather than to understand why they turned out that way
10. Being in touch with emotions is essential
15. I prefer talking to people about their daily activities rather than their feelings
16. I prefer to watch "light" entertainment shows rather than psychological dramas
18. I can feel close to someone, even in moments of silence
19. I find examination of my feelings useful in solving personal problems
20. Looking for hidden meanings in movies or plays distracts from their enjoyment

The *Personality Diagnostic Questionnaire*–Fourth Edition (PDQ4; Hyler, 1994)
99 items (True/False)

CLIENT NO._____ DATE_____
ASSESSMENT TIME BL SSN

PDQ-4+ Questionnaire

The purpose of this questionnaire is for you to describe the kind of person you are. When answering the questions, think about how you have tended to feel, think, and act over the past several years. To remind you of this, on the top of each page you will find the statement: "**Over the past several years...**"

Please answer either True or False to each item..
Where:
T (True) means that the statement is generally true for you.
F (False) means that the statement is generally false for you.

Even if you are not entirely sure about the answer, indicate "T" or "F" for every question.

For example, for the question:
xx. I tend to be stubborn. T F

If, in fact you have been stubborn over the past several years, you would answer True by circling T.

If, this was not true at all for you, you would answer False by circling F.

There are no correct answers.

Over the past several years...

1.	I avoid working with others who may criticize me.	T	F
2.	I can't make decisions without the advice, or reassurance, of others.	T	F
3.	I often get lost in details and lose sight of the "big picture."	T	F
4.	I need to be the center of attention.	T	F
5.	I have accomplished far more than others give me credit for.	T	F
6.	I'll go to extremes to prevent those who I love from ever leaving me.	T	F
7.	Others have complained that I do not keep up with my work or commitments.	T	F
8.	I've been in trouble with the law several times (or would have been if I had been caught).	T	F
9.	Spending time with family or friends just doesn't interest me.	T	F
10.	I get special messages from things happening around me.	T	F
11.	I know that people will take advantage of me, or try to cheat me, if I let them.	T	F
12.	Sometimes I get upset.	T	F
13.	I make friends with people only when I am sure they like me.	T	F
14.	I am usually depressed.	T	F
15.	I prefer that other people assume responsibility for me.	T	F
16.	I waste time trying to make things too perfect.	T	F
17.	I am "sexier" than most people.	T	F

18.	I often find myself thinking about how great a person I am, or will be.	T	F
19.	I either love someone or hate them, with nothing in between.	T	F
20.	I get into a lot of physical fights.	T	F
21.	I feel that others don't understand or appreciate me.	T	F
22.	I would rather do things by myself than with other people.	T	F
23.	I have the ability to know that some things will happen before they actually do.	T	F
24.	I often wonder whether the people I know can really be trusted.	T	F
25.	Occasionally I talk about people behind their backs.	T	F
26.	I am inhibited in my intimate relationships because I am afraid of being ridiculed.	T	F
27.	I fear losing the support of others if I disagree with them.	T	F
28.	I have many shortcomings.	T	F
29.	I put my work ahead of being with my family or friends or having fun.	T	F
30.	I show my emotions easily.	T	F
31.	Only certain special people can really appreciate and understand me.	T	F
32.	I often wonder who I really am.	T	F
33.	I have difficulty paying bills because I don't stay at any one job for very long.	T	F
34.	Sex just doesn't interest me.	T	F
35.	Others consider me moody and "hot tempered."	T	F
36.	I can often sense, or feel things, that others can't.	T	F
37.	Others will use what I tell them against me.	T	F
38.	There are some people I don't like.	T	F
39.	I am more sensitive to criticism or rejection than most people.	T	F
40.	I find it difficult to start something if I have to do it by myself.	T	F
41.	I have a higher sense of morality than other people.	T	F
42.	I am my own worst critic.	T	F
43.	I use my "looks" to get the attention that I need.	T	F
44.	I very much need other people to take notice of me or compliment me.	T	F
45.	I have tried to hurt or kill myself.	T	F
46.	I do a lot of things without considering the consequences.	T	F
47.	There are few activities that I have any interest in.	T	F
48.	People often have difficulty understanding what I say.	T	F
49.	I object to supervisors telling me how I should do my job.	T	F
50.	I keep alert to figure out the real meaning of what people are saying.	T	F
51.	I have never told a lie.	T	F
52.	I am afraid to meet new people because I feel inadequate.	T	F
53.	I want people to like me so much that I volunteer to do things that I'd rather not do.	T	F
54.	I have accumulated lots of things that I don't need but I can't bear to throw out.	T	F
55.	Even though I talk a lot, people say that I have trouble getting to the point.	T	F

Over the past several years...

92.	Others consider me to be stuck up.	T	F
93.	When stressed, things happen. Like I get paranoid or just "black out."	T	F
94.	I don't care if others get hurt so long as I get what I want.	T	F
95.	I keep my distance from others.	T	F
96.	I often wonder whether my wife (husband, girlfriend, or boyfriend) has been unfaithful to me.	T	F
97.	I often feel guilty.	T	F
98.	I have done things on impulse that could have gotten me into trouble.	T	F
99.	When I was a kid (before age 15), I was somewhat of a juvenile delinquent.	T	F

56.	I worry a lot.	T	F
57.	I expect other people to do favors for me even though I do not usually do favors for them.	T	F
58.	I am a very moody person.	T	F
59.	Lying comes easily to me and I often do it.	T	F
60.	I am not interested in having close friends.	T	F
61.	I am often on guard against being taken advantage of.	T	F
62.	I never forget, or forgive, those who do me wrong.	T	F
63.	I resent those who have more "luck" than I.	T	F
64.	A nuclear war may not be such a bad idea.	T	F
65.	When alone, I feel helpless and unable to care for myself.	T	F
66.	If others can't do things correctly, I would prefer to do them myself.	T	F
67.	I have a flair for the dramatic.	T	F
68.	Some people think that I take advantage of others.	T	F
69.	I feel that my life is dull and meaningless.	T	F
70.	I am critical of others.	T	F
71.	I don't care what others have to say about me.	T	F
72.	I have difficulties relating to others in a one-to-one situation.	T	F
73.	People have often complained that I did not realize that they were upset.	T	F
74.	By looking at me, people might think that I'm pretty odd, eccentric or weird.	T	F
75.	I enjoy doing risky things.	T	F
76.	I have lied a lot on this questionnaire.	T	F
77.	I complain a lot about my hardships.	T	F
78.	I have difficulty controlling my anger, or temper.	T	F
79.	Some people are jealous of me.	T	F
80.	I am easily influenced by others.	T	F
81.	I see myself as thrifty but others see me as being cheap.	T	F
82.	When a close relationship ends, I need to get involved with someone else immediately.	T	F
83.	I suffer from low self esteem.	T	F
84.	I am a pessimist.	T	F
85.	I waste no time in getting back at people who insult me.	T	F
86.	Being around other people makes me nervous.	T	F
87.	In new situations, I fear being embarrassed.	T	F
88.	I am terrified of being left to care for myself.	T	F
89.	People complain that I'm "stubborn as a mule."	T	F
90.	I take relationships more seriously than do those who I'm involved with.	T	F
91.	I can be nasty with someone one minute, then find myself apologizing to them the next minute.	T	F

The *Attachment Style Questionnaire* (ASQ; Feeney, Noller, & Hanrahan, 1994)
6 point scale (1= totally disagree/6=totally agree)

Items

C = Confidence
C1. Overall, I am a worthwhile person
C2. I am easier to get to know
C3. I feel confident that other people
C4. I find it relatively easy to get close
C5. I feel confident about relating to others
C6. I often worry that I do not really fit in
C7. If something is bothering me
C8. I am confident that other people

DC = Discomfort with Closeness
DC1. I prefer to depend on myself
DC2. I prefer to keep to myself
DC3. I find it hard to trust other people
DC4. I find it difficult to depend on others
DC5. I find it easy to trust others
DC6. I feel comfortable depending
DC7. I worry about people getting too close
DC8. I have mixed feelings about being close
DC9. While I want to get close to others, I feel
DC10. Other people have their own problems

RS = Relationships as Secondary
RS1. To ask for help is to admit
RS2. People's worth should be judged
RS3. Achieving things is more important
RS4. Doing your best is more important than
RS5. If you've got a job to do, you should do it
RS6. My relationships with others are
RS7. I am too busy with other activities

NA = Need for Approval
NA1. It's important to me that others like me
NA2. It's important to me to avoid
NA3. I find it hard to make a decision
NA4. Sometimes I think I am no good at all

NA5. I worry that I won't measure up
NA6. I wonder why people would want
NA7. When I talk over my problems

PR = Preoccupation with Relationships
PR1. I find that others are reluctant
PR2. I worry that others won't care
PR3. It's very important to me to have
PR4. I worry a lot about my relationships
PR5. I wonder how I would cope
PR6. I often feel left out or alone
PR7. I get frustrated when others
PR8. Other people often disappoint me

The *Childhood Trauma Questionnaire* (CTQ; Bernstein & Fink, 2003)
6-point Likert scale (0 = *never true*, 5 = *very often true*).

Emotional abuse
Called names by family
Parents wished was never born
Felt hated by family
Family said hurtful things
Was emotionally abused

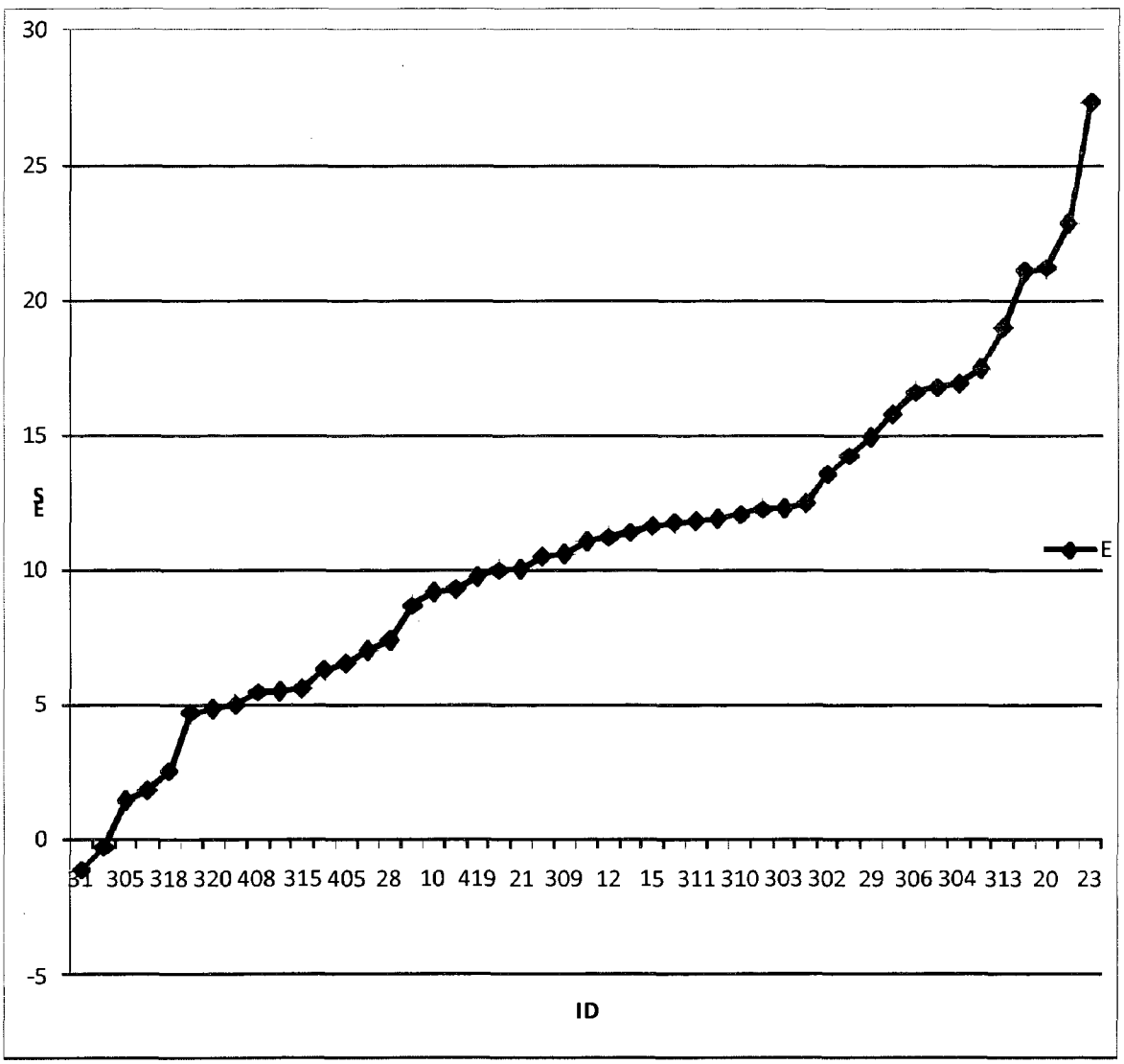
Physical abuse
Hit hard enough to see doctor
Hit hard enough to leave bruises
Punished with hard objects
Was physically abused
Hit badly enough to be noticed

Sexual abuse
Was touched sexually
Hurt if didn't do something sexual
Made to do sexual things
Was molested
Was sexually abused

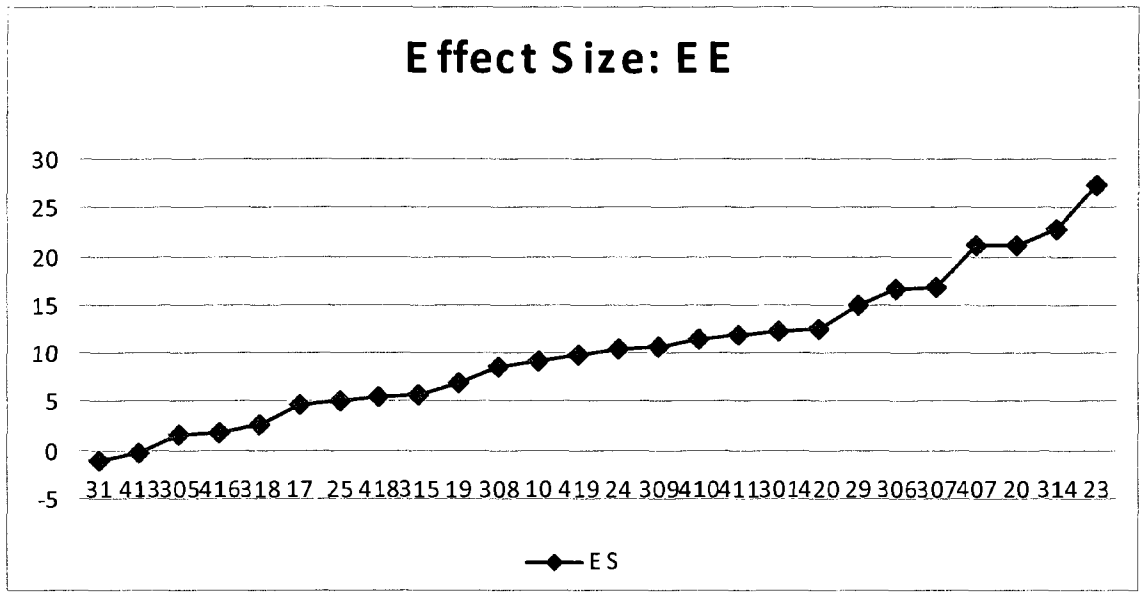
Emotional neglect
Felt loved
Made to feel important
Was looked out for
Family felt close
family was source of strength

Physical neglect
Not enough to eat
Got taken care of
Parents were drunk or high
Wore dirty clothes
Got taken to doctor

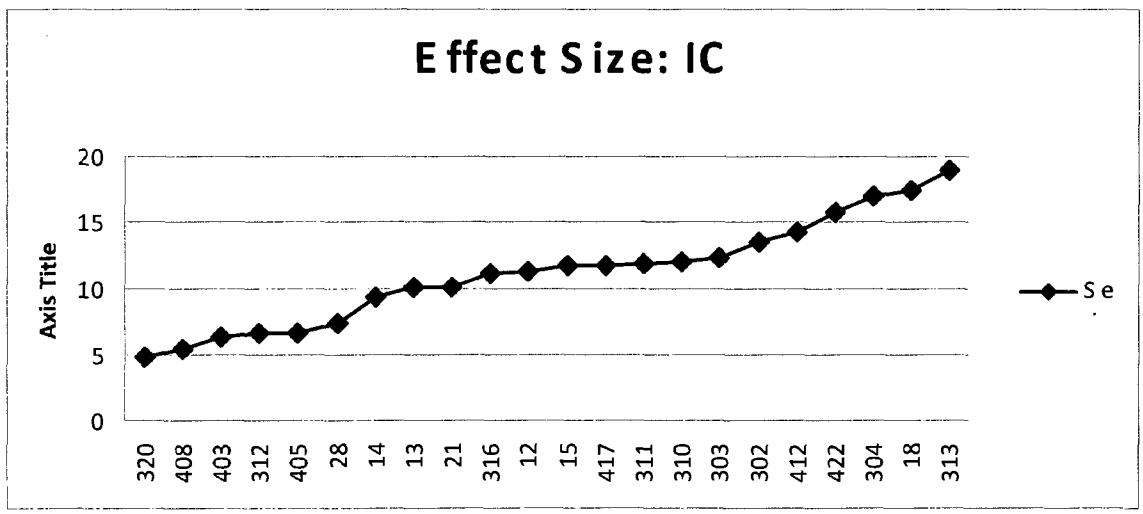
Appendix G
Effect Size Graph for Total Sample



Effect Size Scores for EE



Effect Size Scores for IC



Vita Auctoris

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