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Lori K. Robichaud

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DEPTH OF EXPERIENCING AS A CLIENT PROGNOSTIC VARIABLE
IN EMOTION-FOCUSED THERAPY FOR
ADULT SURVIVORS OF CHILDHOOD ABUSE

By
Lori K. Robichaud
B.Sc. (Hon.) University of Guelph, 2002

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

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Depth of Experiencing as a Client Prognostic Variable in Emotion-Focused Therapy for Adult Survivors of Childhood Abuse

by

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ABSTRACT

The term "experiencing" has been used to describe the quality of clients' engagement with their own internal experience (e.g., thoughts, feelings, images) during therapy. The present study investigated the relationship between depth of experiencing as a client characteristic and outcomes in Emotion-Focused Therapy for Adult Survivors of Child Abuse (EFT-AS). The study utilized archival data (audiotaped treatment sessions and self-report outcome measures) collected from 37 EFT-AS clients, who were dealing with issues of past emotional, physical, or sexual childhood abuse (Paivio & Nieuwenhuis, 2001). Clients' depth of experiencing was rated early in the therapy process during clients' discussion of core issues related to past abuse. Selected segments were transcribed and then rated using the Experiencing Scale (EXP; Klein, Mathieu-Coughlan, & Kiesler, 1986). A series of hierarchical multiple regressions were used to determine whether deeper levels of experiencing, early in therapy, predicted therapeutic outcomes. The results revealed that modal EXP ratings independently contributed to less symptomatology, reduced trauma symptoms, reduced interpersonal problems, and improved resolution of abuse issues. Peak EXP ratings did not significantly predict therapeutic outcomes. Together, the results suggest that experiencing can be used as a prognostic measure in EFT-AS and that maintaining a high EXP level seems to be more important to therapeutic outcomes than briefly attaining a high EXP level.
DEDICATION

This thesis is gratefully dedicated to my fiancé, Ryan Gray, for his unwavering support, endless encouragement, and patience; and to my mother, Vera Robichaud, for instilling the perseverance, dedication, and intellectual enrichment that is critical to personal and academic growth and success.
ACKNOWLEDGEMENTS

I would like to express my sincerest appreciation to my supervisor, Dr. Sandra Paivio, for her continuous wisdom, guidance, and support, which were pivotal to the success and completion of this project. Furthermore, the contributions of Dr. Kim Harper and Dr. Barry Taub have been insightful, motivational, and critical to this project. Special thanks are extended to the University of Windsor Departments of Psychology and Graduate Studies, Social Sciences and Humanities Research Council, and the Ontario Graduate Scholarships for making graduate studies possible.

I would also like to extend my sincerest gratitude to the many individuals who stimulated my interest in the sequelae of traumatic stress: Dr. Will Brooks, Steve Darling, Elizabeth and Gordon Glibbery, Dr. Gerry Goldberg, Arthur Graham, Dr. Christopher Mazza, Merideth Morrison, Randy Piercy, and Dean Shaddock. Furthermore, I would like to extend my appreciation to Dr. Ray Blanchard, Dr. James Cantor, Dr. Raymond Daly, and Dr. Kathryn Lafreniere for offering their continuous support through my pursuit of higher education, research, and clinical experience. I also feel grateful to Trang Le, for her invaluable assistance in this project.

I would like to extend my deepest gratitude to my mother, Vera Robichaud, for teaching me to continue to strive for my dreams and to Ryan Gray, for his endless support and encouragement. I would also like to extend my gratitude to my family and friends. Finally, I would like to extend my appreciation to Debbie Roberts, who has played a pivotal role in my personal and academic growth and who has taught me that, “each of us has something truly unique to offer the world, if only we have the courage to dream and the determination to make our dreams come true.”
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Chapter I

Introduction

Context of the Problem

The severity of child abuse can range from a single episode of emotional, physical, or sexual abuse to prolonged and multiple forms of abuse (Paivio & Nieuwenhuis, 2001). According to the Canadian Incidence Study of Reported Child Abuse and Neglect for Health Canada, 61, 201 substantiated cases of child abuse and another 29,669 suspected cases of child abuse were reported in 1998 (Trocme et al., 2001). Furthermore, these statistics are considered to be considerably underestimated due to the significant number of unreported cases (Hopper, 2003). Despite preventative measures and treatment resources, child abuse continues to occur and the long-term effects can be devastating. The consequences of child abuse can include symptoms of Posttraumatic Stress Disorder and Depression, difficulties in affect regulation, self-esteem, and interpersonal relationships, and chronic feelings of anger, guilt, powerlessness, and shame (Paivio & Shimp, 1998). The prevalence of child abuse, combined with the negative consequences, underlines the importance of enhancing the understanding of the treatment of survivors of child abuse.

One promising treatment approach for the long-term effects of child abuse is Emotion-Focused Therapy for Adult Survivors of Childhood Abuse (EFT-AS; Paivio & Nieuwenhuis, 2001). EFT-AS is a short-term experiential-based psychotherapy that focuses upon and has demonstrated promising improvements in symptomatology, self-esteem, and distress from interpersonal sources. The present research investigated the variables that account for successful outcomes in EFT-AS. More specifically, the present research investigated the depth of clients’ experiencing, which refers to the clients’
engagement with their own internal experience during therapy. Experiencing encompasses clients’ capacity to access and explore trauma material and it is thought to be essential to the construction of new meaning (Goldman, 1997). The present research examined whether the depth of clients’ experiencing, early in the therapy process (during one of the first three therapy sessions), predicted outcomes in EFT-AS. It was found that modal EXP ratings independently contributed to less symptomatology, reduced trauma symptoms, reduced interpersonal problems, and improved resolution of abuse issues. Peak EXP ratings did not significantly predict therapeutic outcomes. These findings enhance the knowledge of the factors that contribute to successful treatment with child abuse survivors. It also contributes to the existing research and theoretical rational that supports the role of experiencing across therapy modalities (Bohart, 1993). In addition, these results have helped to clarify the role of experiencing in successful treatment with child abuse survivors. The identification of experiencing as a client variable could also help to inform client by treatment interactions and, in turn, client selection.
Chapter II

Literature Review

Prevalence and Nature of Child Abuse

Throughout Canada, 90,870 cases of child abuse were reported 1998 (Trocme et al., 2001). More specifically, a recent study of child abuse in Ontario reported that 13 percent of females and four percent of males had been victims of sexual abuse whereas 21 percent of females and 31 percent of males had been victims of physical abuse (MacMillen et al., 1997). Another study reported rates of emotional abuse in Ontario university students at 25 percent for females and 35 percent for males (Turner & Paivio, 2002). Although the prevalence of child abuse seems disturbingly high, these estimates are consistent with international estimates (Finkelhor, 1994; Yamamoto et al., 1999) and the prevalence is considered to be largely underestimated because of the significant number of unreported cases (Hopper, 2003).

Considering children’s psychological immaturity and that nearly half of the reported cases of child abuse are intrafamilial (Fischer & McDonald, 1998), it is not surprising that child abuse negatively impacts the development of children’s early attachment relationships. Child abuse differs from acute trauma because it frequently involves prolonged and repeated exposure to interpersonal violence in early attachment relationships (Herman, 1992). Childhood abuse at the hands of a parental figure can be more detrimental than abuse by a stranger because it involves greater betrayal and loss of trust (Beitchman et al., 1990). Furthermore, the consequences of child abuse can be exacerbated in situations of family disturbance that lead to less available emotional support to the child (Beitchman et al., 1990). On the other hand, positive early
attachment experiences may lessen the long-term consequences of childhood abuse (Styron & Janoff-Bulman, 1997).

*Long-Term Effects of Child Abuse*

The negative consequences of child abuse can manifest across multiple domains of functioning and can be long lasting (Briere, 1998; Briere & Runtz, 1993; Herman, 1992; Zlotnick, Zakrisky, Shea, & Costello, 1996). Herman (1992) proposed the term, Complex Posttraumatic Stress Disorder, to reflect three broad and interrelated areas of disturbance that can result from child abuse. The first area of disturbance is symptomatic and has been divided into impairments in affect regulation, sense of self, and interpersonal relations, which will each be discussed below. The second area of disturbance is characterological, meaning that there is a relationship between child abuse and characteristic personality changes such as borderline personality disorder (Barnard & Hirsch, 1985; Beitchman et al., 1990; Bliss, 1984). The third area of disturbance is the victims’ vulnerability to subsequent harm that is inflicted by either him/herself or by another individual. Simply stated, survivors of child abuse are at increased risk of subsequent revictimization in later relationships (Beitchman et al., 1990). The following review will focus on the symptoms and disturbances addressed by EFT-AS.

*Impairments to Affect Regulation.* Dysfunctional emotion regulation can be divided into emotional underregulation and overregulation. In the case of underregulation, emotions are overwhelming and unmanageable (Paivio & Laurent, 2001). For instance, an individual may be overwhelmed with unmanageable anger, sadness, fear, or shame. On the other hand, emotions can be overregulated through dissociation, disavowal, denial, numbing, and avoidance (Paivio & Greenberg, 2000;
Paivio & Laurent, 2001). Overregulation of emotions means that there is too little spontaneous affect (Greenberg, 2002) and is frequently a means of coping with potentially overwhelming affect (Herman, 1992). An example of overregulation is the abuse victim who does not cry or express anger. Both underregulation and overregulation are problematic because emotions are associated with important information (Paivio & Shimp, 1998), so dysfunctional emotion regulation may disconnect a person from the meaning that is transmitted through emotions (Greenberg, 2002).

Impairments to Sense of Self. Prolonged child abuse can negatively shape an individual’s sense of self in several ways. Survivors of abuse can develop a sense of self as powerless, damaged, worthless, bad, unlovable, or different from others along with chronic feelings of depression, anxiety, guilt and shame (Liem, O’Toole, & James, 1996). As well, child abuse has been associated with identity confusion, boundary issues, and feelings of emptiness (Bagley & Ramsay, 1986; Briere & Runtz, 1993). Survivors of abuse can exhibit identity confusion and boundary issues, meaning that they do not know what they feel, believe, want, or need. Alternately, boundary issues can manifest as too much trustworthiness or even gullibility. Feelings of emptiness can result from feelings of being unloved, used, being different from others, or being cut-off from one’s feelings. The quantity and pervasiveness of these consequences has led Beitchman et al. (1990, p. 108) to describe child abuse as having a “corrosive effect on self-esteem.”

Impairments to Interpersonal Relationships. Child abuse can impact perceptions of relationships that, in turn, can produce lasting alterations in social functioning. This is because “how we come to think about ourselves and significant others in the present are closely tied to the manner in which we have been treated and valued by significant others
early in life” (Liem et al., 1996, p.746). Survivors of child abuse have been found to have less secure adult relationships compared to their non-abused counterparts (Styron & Janoff-Bulman, 1997) because child abuse often disrupts individuals’ sense of trustworthiness in others (Liem et al., 1996). Often times, interpersonal relationships are a source of pervasive and consistent lack of confidence in oneself or view of others as untrustworthy, unreliable, unsupportive, and dangerous (Bagley & Ramsay, 1986; Paivio & Shimp, 1998). Davis, Petretic-Jackson, and Ting (2001) found that survivors of child abuse had a lower quality of past interpersonal relationships and a greater fear of intimacy, when compared to non-abused women. When compared to psychiatric clients, child abuse survivors evidenced interpersonal problems in the areas of sociability, submissiveness, intimacy, responsibility, and control, but there was no significant difference in assertiveness (Cloitre, Scarvalone, & Difede, 1997). Therefore, these impairments can span not only intimate relationships, but also interpersonal relationships with family, friends, and coworkers. In summation, experiences with attachment figures as hurtful, untrustworthy, and unsupportive can influence subsequent relationships.

*Emotion-Focused Therapy for Adult Survivors of Childhood Abuse (EFT-AS)*

EFT-AS is a brief psychotherapy for adult survivors of childhood abuse (emotional, physical, and sexual) that is based on the integration of experiential, emotion, attachment, and trauma theories (Paivio & Nieuwenhuis, 2001). EFT-AS incorporates experiential theory (Greenberg & Paivio, 1997; Greenberg, Rice, & Elliot, 1993) through an emphasis upon the exploration and symbolization of emotional experience, the client-centred relationship, and gestalt-derived techniques (Paivio & Nieuwenhuis, 2001). EFT-AS adopts the perspective of emotion theorists who purport that certain primary
emotions, such as sadness and anger, are biologically adaptive and enhance functioning through the acquisition of information that is associated with these emotions (Fridja, 1986; Lazarus, 1991). As such, EFT-AS strives to help clients attain full awareness of their emotional experience in therapy so that they may benefit from the associated adaptive information. Attachment theory (Bowlby, 1988; Sroufe, 1997) plays a central role in EFT-AS, such that the consequences of child abuse are viewed largely as a product of destructive early attachment relationships. Therefore, EFT-AS recognizes that early violations of trust, security, and autonomy are encoded in memory and that these memories form the templates for future expectations of self and others (Bowlby, 1988). It is for this reason that empathy and collaboration are employed to achieve a supportive therapeutic relationship, which can counteract early negative attachment experiences (Paivio & Patterson, 1999). Finally, trauma theory (Briere, 1992; Foa, Rothbaum, Riggs, & Murdock, 1991; Herman, 1992; Shapiro, 1999; Van der Kolk et al., 1996) is incorporated in EFT-AS whereby feelings and trauma memories are accessed, explored, and reprocessed in order to reduce symptom distress and acquire new understanding of the self, others, and reality. Emotional engagement with trauma material (i.e., exposure and the construction of new meaning) is thought to be necessary to recovery from trauma.

**EFT-AS Change Processes.** EFT-AS posits two distinct yet overlapping processes that are central to change (Paivio & Patterson, 1999). These are the therapeutic relationship and emotional processing of trauma memories (Paivio & Nieuwenhuis, 2001). The therapeutic relationship provides an empathic and collaborative environment within which (1) trauma material can be safely explored and (2) a corrective interpersonal experience can be provided, particularly for those whose past experiences were riddled
with a lack of empathy and personal control (Herman, 1992; Van der Kolk et al., 1996). The emotional processing of trauma material activates cognitive-affective information, making it available for modification through the incorporation of new information, such as previously inhibited adaptive emotions such as anger at having been violated. Together then, the therapeutic alliance and processing of trauma memories facilitate the goals of therapy, which are to reduce symptom distress and develop a new view of self, others, and traumatic events. Therefore, EFT-AS strives to establish a safe environment that facilitates the therapeutic relationship and creates an environment where trauma memories may be accessed and explored (Paivio, Hall, Holowaty, Jellis, & Tran, 2001).

Accessing and exploring trauma material reduces symptom distress while simultaneously helping to construct a new understanding of the self, others, and the traumatic events (Paivio et al., 2001). New understanding may be attained through emotional exploration because emotions carry information about the self and external events. Emotions also can be adaptive because they are associated with a meaning system (internal experience) that informs people of the significance of events to their well-being, and they predispose an individual to be prepared for rapid action in appropriate situations (Greenberg, 2002). By attending to and activating core emotional experience, one can access this information about the self and after the information is accessed, it can be worked with in a meaningful way. Empathic responding to emerging experience as well as a Gestalt-derived imaginal confrontation procedure are the primary interventions used throughout EFT-AS in order to facilitate the processing of emotional experience and construction of new meaning (Paivio et al., 2001; Paivio & Patterson, 1999). During imaginal confrontation the client is asked to remember the perpetrator of
abuse or neglect and to express previously constricted feelings and needs to this imagined person (Paivio et al., 2001). These interventions are embedded in an empathetically responsive and collaborative relationship between the client and the therapist (Paivio et al., 2001; Paivio & Patterson, 1999).

*Research on EFT-AS.* An outcome study by Paivio and Nieuwenhuis (2001) supported the efficacy of EFT-AS in treating different types of child abuse (emotional, physical, and sexual) among men and women. Improvements were demonstrated in global and trauma symptomatology, self-esteem, interpersonal problems, abuse-related target complaints, and resolution of issues with past abusive and neglectful others. Overall, clients receiving EFT-AS ($n = 22$) achieved significantly greater improvements in multiple domains of disturbance compared to individuals in the wait list condition ($n = 24$) and furthermore, the clients receiving treatment after the wait interval achieved comparable gains to the immediate treatment group following treatment.

Subsequent research has investigated key process variables and their relationship to outcomes in EFT-AS. The contributions of therapeutic alliance and clients’ emotional engagement with child abuse material, during the imaginal confrontation intervention, have been related to outcome in EFT-AS (Paivio et al., 2001; Paivio & Patterson, 1999). However, to date, research has revealed limited information on client variables that contribute to outcome in EFT-AS. There is some evidence that the severity of trauma and trauma symptoms (Paivio & Patterson, 1999) and Axis II psychopathology (Paivio, Hall, & Holowaty, 2004) predicted poorer outcomes. One client variable that could contribute to positive outcomes in EFT-AS, because of its central role in the acquisition of new meaning and recovery from trauma, is clients’ capacity for depth of experiencing.
The Concept of Experiencing

Definition. The term experiencing has been used to describe the quality of clients' engagement with their own internal experiences (e.g., thoughts, feelings, images, sensations, memories) during therapy. It refers to the "extent to which inner referents become the felt data of attention and the degree to which efforts are made to focus on, expand, and probe those data" (Klein et al., 1986, p. 21). Gendlin (1997) described inner referents as the focus of one's inwardly directed attention; a bodily felt, inward sense that provides the significance of everything in one's life. Experiencing is what we "inwardly are, mean, or feel at any given moment" (Gendlin, 1997, p. 27). Bohart (1993) identified key aspects of experiencing as immediate, bodily, holistic, and contextual. Experiencing is not merely a re-enactment of events or feelings but instead, it includes personally felt significance and exploration. Experiencing plays an important role through which we come to know, apprehend, order, and categorize our world (Goldman, 1997).

Experiencing is not an all-or-none concept. Instead, the process of experiencing progresses from rigidity to fluidity and a closed to an open exploration of past events (Rogers, 1958; Walker, Rablen, & Rogers, 1960). Negative symptomatology is anchored at the lower end of the experiencing continuum and personality change and growth are found at the higher end of the experiencing continuum (Gendlin, 1962). This is because the lower end of the experiencing continuum is associated with an external focus, limited access to internal experience, and less psychological mindedness.

Experiencing in Therapy. The relationship between negative symptomatology and experiencing is a central component of the therapeutic process, at least in insight-oriented treatments. More specifically, the goal of therapy in reducing negative effects
is: "to go beyond surface bad feelings, to access their determinants, and to restructure core maladaptive emotion schemes and/or integrate disowned emotional experience" (Goldman, 1997, p.59). Productive experiencing within therapy encompasses a client's ability to focus and articulate the feelings and meanings associated with past events (Goldman, 1997). In turn, this information is integrated and can then be used to structure present and subsequent experiences and to construct new meaning. When an individual begins to make sense of present and subsequent experiences, he/she may assimilate the information gained from experiencing into his/her ongoing self-narrative to promote continued psychological growth (Greenberg, 2002). Experiencing has been said to increase or proceed to a more fluid level within the therapy process. This occurs most notably in relation to clients' exploration of core thematic problems, such as past abuse, and it is the increase in experiencing during these core themes that has been related to therapeutic outcome (Goldman, 1997).

*Experiencing in EFT-AS.* Experiencing is thought to involve two processes. First, the impact of sensory events must be received in the moment. This means that in order to experience past abuse, it is not sufficient to know or think about the past abuse in a distant or detached manner. Instead, the memory of past abuse must be received in the moment, at the phenomenological level, so that it is salient and real at that moment. This is in marked contrast to a flashback, which consists of an image, but does not carry meaning at the phenomenological level. Second, both cognitive and affective information must be synthesized to construct new meaning (McGuire, 1991; Wiser & Arnow, 2001). This involves the construal of meaning from the affective experience,
such as "this is scary, I feel violated, I don't deserve this, I don't want this, or what does it mean that they did this to me?"

The physiological arousal associated with abuse can be so overwhelming at the time of abuse, that the survivor often does not synthesize the cognitive and affective information. It is for this reason that EFT-AS emphasizes the exploration of past abuse. Exploration allows the past abuse to become affectively alive so that the overwhelming nature of this process can be slowed down in a safe environment. This allows the information to be created and synthesized into new meaning. In this way, the survivor can now have the opportunity to question and explore maladaptive beliefs about the self that were formed at the time of abuse. In turn, the client can come to know and feel that he/she did not deserve the past abuse, did not want to be abused, and so forth. The exploration of past abuse and therefore, experiencing, is facilitated in EFT-AS through a direct focus on past abuse, imaginal confrontation, and exploration of the feelings and meaning associated with past abuse.

*Distinguishing Experiencing from Emotion and Cognition*

Although the concept of experiencing is similar to the concepts of emotion and cognition, there are important distinctions. According to Bohart (1993), experiencing can be mistakenly equated with emotion because personally significant events usually invoke some degree of both experiencing and emotion and because a bodily felt process is involved in both experiencing and emotion. However, contact with one's emotions is only one part of experiencing. While emotions are part of the experience of an event, emotions are secondary to the learning-through-experiencing process (Bohart, 1993). Experiencing is primarily a meaning apprehension process (Bohart, 1993). The
articulation of emotions is involved in the intermediate levels of experiencing, but at higher levels of experiencing, the focus shifts from clearly discernable emotions to a sense of unidentified, unrecognizable, or unfamiliar feelings (Klein et al., 1986). In fact, high emotional arousal has been negatively correlated with experiencing (Clarke, 1989). This negative relationship is depicted by the client who sobs deeply and at length, but does not use the felt experience for self or situational clarification (Wiser and Arnow, 2001).

The concept of experiencing is more highly correlated with cognition than with emotion (Klein et al., 1986). However, cognition also does not completely capture the concept of experiencing. Bohart (1993) stated that thinking and conceptualizing are secondary derivations of what is first known experientially and non-conceptually. In this way, an individual must first experience the felt sense of his/her inner referents before he/she can think about this experience or conceptualize it. Simply stated, knowing or thinking about information is quite different than experiencing something at the phenomenological level (Bohart, 1993). Cognition that exceeds or proceeds in the absence of experiencing, is depicted by the client who intellectualizes discussions of past events but does not explore the personally felt significance of the events.

The Experiencing Scale

The Experiencing Scale (EXP; Klein et al., 1986) operationalized the construct of experiencing. It was developed to measure the progression of clients’ experiencing from rigid to fluid expression and evaluate the depth and quality with which clients attend to and explore inner referents. The EXP specifies seven levels of experiencing whereby client involvement with inner referents moves from (1) impersonal, to (2) superficial, to
(3) externalized or limited references to feelings, to (4) direct inner referents, to (5) questioning unclear inner reference, to (6) focusing with a step of resolution, and (7) to the point where focusing is effortless and provides the connections for inner discourse. The main features of each level of experiencing are detailed below (see Appendix A for sample ratings of each of the following levels). The following information was paraphrased from Klein et al. (1986).

*Level 1* is characterized by material that is impersonal and superficial, references to external events, and a refusal to participate in reprocessing of past abuse. Statements at this level are very abstract, superficial, or journalistic accounts that have no established personal referent.

*Level 2* comments are personal but involvement is detached. Here the association between the speaker and the content is explicit yet comments serve to tell the story but do not refer to the client’s feelings. The remarks serve to get the story across but do not refer to the individual’s feelings or private experiences.

*Level 3* material is narrative and descriptive. At this level, there are added comments on feelings but these remarks are limited to the situations described and do not describe the speaker more generally. This produces a dialogue that seems narrative with a personal touch because self-descriptions are restricted to specific situations and do not describe the speaker more generally.

*Level 4* is where clients shift to an internally elaborated focus. At this level the content is a clear presentation of the speaker’s feelings, giving a personal, internal account of feelings about the self. The individuals’ feelings are described more generally and do not refer to specific situations or events. Feelings or the experience of events are
the discourse rather than the events themselves. Essentially, the speaker is trying to communicate what it is like to be him or her.

*Level 5* is characterized by the purposeful exploration of the speaker’s feelings. Here clients self-reflexively pose a problem about the self and elaborate on it from an internal perspective. There are two necessary components for this level. First, the speaker must pose a problem, proposition, or question about the self. This must be phrased in terms of feelings. Second, the speaker must explore or work with the problem in a personal way that is related to the initial problem, proposition, or question.

*Level 6* is where clients synthesize newly realized feelings and experiences to produce meaning and resolve issues. At this level, there is a sense of “more” that comes along with the identified feelings; it is more than recognizable feelings and it is a felt sense of an unclear inner referent that has a life of its own. It is the feeling of a “there-and-yet-to-be-fully-discovered” (Klein et al., 1986, pg. 23).

*Level 7* is characterized by speech content that reveals a steady and expanding awareness of immediately present feelings and internal processes. At this level the client is able to move from one inner referent to another. The client links and integrates each experience as it occurs in the moment. In this way, the felt experience can be used as a “springboard” for further exploration (Klein et al., 1986, p.23).

*The Relationship between Experiencing and Therapeutic Outcome*

Theoretically, depth of experiencing should be related to therapeutic outcome because experiencing facilitates movement of inner referents from rigidity to fluidity and closed to open discussion of issues so that new meaning can be attained (Rogers, 1958; Walker et al., 1960). As well, it is believed that negative effects, such as emotional
dysregulation, are anchored at the lower end of the experiencing continuum and change and growth are anchored at the higher end (Gendlin, 1962). This is because exploration of inner referents and self-reflexive examination, that are characteristic of deeper levels of experiencing, facilitate the acquisition of new meaning. Since maladaptive emotion schemes (e.g., view of the self as dirty or unwanted) are at the root of the long-term effects of child abuse, restructuring these emotion schemes facilitates new and more adaptive meaning of past events and present relationships (e.g., view of the self as good and wanted). On the other hand, if a client is unable to meaningfully explore and restructure his/her core maladaptive beliefs, then the negative effects of child abuse will likely persevere. Because experiencing facilitates the construction of new meaning, deeper levels of experiencing should predict better therapeutic outcomes.

Evidence of the Relationship between Experiencing and Therapeutic Outcome

Research that has investigated the relationship between experiencing and therapeutic outcome can be dichotomized between studies that have investigated experiencing as a process variable and those that have examined experiencing as a client variable. Research that has examined experiencing as a process variable has measured clients' depth of experiencing across the course of treatment, whereas research that has examined experiencing as a client variable has measured clients' depth of experiencing prior to treatment or early in treatment. Although the present study examined experiencing as a client variable, research on experiencing as a process variable will be reviewed first because stable patterns in experiencing levels across treatment can help to inform and support the investigation of experiencing as a client variable.
Experiencing as a Process Variable. Process research has sought to determine whether experiencing reflects (1) an improvement dimension, such that experiencing is a state variable that changes throughout the course of therapy, or (2) a readiness or ability to engage in a certain level of experiencing, such that experiencing is a trait dimension that remains relatively stable throughout therapy.

Overall, the evidence for experiencing as a trait versus state variable has been mixed. Some early studies supported experiencing as a state variable (Gendlin & Tomlinson, 1962; Rogers, 1959, 1958; Tomlinson, 1967, 1962; Van Der Veen, 1967, 1965; Walker et al., 1960). For example, Walker et al. (1960) evaluated 24 samples and found evidence of significant change, as measured by gradation from “stasis and fixity to changingness and flow” in areas such as relations to feelings and meaning, manner of experiencing, and construal of experience. Similarly, Van der Veen (1965) found that levels of experiencing changed throughout the therapy process and related these changes to two therapist variables: congruence and empathy.

Other studies found evidence supporting experiencing as a trait variable (Rogers, Gendlin, Kiesler, & Truax, 1967; Ryan, 1966; Tomlinson & Hart, 1962). For instance, Tomlinson and Hart (1962) rated taped interviews and found that more successful cases had higher levels of experiencing at both the beginning and end of therapy. The studies by Gendlin et al. (1967) and Ryan (1966) extended this research by looking at the relationship between the pattern of experiencing and therapeutic outcomes. Both of these studies found that it was a lack of backsliding in levels of experiencing that predicted therapeutic outcomes for a sample of counselling centre neurotics. In doing so, these
studies found evidence for experiencing as a trait variable, but more importantly, a relationship between experiencing and therapeutic outcome.

Subsequent research continued to investigate the relationship between experiencing and therapeutic outcomes (Goldman, 1997; Gomez-Schwartz, 1978; Kiesler, 1971). Kiesler (1971) found that clients who had better outcomes at post-treatment, regardless of psychological diagnoses, also demonstrated higher levels of experiencing at all points across the first 30 sessions of therapy, when compared to less successful clients. In this way, Kiesler found no evidence for a consistently greater movement towards deeper levels of experiencing as therapy progressed. It follows that if experiencing remains consistent throughout therapy and if more successful clients demonstrate higher levels of experiencing at all points in therapy, experiencing appears to be a client characteristic that also should predict therapeutic outcome. Conversely, Kiesler (1971) found no evidence that experiencing levels measured across the first five therapy sessions predicted outcome. Research by Gomez-Schwartz (1978), however, found that experiencing is the process dimension that most consistently predicted therapy outcome and that clients’ experiencing across therapy accounted for up to 38% of the variance in outcome measures.

It remains unclear why some studies found evidence for stable patterns in experiencing along with a relationship between late session experiencing and outcomes, but that the same relationship for early session experiencing had not been substantiated. Logically, if experiencing remains consistent throughout therapy and if more successful clients demonstrate higher levels of experiencing at all points in therapy, experiencing appears to be a client characteristic that also should predict therapeutic outcome.
However, the above-cited studies sampled segments randomly and for this reason, it is possible that they were confounded by the fact that early sessions could involve events that do not reflect an exploration or discussion of core issues. Exploring core issues is assumed to be essential to good outcomes (Goldman, 1997) and therefore, random sampling of early session experiencing could introduce a less potent measure of clients' experiencing. Therefore, it is possible that random sampling during early therapy sessions could explain the mixed findings. Nevertheless, it remains important to continue to examine, clarify, and refine knowledge of the relationship between experiencing and therapeutic outcome.

A recent study addressed the above methodological shortcoming. Goldman (1997) argued that a relationship between experiencing and outcome more likely would be observed when the ratings were not sampled randomly. She theorized that “it is unlikely that people change in psychotherapy in such a way that they are constantly processing at higher levels of experiencing” (Goldman, 1997, p.5). Because core issues “characterize an important thread that weaves and is carried forward through the therapeutic process” (Goldman, 1997, p.43), Goldman obtained experiencing ratings from depressed clients' ($n = 35$) exploration of core themes during two types of brief experiential therapy (client-centred, $n = 17$; process-experiential, $n = 18$). The results supported a relationship between experiencing and outcome. More specifically, Goldman found that overall average experiencing ratings across the therapy process, during core thematic material, were correlated with changes in depressive symptoms and self-esteem.

*Experiencing as a Client Variable.* Research also has examined experiencing as a client variable, whereby clients' depth of experiencing has been measured prior to
treatment or early in treatment. It is important to examine experiencing as a client characteristic because such investigation could contribute to the knowledge of client by treatment interactions and in turn, could be applied toward the selection of appropriate treatment approaches for individuals. Research on experiencing as a client characteristic has unfortunately mirrored the research on experiencing as a process variable, in so far that it has been mixed and can be attributed to random sampling and thus, less potent measures of clients’ capacity for experiencing.

For example, O’Malley, Suh, and Strupp (1983) sampled segments across the first three sessions of therapy and found that experiencing was the most powerful predictor of overall improvement. This relationship held across three measured perspectives - clients’ self-reports, therapists’ evaluations, and evaluators’ judgements. O’Malley et al. (1983) also found that there was “virtually no relationship” between experiencing in the first therapy session and outcome, but that the predictive association increased across the first three therapy sessions to a consistent association in the third session.

Other research failed to find a relationship between experiencing, as a client variable, and therapeutic outcomes (e.g., Bommert & Dahlhoff, 1978; Custers, 1973; Luborsky; 1982; Fishman, 1971). Using the German translation of the EXP scale, Bommert and Dahlhoff (1978) did not find a significant difference between second-session experiencing levels between more and less successful clients. Similarly, Custers (1973) failed to find a significant relationship between experiencing levels from two early client-centred therapy sessions and personality change. Luborsky (1982) did not find a significant relationship between experiencing levels early in psychodynamic therapy with either raw, rated, or residual patient improvement scores. Consistent with these findings,
Fishman (1971) also failed to find a significant relationship between outpatients’ experiencing levels and outcomes in psychodynamic therapy.

Other studies claimed to investigate experiencing as a client variable. However, sampling from sessions as late as the middle of therapy requires that the findings be interpreted with caution because therapeutic interventions could confound the results. For example, a study by Castonguay, Godfried, Wiser, Raue, and Hayes (1996) randomly sampled a segment from the first half of therapy and found that higher levels of experiencing, while controlling for alliance quality, predicted decreased depressive symptomatology. Similarly, Windholtz and Silberschatz (1988) sampled from the middle of therapy and they found that experiencing correlated significantly with outcome.

The Proposed Research

Purpose. The purpose of the present study was to evaluate the relationship between thematic depth of experiencing early in EFT-AS and therapeutic outcome. More specifically, thematic experiencing was investigated during one of the first three therapy sessions. The present study extended Goldman’s (1997) research to assess the contribution of thematic depth of experiencing as a client characteristic in a specific therapy for child abuse issues (i.e., EFT-AS). The proposed research used the EXP scale to investigate experiencing during clients’ exploration of core material, related to past child abuse, during an early EFT-AS therapy session. By investigating experiencing during exploration of core issues, the present research circumvented the methodological concerns of random sampling and less potent measures of experiencing.
Hypotheses. It was hypothesized that deeper levels of thematic experiencing, early in EFT-AS, would predict improvements in (1) symptomatology, (2) sense of self, and (3) distress from interpersonal sources.

Klein et al. (1986) stated that the concept of experiencing is theoretically relevant to any therapeutic situation because it specifies alterations in a person’s functioning, which is a necessary component for personality change. In accordance with the previously cited research, experiencing levels at the onset of EFT-AS should also predict improvements in symptomatology. However this rationale does not negate the possibility that therapy can enhance or facilitate experiencing in those who lack the ability to articulate their experiencing or who lack the ability to experience (Goldman, 1997).

Negative expectations of self and others form the basis of impairments in the sense of self. Since experiencing involves accessing internal experiences (e.g., thoughts, feelings, needs) along with exploring and constructing new meaning, increased depth of experiencing should be associated with stronger and clearer sense of self and differentiated perspectives of others.

Goldman (1997) stated that core maladaptive emotion structures are seen as the underlying determinants that produce the dysfunctional bad feelings and meanings that people bring to therapy. It is the core emotion structures formed during negative early attachment relationships that are posited to be responsible for interpersonal problems, such as consistently perceiving others as untrustworthy. The ability to engage in deeper levels of experiencing facilitates exploring the thoughts and feelings about significant others so that clients may create new meaning. In so doing, they are less likely to see
others as unreliable, untrustworthy, and dangerous, and in turn, this process is likely to
decrease distress from interpersonal relationships.

*Importance.* The present research will shed light on whether an individual’s
capacity for experiencing can be used as a prognostic measure in EFT-AS. The research
will inform Bohart’s (1993) theory that experiencing is a common mechanism of change
across therapy modalities. The present research also has the potential to extend the
knowledge of client characteristics that contribute to therapeutic outcomes, which can
have implications for selecting appropriate treatment approaches for individuals. More
specifically, the present research can help to extend the knowledge of client variables that
contribute to success in EFT-AS. In doing so, it could generalize the research on
experiencing to treatment with adult survivors of child abuse and could lend itself to
future research with other samples.
Chapter III

Method

Participants

The present study used archival data from 37 EFT-AS clients (tapes and self-reports) that was collected between 1995 and 1997 at the University of Saskatchewan under the direction of Dr. S. Paivio. All treatment sessions were audiotaped and outcome measures were administered at pre- and post-treatment. Paivio et al. (2001) reported the following information about recruitment, client characteristics, and therapy used in the present study.

Recruitment. Paivio et al., (2001) reported that participants were recruited through referrals and newspaper articles that advertised free psychotherapy in exchange for completion of assessment questionnaires. The therapy was described as focusing on child abuse experiences and emotional expressiveness. One hundred and ten respondents were screened via telephone and selection interviews were conducted with 63 of these individuals. The screening assessed compatibility with the therapy, mental health, interpersonal history, abuse characteristics, and current symptom status. Trauma symptomatology was assessed through the PTSD Symptom Severity-Interview (PSS-I; Foa, Riggs, Dancu, & Rothbaum, 1993).

Inclusion and Exclusion Criteria. Paivio et al., (2001) employed the following exclusion and inclusion criteria. Respondents were excluded if they were younger than 18 years of age, undergoing another therapy, taking psychoactive medication, involved in a crisis that required immediate attention, or had no conscious recollections of child abuse. In addition, respondents were excluded if they met any of the following
conditions: the primary presenting problem involved extreme emotion dysregulation with a risk of aggressive or self-harm behaviour, if they were currently in a violent relationship, or if they had current drug or alcohol problems. These factors were considered contraindications for emotion intensification and take precedence over a focus on past issues. Respondents were included on the basis of commonly accepted criteria for short-term insight-oriented therapy (e.g. Malan, 1976) including motivation, capacity to form a therapeutic relationship, and capacity to focus on circumscribed issues of child abuse. In addition, respondents were included on the basis of compatibility and agreement with the treatment focus on re-experiencing traumatic events and emotional expression, rather than affect management or current interpersonal problems.

Forty-four individuals participated in the EFT-AS study, which was approved by the University of Saskatchewan Advisory Committee on Ethics in Human Experimentation (see Appendix B). All participants were provided with information about the research project (see Appendix C), were required to sign a consent form (see Appendix D), and signed a release of therapy audio/video tapes (see Appendix E). Twenty-three individuals immediately began EFT-AS and another 21 began therapy following a wait period. After attrition, 37 participants completed therapy. The proposed research will include the complete sample of treatment completers, as approved by the University of Windsor Research Ethics Board (see Appendix F).

Client Characteristics. The client characteristics, as reported by Paivio et al. (2001), are as follows. The clients' mean age was 38 years ($SD = 11.32$, $R = 19-72$). Thirty-one clients (84%) were Caucasian, three (8%) were Aboriginal, and three (8%) were Asian. Most clients were female (78%), married (46%), had one or more children
(62%), were employed full or part time (41%), had a household income of less than
39,000 (76%), and had some college or university education (41%). See Table 1 for
detailed client characteristics.

Paivio et al., (2001) reported that although 68% of clients reported multiple types
of childhood maltreatment, they were asked to identify a primary focus for therapy.
Sixteen clients (43%) identified sexual abuse as the treatment focus and the sexual abuse
ranged from a single episode of anal penetration to paternal incest over many years
and/or repeated victimization by several perpetrators. Emotional abuse was identified as
the treatment focus by 14 clients (38%) and ranged from chronic verbal derogation by a
caregiver to repeated threats of harm or witnessing extreme family violence. Physical
abuse was identified as the treatment focus by seven clients (19%) and ranged from harsh
physical discipline to severe beatings that resulted in injury.

Paivio et al., (2001) reported that scores on the Childhood Trauma Questionnaire
(CTQ; Bernstein, Ahluvalia, Pogge, & Handelsman, 1997; Bernstein et al., 1994) were all
above recommended thresholds (C) for moderate levels of abuse (sexual abuse, \( C = 9, R
= 16-35 \); physical abuse, \( C = 12, R = 20-31 \); emotional abuse, \( C = 30, R = 34-56 \);
Bernstein et al., 1997). This indicated that the clients reported histories of relatively
severe childhood abuse. As measured on the Symptom Checklist-90-Revised (SCL-90-
R; Derogatis, 1983), the clients reported moderate levels of symptom distress \( T = 51,\)
using out-patient norms).
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<td>&gt;$60,000</td>
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According to Paivio et al. (2001), nineteen clients (52.7%) met criteria for a diagnosis of PTSD on the PTSD Symptom Severity-Interview (PSS-I; Foa et al., 1993). The mean severity on the PSS-I was 22.79 ($SD = 9.85$) and this is comparable to results reported by Foa et al. (1991). Of the clients who were not given a diagnosis of PTSD ($n = 14$), nine met DSM-IV criterion A for the disorder. This indicated that these individuals had been exposed to events that were extremely threatening to themselves or others and that these events were intensely frightening. This means that 75% if the clients in the study had experienced childhood abuse that is considered traumatic. Clinical judges and therapists determined that 11 clients (29.7%) met DSM-IV criteria for an Axis II diagnosis, which indicated that these clients experienced difficulties in interpersonal functioning. Mean distress on the Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureno, & Villasneno, 1988) was 1.90 ($SD = .59$), which was almost two standard deviations higher than the norms for an outpatient psychiatric sample reported by Horowitz et al. (1988). Overall the clients were moderately distressed and experienced relatively severe abuse histories and marked interpersonal problems, which is similar to other clinical groups of adult survivors listed in the literature. However, the present sample is more healthy than those described by Briere (1988) and Hermann (1992) because the current study excluded those with more severe symptomatology such as self-harm behaviour.

**Process Measure**

*The Experiencing Scale* (EXP; Klein et al., 1986) measures the progression of clients’ experiencing from rigid to fluid expression and evaluates the depth and quality with which clients attend to and explore inner referents. As discussed previously (see pg.
12 or Appendix A), raters are required to rate client statements as characteristic of one of the seven levels of experiencing. Both modal and peak ratings are obtained, because each captures unique information (Klein et al., 1986). Modal ratings characterize the most frequently occurring experiencing level in the segment, whereas peak ratings characterize the highest experiencing level reached in the segment. Interrater reliability on the EXP has ranged from .76 to .91 (Klein et al., 1969). A study of different segment lengths demonstrated that inter-rater and rate-rerate reliabilities were not affected by segment length (Kiesler, Mathieu, & Klein, 1965), with rate-rerate correlations showing a median value of .80. More recently, Goldman (1997) reported interrater reliabilities of .78 on modal ratings and .75 on peak ratings using intraclass correlation coefficients.

Outcome Measures

The Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1983) is a 90-item questionnaire that measured global symptom distress. Clients rate their degree of distress during the past seven days on a 5-point scale (0 = not at all, 4 = extremely). Derogatis (1983) reported internal consistencies between .77 to .90, test-retest reliabilities between .80 and .90 over one week, and convergence with other measures of symptom distress. Furthermore, the SCL-90-R has been shown to converge with other measures of psychopathology and is sensitive to changes in psychopathology (Derogatis, 1983). The proposed study will use the Global Severity Index (GSI) in the analyses. The SCL-90-R is provided in Appendix G.

The Impact of Event Scale (IES; Horowitz, 1986) is a 15-item questionnaire measuring trauma-related intrusion and avoidance. The frequency of each symptom within the past seven days is rated on a 4-point scale (0 = not at all, 3 = often
Horowitz (1986) reported split-half reliability of .86, test-retest reliability of .87, and alphas for the subscales of .78 and .80. The IES is provided in Appendix H.

*The Structural Analysis of Social Behaviour, Intrex (Introject) Questionnaire* (SASB; Benjamin, 1988) is a 32-item self-report measure that asks clients how they most often treat themselves on an 11-point scale (0 = *never true*, 100 = *always true*). Scores on the dimensions of Affiliation (SASB-A) and Control (SASB-C) range from +1600 (affiliative, spontaneous) to −1600 (hostile, overcontrolled; Paivio & Nieuwenhuis, 2001). Test-retest reliabilities have been reported to range from .67 to .90 and there has been substantial evidence for the construct validity of the measure (Benjamin, 1988). Previous analyses employing the same sample (Paivio & Nieuwenhuis, 2001) revealed a significant effect of time on all criterion measures except the SASB-C. If SASB-C scores did not change throughout the course of therapy, one would not expect to find statistically significant results based on pre-post-treatment differences using this measure. As such, only the SASB-A scores, which measure self-esteem, were used in the subsequent analyses. The SASB questionnaire is provided in Appendix I.

*The Inventory of Interpersonal Problems.* (IIP; Horowitz et al., 1988) is a 127-item measure that yields an average score for distress from interpersonal sources. Clients rate the degree of distress experienced during the past seven days on a 5-point scale (0 = *not at all*, 4 = *extremely*). Horowitz et al. (1988) reported test-retest reliabilities between .89 and .98, internal consistencies between .89 and .94, and high agreement between the IIP and other measures of client improvement. The IIP is provided in Appendix J.

*The Resolution Scale* (RS; Singh, 1994) assesses the degree of resolution of past issues with abusive and neglectful others. Clients rate, on a Likert scale (1 = *not at all*, 5
= very much), the degree to which they feel troubled by negative feelings and unmet needs, feel worthwhile, and feel accepting toward the identified other person. The RS was completed concerning the primary perpetrator of abuse (usually the father or brother) and, where appropriate, a second RS was completed usually concerning a neglectful mother (Paivio et al., 2001; Paivio & Nieuwenhuis, 2001). The two RS scores were averaged to obtain an overall index of resolution. Test-retest reliabilities were reported between .73 and .81, in addition to correlations between change on the RS and changes on other outcome measures (Singh, 1994). Paivio et al. (2001) reported an alpha reliability of .82 in the sample of EFT-AS clients. The RS is provided in Appendix K.

Therapists and Therapy

Ten therapists were involved in the Paivio et al. (2001) study (seven females, three males). The therapists were six doctorate-level students and three masters-level students in educational and clinical psychology in addition to the supervisor, Dr. S. Paivio, who was a registered psychologist with 14 years of experience at the time of the study. The mean age of the therapists was 34 years (\( R = 24-49 \) years). Clinical experience ranged from one to 14 years (\( M = 6.3 \) years). Student therapists received 54 hours of training in EFT-AS over 14 weeks. This consisted of reviewing the treatment manual and videotaped therapy sessions with expert therapists as well as supervised peer skills practice and therapy with “practice” clients. Clients were assigned to therapists on the basis of clients’ gender preference and a compatible schedule. Analyses of variance (ANOVA) revealed no significant differences among the therapists in terms of adherence and treatment effects (Paivio et al., 2004). All therapy sessions were conducted in the
Psychology Department at the University of Saskatchewan and were tape-recorded and monitored by the supervisor.

According to Paivio et al. (2001), the EFT-AS therapy protocol specified 20 weekly, one-hour sessions. The actual number of therapy sessions was determined according to client needs ($M = 19.05, SD = 4.01, R = 7-27$). The therapy manual (Paivio, 1996) applies the general principles of EFT (Greenberg & Paivio, 1997) in combination with techniques used in process-experiential therapy (Greenberg et al., 1993). Three interrelated therapeutic tasks were involved in EFT-AS. The first was establishing a safe and collaborative therapeutic relationship, which was largely achieved through empathic responses. The first three sessions were devoted to establishing this relationship along with understanding each client’s problems. The second task was to reduce the degree of experiential avoidance and defensive processes so that the client could accept painful and threatening internal experiences. This was achieved through empathetic exploration and Gestalt-derived and imagery techniques. The third task was resolving issues with past abusive or neglectful others, who had been identified as the primary focus of therapy. This involved accessing maladaptive aspects of memory (e.g. fear, shame) and accessing previously inhibited adaptive emotional responses (e.g. anger, sadness). In this way, the associated adaptive information could be used to modify meaning. An imaginal confrontation intervention was used to evoke trauma material and help clients to express previously constricted emotions and needs, toward imagined others. The imaginal confrontation intervention was generally introduced in the fourth session. For patients with extreme distress from intrusive symptoms, anxiety management strategies (e.g. provision of structure, breathing regulation, and present-centeredness) were used to help
regulate emotional intensity. The final focus of therapy was upon the integration of information from therapy experiences into a new view of the self, others, and abusive events. The last session was devoted to feedback and termination.

Procedure

Sampling Procedure. Segments of therapy were sampled from one of the first three therapy sessions because the earlier sessions would be less impacted by therapy, which would provide a more accurate measure of experiencing as a client characteristic. In addition, imaginal confrontation is usually introduced following the third session of EFT-AS (Paivio et al., 2001) and sampling a segment that follows a therapeutic intervention designed to promote experiencing could introduce a confound. Following the method successfully used by Goldman (1997) in her study of experiencing, segments were selected in which the client was discussing his/her core issues (i.e., child abuse). Therapists’ clinical notes and a review of audiotaped therapy sessions were used to locate early sessions that contain a discussion of core issues.

One session segment per client was selected and therefore, the following decision process was employed when multiple relevant segments were available. From any of the first three sessions, segments were first selected from sessions in which the client was discussing the past abuser that had been identified as the primary focus of therapy. This was the individual who was the most frequent focus of therapy and therefore, was not necessarily the primary perpetrator of abuse. If multiple relevant segments still remained, then the final segment was selected on the basis of the length and quality of the segments, with priority assigned to those segments with longer and more in-depth discussions about the abuser. If multiple relevant segments still remained, then the earliest segment was

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selected. A segment commenced with the client’s discussion of his/her core issues (i.e., the abusive event) and terminated when the core issue was no longer being discussed and the topic changed or the session ended (Goldman, 1997). The author then transcribed the located segments verbatim.

Klein et al. (1986) have reviewed the implications of various sampling durations and have stated that the duration of segments can introduce a potential confound. Klein et al. (1986) advised that it is best to sample proportionate durations in each therapy session. Nevertheless, the segments used in the current study consisted of discussions of past abuse, which varied in duration. It was felt that this would provide a more naturalistic measure and was consistent with the procedures employed in the most recent research on experiencing (e.g., Goldman, 1997; Holowaty, 2004). Another sampling issue addressed by Klein et al. (1986) is that previous research has demonstrated that strong interrater reliability using segments as short as 30 seconds. This segment duration was substantially exceeded for every segment employed in the present study.

Data Format. The selected audiotaped segments were transcribed and then rated. Klein et al. (1986) stated that ratings of transcripts and audiotapes do not differ significantly in the level of experiencing that is assigned and either rating procedure can be used in the rating process. Although it is likely that videotapes provide a richer source of information, such as the observation of nonverbal behaviour, the use of transcripts for rating is the most commonly used method and is consistent with the procedures of Goldman (1997) and Greenberg, Ford, Alden, and Johnson (1993).

In accordance with the EXP training manual (Klein et al., 1986) and subsequent research, both modal ratings and peak ratings were obtained because each captures
unique information. More specifically, modal ratings characterize the most frequently occurring experiencing level in the segment. Each client utterance in the present sample was assigned an EXP level and from these ratings, the mode of all of the utterances in the segment was determined. The peak rating is the highest experiencing level reached in the segment.

_Training on the Experiencing Scale._ Two M.A. students underwent approximately 20 hours of training on the rating method. An experienced EXP rater, who was a senior Ph.D. student, trained the author. The author then trained the reliability rater. The background preparation included reading the basic EXP manual (Klein et al., 1986). The training involved direct instruction, background preparation, practice ratings, feedback, and supervision. In addition, practice ratings were conducted on approximately 10 transcripts, which were not included in the present study.

_Rating Procedure._ Rating of the segments that were employed in the present study did not commence until the practice ratings demonstrated strong validity and reliability. Kappa was used to calculate inter-rater reliability because it controls for agreement by chance (Cohen, 1968; Cohen, 1960). Three individuals rated the final practice transcript, which consisted of 79 statements: the primary rater (author), reliability rater, and an expert EXP rater (Dr. S. Paivio). The validity of the ratings was supported by the strong agreement between the primary rater and the expert rater \( (k = .80) \). The reliability of these ratings was supported by the strong agreement between the primary rater and the reliability rater \( (k = .88) \).

The primary rater and reliability rater then proceeded by independently rating the selected segments, which were employed in the present study. The primary rater rated all
segments and the reliability rater rated one-third of the segments \((n = 13)\). These segments were randomly selected and both the primary and reliability raters were blind to the therapy outcome of the clients being rated. Rater drift was controlled for by discussing and resolving rating discrepancies after approximately every third segment was coded. These ratings consisted of 254 client statements and a Cohen’s kappa of .81 was achieved, demonstrating strong inter-rater agreement between the primary rater and the reliability rater. Examples of ratings from present study are provided in Appendix L.
Chapter IV

Results

Descriptive and Exploratory Analyses

Descriptive statistics for the modal and peak EXP ratings are reported in Table 2. Modal and peak EXP ratings are reported in Table 3 for the following groups: (1) the gender of the adult survivor (male, female), (2) the primary type of abuse (emotional, physical, sexual), and (3) the primary perpetrator of the abuse (father figure, mother figure, other). As a result of the small cell sizes and exploratory nature of these analyses, the following analyses must be interpreted with caution (see Table 3 for the corresponding cell sizes).

Table 2
Descriptive Statistics for Modal and Peak EXP Ratings (N = 37)

<table>
<thead>
<tr>
<th>EXP Rating</th>
<th>M</th>
<th>SD</th>
<th>$s^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modal EXP</td>
<td>3.14</td>
<td>0.95</td>
<td>0.90</td>
</tr>
<tr>
<td>Peak EXP</td>
<td>4.08</td>
<td>0.89</td>
<td>0.80</td>
</tr>
</tbody>
</table>

Participant Gender. An independent samples t-test revealed that male and female participants did not differ significantly in terms of modal EXP ratings, $t (1, 35) = -.45$, $ns$, or peak EXP ratings, $t (1, 35) = -.29$, $ns$.

Type of Abuse. In order to determine if modal or peak EXP ratings differed as a function of the type of abuse (emotional, physical, sexual), two one-way ANOVAs were conducted, with modal and peak EXP ratings respectively serving as the dependent variable. Results revealed no significant differences for modal EXP ratings, $F (2, 36) = 2.47$, $ns$, or peak EXP ratings, $F (1, 36) = -0.39$, $ns$. A follow-up independent samples t-
test revealed that participants who had been physically abused demonstrated significantly higher modal EXP ratings, compared to participants who had been emotionally abused, $t(1, 19) = 2.36, p < .05$. The remaining independent samples t-tests did not reveal any significant differences between groups.

Table 3

Descriptive Statistics for EXP Ratings across Gender, Type of Abuse, and Primary Perpetrator ($N = 37$)

<table>
<thead>
<tr>
<th></th>
<th>Modal EXP</th>
<th></th>
<th>Peak EXP</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n$</td>
<td>$M$</td>
<td>$SD$</td>
<td>$M$</td>
</tr>
<tr>
<td>Participant Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>8</td>
<td>3.00</td>
<td>0.76</td>
<td>4.00</td>
</tr>
<tr>
<td>Female</td>
<td>29</td>
<td>3.17</td>
<td>1.00</td>
<td>4.10</td>
</tr>
<tr>
<td>Type of Abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td>7</td>
<td>3.71</td>
<td>0.95</td>
<td>4.29</td>
</tr>
<tr>
<td>Emotional</td>
<td>14</td>
<td>2.79</td>
<td>0.80</td>
<td>3.93</td>
</tr>
<tr>
<td>Sexual</td>
<td>16</td>
<td>3.19</td>
<td>0.98</td>
<td>4.13</td>
</tr>
<tr>
<td>Primary Perpetrator</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father figure</td>
<td>22</td>
<td>3.09</td>
<td>0.81</td>
<td>4.18</td>
</tr>
<tr>
<td>Mother figure</td>
<td>7</td>
<td>3.00</td>
<td>1.16</td>
<td>3.71</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>3.38</td>
<td>1.19</td>
<td>4.13</td>
</tr>
</tbody>
</table>

*Primary Perpetrator.* Two one-way ANOVAs were conducted to determine if modal and peak EXP ratings differed as a function of the primary perpetrator of abuse (mother figure, father figure, other), with modal and peak EXP ratings respectively serving as the dependent variable. Results revealed no significant differences for modal EXP ratings, $F(2, 36) = 0.34, ns$, or peak EXP ratings, $F(2, 36) = 0.73, ns$. A series of
independent samples t-tests confirmed that there were no significant differences between groups.

*Pre-treatment and Post-treatment Data*

Table 4 presents the mean and standard deviations for the pre-treatment and post-treatment outcome measures employed in the subsequent analyses.

Table 4

*Means and Standard Deviations of the Pre-treatment and Post-treatment Outcome Measures Employed in the Current Study (N = 37).*

<table>
<thead>
<tr>
<th>Measures</th>
<th>Pre-treatment</th>
<th>Post-treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>SCL-90-R</td>
<td>1.44</td>
<td>0.77</td>
</tr>
<tr>
<td>IIP</td>
<td>1.93</td>
<td>0.58</td>
</tr>
<tr>
<td>RS</td>
<td>43.53</td>
<td>6.65</td>
</tr>
<tr>
<td>SASB-A</td>
<td>-306.00</td>
<td>560.00</td>
</tr>
</tbody>
</table>


*Process-Outcome Results*

In order to assess whether modal and peak EXP ratings were correlated with the post-treatment outcome measures, while controlling for pre-treatment scores, a series of partial correlations were performed. Table 5 presents the partial correlations.

In accordance with expectations, modal EXP ratings were significantly associated with post-treatment SCL-90-R, IES, IIP, and RS scores and peak EXP ratings were significantly associated with SCL-90-R, IES, and IIP scores. Contrary to expectations,
post-treatment RS scores were not significantly associated with peak EXP ratings and post-treatment SASB-A scores were not significantly associated with modal or peak EXP ratings.

Table 5

Partial Correlations Between Modal and Peak EXP Ratings and Post-treatment Outcome Measures, While Controlling for Pre-treatment Scores (N = 37).

<table>
<thead>
<tr>
<th></th>
<th>SCL-90-R</th>
<th>IES</th>
<th>IIP</th>
<th>RS</th>
<th>SASB-A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modal EXP</td>
<td>-.35*</td>
<td>-.40**</td>
<td>-.32*</td>
<td>-.39**</td>
<td>.03</td>
</tr>
<tr>
<td>Peak EXP</td>
<td>-.34*</td>
<td>-.37*</td>
<td>-.27*</td>
<td>-.17</td>
<td>.01</td>
</tr>
</tbody>
</table>

*Note.***p < .001, **p < .01, *p ≤ .05. SCL-90-R – Symptom Checklist-90-Revised; IES – Impact of Events Scale; IIP – Inventory of Interpersonal Problems; RS – Resolution Scale; SASB-A – The Structural Analysis of Social Behaviour, Intrexx (Introject) Questionnaire – Affiliation Dimension.

Next a series of hierarchical multiple regressions were performed in order to examine the unique contributions of modal and peak EXP ratings to the post-treatment outcome measures. Categorical descriptive variables were not included in the regression analyses. Since modal and peak EXP ratings were moderately correlated (r = .71, p < .01), these variables were entered in a single block. Thus in the following regression analyses, the pre-treatment scores were entered in the first block of regression analyses, followed by modal and peak EXP ratings in the second block, and post-treatment scores were employed as the criterion measures. This structure was applied in each of four regressions, with each of the post-treatment scores respectively serving as the criterion variables. The SASB-A scores were not included in the subsequent analyses because the partial correlations were not significant. In light of the exploratory nature of the study
and the sample size, no Bonferroni corrections were made and alpha was set at .05 (one-tailed) for all comparisons (cf. Kazdin, 1994). Table 6 shows the results of the regression analyses.

As indicated in Table 6, EXP ratings accounted for a significant portion of outcome variance on all post-treatment measures. The change in the coefficient of multiple determination ($\Delta R^2$) reveals that EXP ratings explain a significant amount of the variance, beyond the variance accounted for by pre-treatment scores. Although modal EXP ratings significantly predicted all post-treatment measures included in the regression analyses, peak EXP ratings did not significantly predict any post-treatment measure. Therefore, modal experiencing levels during early sessions that focused on core abuse issues independently contributed to multiple dimensions of client change, that is, less symptomatology (SCL-90-R), reduced trauma symptoms (IES), reduced interpersonal problems (IIP), and improved resolution of abuse issues (RS). These findings supported the study hypotheses.
Table 6

Summary of Regression Analyses with Post-treatment Scores Respectively Serving as the Criterion Variables (N = 37).

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SEB</th>
<th>β</th>
<th>R</th>
<th>ΔR²</th>
<th>F (1, 36)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Analysis 1 (criterion: SCL)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>27.75</strong>*</td>
</tr>
<tr>
<td>Pre-treatment scores</td>
<td>0.82***</td>
<td>0.34</td>
<td>.80</td>
<td>.72</td>
<td>.52***</td>
<td></td>
</tr>
<tr>
<td>Modal EXP</td>
<td>-0.35**</td>
<td>0.10</td>
<td>-.47</td>
<td>.85</td>
<td>.19***</td>
<td></td>
</tr>
<tr>
<td>Peak EXP</td>
<td>0.03</td>
<td>0.11</td>
<td>.04</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Analysis 2 (criterion: IES)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>7.99</strong>*</td>
</tr>
<tr>
<td>Pre-treatment scores</td>
<td>0.49***</td>
<td>0.13</td>
<td>.54</td>
<td>.47</td>
<td>.22**</td>
<td></td>
</tr>
<tr>
<td>Modal EXP</td>
<td>-3.85*</td>
<td>1.93</td>
<td>-.39</td>
<td>.65</td>
<td>.21**</td>
<td></td>
</tr>
<tr>
<td>Peak EXP</td>
<td>-1.05</td>
<td>2.01</td>
<td>-.10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Analysis 3 (criterion: IIP)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>15.11</strong>*</td>
</tr>
<tr>
<td>Pre-treatment scores</td>
<td>0.79***</td>
<td>0.13</td>
<td>.70</td>
<td>.60</td>
<td>.36***</td>
<td></td>
</tr>
<tr>
<td>Modal EXP</td>
<td>-0.28*</td>
<td>0.12</td>
<td>-.38</td>
<td>.76</td>
<td>.22**</td>
<td></td>
</tr>
<tr>
<td>Peak EXP</td>
<td>-0.10</td>
<td>0.12</td>
<td>-.13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Analysis 4 (criterion: RS)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>3.68</strong>*</td>
</tr>
<tr>
<td>Pre-treatment scores</td>
<td>0.25</td>
<td>0.14</td>
<td>.28</td>
<td>.31</td>
<td>.10</td>
<td></td>
</tr>
<tr>
<td>Modal EXP</td>
<td>-4.54*</td>
<td>1.98</td>
<td>-.51</td>
<td>.51</td>
<td>.16*</td>
<td></td>
</tr>
<tr>
<td>Peak EXP</td>
<td>1.58</td>
<td>2.06</td>
<td>.17</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. ***p < .001, **p < .01, *p ≤ .05. SCL-90-R – Symptom Checklist-90-Revised; IES – Impact of Events Scale; IIP – Inventory of Interpersonal Problems; RS – Resolution Scale; SASB-A – The Structural Analysis of Social Behaviour, Intrext (Introject) Questionnaire – Affiliation Dimension.
Chapter V

Discussion

Summary

This study explored the relationship between depth of experiencing during early sessions that focused on core child abuse themes and therapeutic outcome. A sample of child abuse survivors (emotional, physical sexual) was employed. Therapy segments of core issues were selected from one of the first three therapy sessions. All segments were assigned modal and peak ratings, using the EXP. The following outcome measures were included: SCL-90-R, IES, IIP, RS, and SASB-A. Partial correlations were performed to determine the association between modal and peak EXP ratings and post-treatment outcome measures, while controlling for pre-treatment scores. A series of hierarchical multiple regression analyses were then employed to determine whether modal or peak EXP ratings, early in therapy, predicted improvements at post-treatment.

Results from this study support the relationship between clients’ thematic depth of experiencing, early in therapy, and therapeutic outcome. More specifically, modal EXP ratings independently contributed to less symptomatology (SCL-90-R), reduced trauma symptoms (IES), reduced interpersonal problems (IIP), and improved resolution of abuse issues (RS). Peak EXP ratings did not significantly predict therapeutic outcome. Thus the findings simultaneously provided evidence for the superior predictive ability of modal EXP ratings, relative to peak EXP ratings, in predicting improvements at post-treatment.

General Discussion

Results of the present study extend and clarify previous findings on the relationship between experiencing and therapeutic outcomes. Overall, the evidence for
experiencing as a trait versus state variable has been mixed. Some early studies supported experiencing as a state variable (Gendlin & Tomlinson, 1962; Rogers, 1959, 1958; Tomlinson, 1967, 1962; Van Der Veen, 1967, 1965; Walker et al., 1960) whereas other studies found evidence supporting experiencing as a trait variable (Rogers, Gendlin, Kiesler, & Truax, 1967; Ryan, 1966; Tomlinson & Hart, 1962). Similarly, research that has examined experiencing as a client variable has been mixed and has had methodological shortcomings. While some studies found evidence for a relationship between experiencing as a client variable and therapeutic outcomes (e.g., O’Malley, Suh, & Strupp, 1983), other research failed to find evidence for such a relationship (e.g., Bommert & Dahlhoff, 1978; Custers, 1973; Luborsky; 1982; Fishman, 1971). Other studies claimed to investigate experiencing as a client variable, but sampled from sessions as late as the middle of therapy (Castonguay, Godfried, Wiser, Raue, & Hayes, 1996; Windholtz & Silberschatz, 1988).

The above-cited studies sampled segments randomly and for this reason, it is possible that they were confounded by the fact that early sessions could involve events that did not reflect an exploration or discussion of core issues. Therefore, it is possible that random sampling during early therapy sessions could have introduced a less potent measure of clients’ experiencing and therefore, could explain the mixed findings. Goldman (1997) theorized that “it is unlikely that people change in psychotherapy in such a way that they are constantly processing at higher levels of experiencing” (Goldman, 1997, p.5) and core issues “characterize an important thread that weaves and is carried forward through the therapeutic process” (Goldman, 1997, p.43). Goldman (1997) found that overall average experiencing ratings across the therapy process, during
core thematic material, were correlated with changes in depressive symptoms and self-
esteeem.

The present study differed from previous research in a number of ways. First, the
present study employed Goldman’s (1997) theoretical rationale of sampling core issues to
discussions of past child abuse. The present study also extended Goldman’s research by
investigating experiencing as a client variable, instead of a process variable. In addition,
the present study extended previous research by investigating the relationship between
experiencing and therapeutic outcome in a specific therapy modality, EFT-AS, and with a
specific sample, child abuse survivors. In doing so, the present study is the first to
examine the relationship between experiencing and therapeutic outcome in a sample of
child abuse survivors. The present study is also the first to examine experiencing as a
client variable in treatment for child abuse issues, and to specifically examine depth of
experiencing during discussions of core abuse-related material.

Present findings indicated that EXP levels early in therapy predict therapeutic
improvements in multiple domains. As such, depth of experiencing appears to be a client
characteristic that predicts outcome in therapy with child abuse survivors. The
implications of these findings support the use of experiencing as a prognostic measures in
therapy with child abuse survivors. This information could also be used to tailor the
therapy process to individual clients, based on their early session experiencing levels.
Furthermore, this finding suggests that training programs should include instruction and
experience with interventions that are intended to deepen clients’ experiencing levels,
such as imaginal confrontation in EFT-AS.
The present study did not find a significant relationship between EXP, measured during a single early session of EFT-AS, and improvements in self-esteem, as measured by SASB-A scores. Goldman (1997) on the other hand, found a significant relationship between EXP, over the course of treatment for depression, and self-esteem using the Rosenberg Self-Esteem Scale (Rosenberg, 1965). This inconsistent finding could be attributable to different measures, treatment focus, or sampling procedure. Nevertheless, further research would be necessary to elucidate the reason why experiencing, during a single early session, did not predict improvements in self-esteem in the current study.

Another issue that warrants discussion is the finding that outcome was predicted by modal EXP ratings, but not peak EXP ratings. The type of EXP rating (i.e., modal or peak) has not been a pivotal issue in previous research. In fact, to the author's awareness, none of the hypotheses in previous research have involved specific predictions about whether a certain type of EXP rating would predict therapeutic outcomes. The present findings suggest that maintaining a high EXP level seems to be more important to therapeutic outcomes than briefly attaining a high EXP level. This logically makes sense, considering that modal ratings seem to be more representative of a client characteristic or trait versus an isolated event or state. The implication of this finding is that therapists should seek to maintain steady and high experiencing levels in their clients, versus briefly obtaining a high experiencing level.

Another finding that merits discussion is the finding that survivors of physical abuse had higher EXP levels than survivors of emotional abuse. Although this analysis was exploratory, it seemed possible that sexual abuse survivors would have displayed lower EXP levels than those who had been emotionally or physically abused because
sexual abuse survivors could be more inhibited during early therapy sessions, compared to survivors of emotional or physical abuse. It is possible that some of the small cell sizes possibly yielded insufficient power to detect small group differences between the other subgroups of abuse. Future research could employ larger samples in order to examine this possibility. Finally, the present study did not find any evidence for gender differences in EXP levels or differences in EXP levels across the primary perpetrator of abuse.

Methodological Limitations

An obvious limitation of the present study is the sample size. The small sample overall and the small number of clients in some cells, for example males, physical abuse, and non-father perpetrators, possibly yielded insufficient power to detect small effects. On the other hand, the inflated Type I error rate means that the findings must be interpreted with caution. Other limitations concern the generalizability of results. The sample employed in the present study was a heterogeneous sample of child abuse survivors in terms of diagnoses, symptom severity, type of abuse, perpetrator of abuse, and participant gender and age. Furthermore the sample was comparable to other moderately distressed samples of outpatients and other outpatient groups of adult survivors in terms of the prevalence and severity of PTSD (Paivio & Nieuwenhuis, 2001). In addition, Paivio and Nieuwenhuis (2001) placed minimal limits on inclusion, to avoid prematurely restricting this sample, and this sample was comparable to the range of abusive experiences likely found in other outpatient groups of adult survivors. Nevertheless, the sample was limited in so far as it consisted exclusively of clients who were moderately disturbed and impaired. More severely disturbed individuals, such as
those with concurrent substance abuse or severe emotion dysregulation problems, were excluded from the study. A final limitation regarding the sample is the lack of ethnic diversity.

Another limitation that warrants discussion is the method employed to minimize rater drift. In the current study, ratings were reviewed and discussed after approximately every third transcript was rated. Given that this procedure was not entirely random and was somewhat predictable, one could argue that these reviews could have influenced the rating process by artificially inflating the raters' diligence and the predictability of these reviews. It would be preferable if these reviews were entirely random in subsequent research.

In addition, therapy segments were sampled from one of the first three therapy segments to minimize the likelihood of therapeutic influence upon clients' EXP levels. Ideally, a narrative of the clients' past abuse would have been obtained prior to initiating therapy. This would entirely eliminate therapeutic effects upon early EXP levels. Another issue is that one would ideally have a larger sample when employing the statistical analyses and number of predictors used in the present study (Tabachnik & Fidell, 2001). As such, further replication with a larger sample is necessary.

Recommendations for Future Research

Subsequent research could expand upon the present research by further investigating the relationship between client and process variables. That is, future research could seek to determine whether experiencing remains stable throughout therapy and if there are therapist variables that elicit or contribute to higher EXP levels in clients.
Furthermore, future research could attempt to identify other factors that are related to clients' capacity for deeper levels of experiencing, such as type of child abuse.

*Implications and Conclusions*

As theorized, experiencing is one client variable that contributes to positive outcomes in EFT-AS because of its central role in the acquisition of new meaning and recovery from trauma. The findings of the present study have several implications. Present findings suggest that an individual's capacity for experiencing could be a prognostic measure in this type of treatment with child abuse survivors. These results also have implications for both treatment and training. More specifically, it is feasible that client's depth of experiencing at the onset of therapy could be used to predict performance in this therapy modality and also could be used to tailor therapeutic interventions, with the goal of deepening clients' capacity for experiencing. In addition, these results suggest that therapists' increased attention and training in methods intended to deepen clients' experiencing could be beneficial to therapeutic outcomes. This research has also supported Bohart's (1993) theory that experiencing is a common mechanism of change across therapy modalities because the present findings are consistent with those of previous studies (e.g., Castonguay, Godfried, Wiser, Raue, & Hayes, 1996; O'Malley, Suh, & Strupp, 1983; Windholtz & Silberschatz, 1988). This suggests that experiencing is a variable that is important to therapeutic outcomes, regardless of the therapy modality employed.
Chapter VI

References


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Madison, University of Wisconsin Press.


Chapter VII

Appendix A

Sample Experiencing Scale (EXP) Ratings

Level 1. “I read a book that said…” or “I went to the store” (Goldman, 1997, p. 22). Notice that this example is impersonal and superficial. Feelings are avoided and personal involvement is absent. For these reasons, the statement received a level one rating.

Level 2. “No, I don’t think she ever got it… I just thought that maybe the only reason I got it was because I wasn’t like her then” (Klein et al., 1986, p. 62). This statement was assigned a level two rating because the association between the speaker and the content is clear, however, the remarks serve to get the story across and do not define the client’s feelings.

Level 3. “I had a dream… I was alone with this guy, ah (silence)… and the dream was real nice, it was a real nice relationship. When I thought about it next day I thought, why don’t I have a real one! I don’t think he could really see anything wrong with me. I was also thinking why I was absent in school so much. When it comes to the end of the line I don’t have a paper, I hold back. I get jittery and then I pull away from it” (Klein et al., 1986, p. 62). This statement received a level three rating because feelings were discussed, albeit they were limited to a specific situation, namely the dream. The statement did not describe the client’s feelings more generally, as achieved by the following example.

Level 4. “The jittery is more a surface than the pull back. The jittery comes when part of me says well, you know, you really have to go it now” (Klein et al., 1986, p. 62).
A level four rating was assigned to this statement because the focus is upon the client’s feelings and the articulated feelings describe the client more generally, instead of referring to a specific event or situation. Importantly, the speaker communicated what it is like to be him/her.

*Level 5.* "Well I think it’s …ah…that I don’t want to test myself. And I’m afraid, ah, the bad things will be confirmed…Yeah. But if I don’t go on the line, then I don’t have to pull back" (Klein et al., 1986, p. 62). A second example is as follows: “When the teacher is disapproving of what I am saying, I find myself hating her and wanting to just close down. I wonder if I get angry when I am feeling inadequate?” (Goldman, 1997, p. 24). Both of these examples were assigned a level five rating for the following reasons. The statements describe the client’s feelings, however, the statements also include the two necessary components for a level five response. That is, each client posed a problem about the self and then continued to work with that problem in a meaningful way.

*Level 6.* “Scared…it’s like the world is going to bite me or something (laughs)” (Klein et al., 1986, p. 62). A second example is as follows: “It used to be that when he would just walk out, I would feel devastated, as if my whole world was caving in. Now it is different. I still feel hurt, but I somehow know that I will be ok” (Goldman, 1997, p. 25). Both of these examples were assigned a level six rating because although the clients were describing their feelings, there are more than recognizable feelings. There is a feeling that they cannot precisely articulate. That is, there is a “felt sense of a there-and-yet-to-be-fully-discovered” (Klein et al., 1986, p. 23).
Level 7. (Often spread over a consecutive number of client statements). “I am no longer going to be a slave in the marriage. I am a good person and I deserve to be treated better. I wonder why I have put up with this for so long as I have. I think it was a pattern that I learned from my mother. I used to think this was the way marriage had to be, but now I know it is not, and I am not going to put up with it anymore. I am going to break the pattern. I don’t want it to be passed on to my children” (Goldman, 1997, p. 25). A level seven rating was assigned to this statement because it demonstrates an expanding awareness of internal processes and the client is moving fluidly between inner referents and is linking and integrating these inner referents.
Appendix C

Information Provided to Participants

The goals of this study are to understand how people come to terms with bad feelings that result from childhood abuse or maltreatment. Your help with this research is important. It will enable us to develop better ways of helping people with these difficult problems. Therapists and researchers in the project are faculty members and graduate students in the Department of Psychology at the University of Saskatchewan. The students are training to become professional psychologists and will be supervised by faculty. Although this is a research project, meeting your needs is our first concern. We are interested in helping real people in real therapy to deal with real life problems. We are interested in learning from your experience.

Your therapy sessions will be tape recorded (audio and/or video). Parts of these tapes will be watched by your therapist and with his/her supervisor. Other therapists in the program also may watch parts of these tapes as part of their training. This will make sure that you and other clients get the best possible service throughout the program. Once your therapy is completed, parts of your tapes will be reviewed by researchers to find out how certain therapy experiences are helpful. Your part in this research will be to fill out questionnaires about yourself. We will ask you to do this before and at the end of therapy, and periodically during the program. All materials will be kept in strict confidence and used only for this research. Identifying information, such as your name, will not appear on test materials. Once your therapy is over, every reasonable effort will be made to make sure that you will not be identified in the tapes.
This is a large project which will take about three to five years to complete. However, feedback about the results of this project will be available to you once they are summarized.

Your signature below means that you have read and understood the above description of the research project.

___________________________________  __________________________
Signature                          Date
Appendix D

Client Consent Form

I __________________ agree to take part in a psychotherapy program. This will entail one hour per week of individual therapy and will last for 16 weeks. This program will be held at a “Psychological Services Facility” at the University of Saskatchewan.

I understand that this program involves research. The main purpose of the research is to study how people come to terms with bad feelings related to childhood abuse or maltreatment. I am aware that this research is being conducted by Dr. S. Paivio who is in the Psychology Department at the University of Saskatchewan. As part of this research I will be asked to answer five questionnaires. These deal with the problems that bother me and my views of myself and the person who abused me. These questionnaires will be given at the beginning and end of therapy, and six months after therapy. They will take about 90 minutes, each time, to complete. Periodically, during the course of therapy, I also will be asked to answer a questionnaire (about 10 minutes) about my experience of therapy.

I understand that all my therapy sessions will be tape recorded. These tapes, as well as my answers to all the questionnaires, will be kept in strict confidence. They will be used only for this research. Materials will be used under the supervision of Dr. Paivio and only seen by members of the research team and therapists taking part in the program. I am informed that identifying information will not appear on the test material. Once my therapy is over, every reasonable effort will be made to make sure that I will not be
identified in the tapes. Any use of my materials other than for this research project will not be made without my written consent.

Furthermore, I understand that, at any time, I can decide not to take part in the research and can withdraw consent for use of my materials. In this case, I still will be able to continue my therapy with the same or another therapist.

My signature indicates that I have read and understood the content of this form and the conditions of taking part in this program.

__________________________________________  ____________________________
Witness Signature                                Client Signature

__________________________________________  ____________________________
Date                                              Address

__________________________________________
Phone

67
Appendix E

Release of Therapy Audio/Videotapes

I ___________________ give my permission for the audio and videotapes of my therapy to be used for research purposes under the supervision of Dr. Sandra Paivio. I understand that they only will be used for this research project and that these materials will be kept in strict confidence. Segments of tapes will be viewed only by members of Dr. Paivio’s research team and every reasonable effort will be made to ensure that I will not be identified on these materials.

I also give permission for the audio and videotapes of my therapy to be used for training purposes under the supervision of Dr. S. Paivio. I understand that this will not be for mass viewing or distribution by strictly will be limited to the teaching of professionals and professionals-in-training who are bound by professional ethical standards of confidentiality. In accordance with these standards, names and other identifying information will be deleted from these tapes.

Additionally, I give permission for publication of anonymous excerpts of my therapy session transcripts where, again, all identifying information will be changed or deleted.

Witness

Client Signature

Address & Postal Code

Phone

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Appendix G

Symptom Checklist-90-Revised (SCL-90-R)

Below is a list of problems people sometimes have. Please read the list below, and for each item, circle the number that describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. Circle only one number for each problem and do not skip any items. If you change your mind, erase your first mark carefully.

0 = Not at all
1 = A little
2 = Moderately
3 = Quite a bit
4 = Extremely

How much were you distressed by:

1. Headaches........................................ 0 1 2 3 4
2. Nervousness or shakiness....................... 0 1 2 3 4
3. Repeated unpleasant thoughts that won't leave your mind... 0 1 2 3 4
4. Faintness or dizziness............................ 0 1 2 3 4
5. Loss of sexual interest or pleasure.............. 0 1 2 3 4
6. Feeling critical of others.......................... 0 1 2 3 4
7. The idea that someone else can control your thoughts......... 0 1 2 3 4
8. Feeling others are to blame for most of your troubles....... 0 1 2 3 4
9. Trouble remembering things..................... 0 1 2 3 4
10. Worried about sloppiness or carelessness.............. 0 1 2 3 4
11. Feeling easily annoyed or irritated.................. 0 1 2 3 4
12. Pains in heart and chest................................ 0 1 2 3 4
13. Feeling afraid in open spaces or on the street.............. 0 1 2 3 4
14. Feeling low in energy or slowed down.............. 0 1 2 3 4
15. Thoughts of ending your life.......................... 0 1 2 3 4
16. Hearing voices that other people do not hear............. 0 1 2 3 4
17. Trembling........................................ 0 1 2 3 4
18. Feeling that most people cannot be trusted.............. 0 1 2 3 4
19. Poor appetite................................... 0 1 2 3 4
20. Crying easily .................................................. 0 1 2 3 4
21. Feeling shy or uneasy with the opposite sex .................. 0 1 2 3 4
22. Feelings of being trapped or caught .......................... 0 1 2 3 4
23. Suddenly scared for no reason .................................. 0 1 2 3 4
24. Temper outbursts that you could not control ............... 0 1 2 3 4
25. Feeling afraid to go out of your house alone .................. 0 1 2 3 4
26. Blaming yourself for things .................................... 0 1 2 3 4
27. Pains in lower back .......................................... 0 1 2 3 4
28. Feeling blocked in getting things done ....................... 0 1 2 3 4
29. Feeling lonely ................................................. 0 1 2 3 4
30. Feeling blue ................................................. 0 1 2 3 4
31. Worrying too much about things .............................. 0 1 2 3 4
32. Feeling no interest in things .................................. 0 1 2 3 4
33. Feeling fearful .................................................. 0 1 2 3 4
34. Your feelings being easily hurt ................................ 0 1 2 3 4
35. Other people being aware of your private thoughts ....... 0 1 2 3 4
36. Feeling others do not understand you or are unsympathetic.. 0 1 2 3 4
37. Feeling that people are unfriendly or dislike you .......... 0 1 2 3 4
38. Having to do things very slowly to insure correctness ..... 0 1 2 3 4
39. Heart pounding or racing ...................................... 0 1 2 3 4
40. Nausea or upset stomach ...................................... 0 1 2 3 4
41. Feeling inferior to others ..................................... 0 1 2 3 4
42. Soreness of your muscles ...................................... 0 1 2 3 4
43. Feeling that you are watched or talked about by others ... 0 1 2 3 4
44. Trouble falling asleep ........................................ 0 1 2 3 4
45. Having to check and double-check what you do ........... 0 1 2 3 4
46. Difficulty making decisions .................................... 0 1 2 3 4
47. Feeling afraid to travel on buses, subways, or trains ..... 0 1 2 3 4
48. Trouble getting your breath ................................... 0 1 2 3 4
49. Hot or cold spells ............................................. 0 1 2 3 4
<table>
<thead>
<tr>
<th></th>
<th>Having to avoid certain things, places, or activities because they frighten you.</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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</thead>
<tbody>
<tr>
<td>50</td>
<td>Your mind going blank.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
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<td>Numbness or tingling in parts of your body.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
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<td>52</td>
<td>A lump in your throat.</td>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>53</td>
<td>Feeling hopeless about the future.</td>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
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<td>Trouble concentrating.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>55</td>
<td>Feeling weak in parts of your body.</td>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>56</td>
<td>Feeling tense or keyed up.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>57</td>
<td>Heavy feelings in your arms or legs.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>58</td>
<td>Thoughts of death or dying.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>59</td>
<td>Overeating.</td>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>60</td>
<td>Feeling uneasy when people are watching or talking about you.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>61</td>
<td>Having thoughts that are not your own.</td>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>62</td>
<td>Having urges to beat, injure, or harm someone.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>63</td>
<td>Awakening in the early morning.</td>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>64</td>
<td>Having to repeat the same actions such as touching, counting, or washing.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>65</td>
<td>Sleep that is restless or disturbed.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>66</td>
<td>Having urges to break or smash things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>67</td>
<td>Having ideas or beliefs that others do not share.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>68</td>
<td>Feeling very self-conscious with others.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>69</td>
<td>Feeling uneasy in crowds, such as shopping or at a movie.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>70</td>
<td>Feeling everything is an effort.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>71</td>
<td>Spells of terror or panic.</td>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>72</td>
<td>Feeling uncomfortable about eating or drinking in public.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>73</td>
<td>Getting into frequent arguments.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>74</td>
<td>Feeling nervous when you are left alone.</td>
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<td>2</td>
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<td>4</td>
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<tr>
<td>75</td>
<td>Others not giving you proper credit for your achievements</td>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>76</td>
<td>Feeling lonely even when you are with people.</td>
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<td>2</td>
<td>3</td>
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<tr>
<td>77</td>
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<td>1</td>
<td>2</td>
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<td>4</td>
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<tr>
<td></td>
<td>Feeling so restless you couldn’t sit still</td>
<td>0 1 2 3 4</td>
<td></td>
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</tr>
<tr>
<td>78</td>
<td>Feeling of worthlessness</td>
<td>0 1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>79</td>
<td>The feeling that something bad is going to happen to you</td>
<td>0 1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>80</td>
<td>Shouting or throwing things</td>
<td>0 1 2 3 4</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>81</td>
<td>Feeling afraid you will faint in public</td>
<td>0 1 2 3 4</td>
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<tr>
<td>82</td>
<td>Feeling that people will take advantage of you if you let them</td>
<td>0 1 2 3 4</td>
<td></td>
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<tr>
<td>83</td>
<td>Having thoughts about sex that bother you a lot</td>
<td>0 1 2 3 4</td>
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<tr>
<td>84</td>
<td>The idea that you should be punished for your sins</td>
<td>0 1 2 3 4</td>
<td></td>
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<tr>
<td>85</td>
<td>Thoughts and images of a frightening nature</td>
<td>0 1 2 3 4</td>
<td></td>
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<td></td>
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<tr>
<td>86</td>
<td>The idea that something serious is wrong with your body</td>
<td>0 1 2 3 4</td>
<td></td>
<td></td>
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<tr>
<td>87</td>
<td>Never feeling close to another person</td>
<td>0 1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>88</td>
<td>Feelings of guilt</td>
<td>0 1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>89</td>
<td>The idea that something is wrong with your mind</td>
<td>0 1 2 3 4</td>
<td></td>
<td></td>
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</tr>
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</table>
Appendix H

Impact of Events Scale (IES)

The "event" refers to the early experiences of childhood trauma/abuse for which you sought therapy. Below is a list of comments made by people after stressful life events. Please read the list below, and for each item, circle the number indicating how frequently these comments were true for you during the past seven days. If they did not occur during that time, please mark the ‘not at all’ column.

0 = Not at all
1 = Rarely experienced
2 = Sometimes experienced
3 = Often experienced

1. I thought about it when I didn’t mean to........................................... 0 1 2 3
2. I avoided letting myself get upset when I thought about it or was reminded of it................................................................. 0 1 2 3
3. I tried to remove it from memory.................................................. 0 1 2 3
4. I had trouble falling asleep or staying asleep.............................. 0 1 2 3
5. I had waves of strong feelings about it...................................... 0 1 2 3
6. I had dreams about it................................................................. 0 1 2 3
7. I stayed away from reminders of it............................................. 0 1 2 3
8. I felt as if it hadn’t happened or it wasn’t real............................ 0 1 2 3
9. I tried not to talk about it............................................................ 0 1 2 3
10. Pictures about it popped into my mind..................................... 0 1 2 3
11. Other things kept making me think about it............................. 0 1 2 3
12. I was aware that I still had a lot of feelings about it, but I didn’t deal with them................................................................. 0 1 2 3
13. I tried not to think about it....................................................... 0 1 2 3
14. Any reminder brought back feelings about it............................ 0 1 2 3
15. My feelings about it were kind of numb................................... 0 1 2 3
Appendix 1

The Structural Analysis of Social Behaviour, Intrex (Introject) Questionnaire (SASB)

Please use the attached answer sheet and indicate how well each statement describes how you most often treat yourself currently.

Please use an answer sheet marked A and indicate how well each question describes YOURSELF:

Use the scale that appears at the top of that answer sheet.

1. I neglect myself, don’t try to develop good skills, ways of being.
2. Because I want to help myself, I try to figure out what is really going on within me.
3. Instead of getting around to doing what I really need to do for myself, I let myself go and just daydream.
4. I just let important personal matters, choices, thoughts, issues slip by without paying much attention.
5. Knowing both my faults and strong points, I comfortably let myself be “as is.”
6. I let myself feel glad about and pleased with myself just as I am.
7. I accuse and blame myself until I feel guilty, bad, and ashamed.
8. I practice and work on developing worthwhile skills, ways of being.
9. I tenderly, lovingly, cherish, and adore myself.
10. I naturally and easily provide for, nurture, and take care of myself.
11. I angrily and harshly reject myself as worthless, and leave what happens to me to fate.
12. I ignore and don’t bother to know my real self.
13. I like myself very much, and feel very good when I have a chance to be with myself.
14. I very carefully watch, hold back, and restrain myself.
15. I have the habit of keeping very tight control of myself.
16. I let myself murder, kill, destroy, and reduce myself to nothing.
17. I tear away at and empty myself by greatly overburdening myself.
18. I gently and warmly stroke and appreciate myself for just being me.
19. I keep an eye on myself to be sure I am going what should and ought to be done.
20. I try very hard to make myself be like an ideal.
21. I comfortably let myself hear and go by my own deepest inner feelings.
22. Even when it means harming myself greatly, I let my own sickness and injury go unattended.
23. I put all kinds of energy into making sure I follow the right standards and am proper.
24. I harshly punish, torture myself; I “take it out” on myself.
25. I make myself do and be things which are known not to be right for me. I fool myself.
26. I just let myself go along with today as it is and don’t plan for tomorrow.
27. I comfortably look after my own interests and protect myself.
28. I let myself drift with the moment; I have no internal direction, goals, or standards.
29. I put a lot of energy into figuring out what I’m going to need or myself and how to get it.
30. I freely, easily, and confidently let myself do whatever comes naturally.
31. I understand and like myself just as I am. I feel solid, “together.”
32. Without concern, I just let myself be free to turn into whatever I will.
33. I am reckless; I carelessly let myself end up in self-destructive situations.
34. I keep myself open to connecting with people, places, or things which would be very good for me.
35. I put myself down, tell myself that I have done everything wrong and that others can do better.
36. I think up ways to hurt and destroy myself. I am my own worst enemy.

<table>
<thead>
<tr>
<th>Never</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not At All</td>
<td>Perfectly</td>
</tr>
<tr>
<td>0</td>
<td>10</td>
</tr>
</tbody>
</table>

A rating of less than 50 indicates “false”; a rating of 50 or more indicates “true.”
**Appendix J**

**Inventory of Interpersonal Problems (IIP)**

Here is a list of problems that people report in relating to other people. Please read the list below, and for each item, select the number that describes how distressing that problem has been for you. Then circle that number.

0 = Not at all  
1 = A little  
2 = Moderately  
3 = Quite a bit  
4 = Extremely

Part I. The following are things you find hard to do with other people

*It is hard for me to:*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<td>1</td>
<td>Trust other people</td>
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<td>2</td>
<td>Say “no” to other people</td>
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<td>3</td>
<td>Join in on groups</td>
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<td>4</td>
<td>Keep things private from other people</td>
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<td>5</td>
<td>Let other people know what I want</td>
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<td>6</td>
<td>Tell a person to stop bothering me</td>
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<td>7</td>
<td>Introduce myself to new people</td>
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<td>8</td>
<td>Confront people with problems that come up</td>
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<td>9</td>
<td>Be assertive with another person</td>
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<tr>
<td>10</td>
<td>Make friends</td>
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<td>11</td>
<td>Express my admiration for another person</td>
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<td>12</td>
<td>Have someone dependent on me</td>
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<td>13</td>
<td>Disagree with other people</td>
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<td>14</td>
<td>Let other people know when I am angry</td>
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<td>15</td>
<td>Make a long-term commitment to another person</td>
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<td>16</td>
<td>Stick to my own point of view and not be swayed by</td>
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<td>other people</td>
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<td>17</td>
<td>Be another person’s boss</td>
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<td>18</td>
<td>Do what another person wants me to do</td>
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<tr>
<td>19.</td>
<td>Get along with people who have authority over me</td>
<td>0 1 2 3 4</td>
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<td>20.</td>
<td>Be aggressive towards other people when the situation calls for it</td>
<td>0 1 2 3 4</td>
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<td>21.</td>
<td>Compete against other people</td>
<td>0 1 2 3 4</td>
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<td>22.</td>
<td>Make reasonable demands of other people</td>
<td>0 1 2 3 4</td>
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<td>23.</td>
<td>Socialize with other people</td>
<td>0 1 2 3 4</td>
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<td>24.</td>
<td>Get out of a relationship that I don’t want to be in</td>
<td>0 1 2 3 4</td>
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<td>25.</td>
<td>Take charge of my own affairs without help from other people</td>
<td>0 1 2 3 4</td>
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<tr>
<td>26.</td>
<td>Show affection around other people</td>
<td>0 1 2 3 4</td>
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<td>27.</td>
<td>Feel comfortable around other people</td>
<td>0 1 2 3 4</td>
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<td>28.</td>
<td>Get along with other people</td>
<td>0 1 2 3 4</td>
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<tr>
<td>29.</td>
<td>Understand another person’s point of view</td>
<td>0 1 2 3 4</td>
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<td>30.</td>
<td>Tell personal things to other people</td>
<td>0 1 2 3 4</td>
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<td>31.</td>
<td>Believe that I am loveable to other people</td>
<td>0 1 2 3 4</td>
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<td>32.</td>
<td>Express my feelings to other people directly</td>
<td>0 1 2 3 4</td>
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<td>33.</td>
<td>Be firm when I need to be</td>
<td>0 1 2 3 4</td>
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<tr>
<td>34.</td>
<td>Experience a feeling of love for another person</td>
<td>0 1 2 3 4</td>
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<td>35.</td>
<td>Be competitive when the situation calls for it</td>
<td>0 1 2 3 4</td>
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<td>36.</td>
<td>Set limits on other people</td>
<td>0 1 2 3 4</td>
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<td>37.</td>
<td>Be honest with other people</td>
<td>0 1 2 3 4</td>
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<td>38.</td>
<td>Be supportive of another person’s goals in life</td>
<td>0 1 2 3 4</td>
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<td>39.</td>
<td>Feel close to other people</td>
<td>0 1 2 3 4</td>
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<td>40.</td>
<td>Really care about other people’s problems</td>
<td>0 1 2 3 4</td>
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<tr>
<td>41.</td>
<td>Argue with another person</td>
<td>0 1 2 3 4</td>
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<td>42.</td>
<td>Relax and enjoy myself when I go out with other people</td>
<td>0 1 2 3 4</td>
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<td>43.</td>
<td>Feel superior to another person</td>
<td>0 1 2 3 4</td>
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<td>44.</td>
<td>Become sexually aroused toward the person I really care about</td>
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<td>45.</td>
<td>Feel that I deserve another person’s affection</td>
<td>0 1 2 3 4</td>
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<td>46.</td>
<td>Keep up my side of a friendship</td>
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<td>47</td>
<td>Spend time alone</td>
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<td>48</td>
<td>Give a gift to another person</td>
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<td>49</td>
<td>Have loving and angry feelings towards the same person.</td>
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<td>50</td>
<td>Maintain a working relationship with someone I don’t like</td>
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<td>51</td>
<td>Set goals for myself without other people’s advice</td>
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<td>52</td>
<td>Accept another person’s authority over me</td>
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<td>53</td>
<td>Feel good about winning</td>
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<td>54</td>
<td>Ignore criticism from other people</td>
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<td>55</td>
<td>Feel like a separate person when I am in a relationship</td>
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<td>56</td>
<td>Allow myself to be more successful than other people.</td>
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<td>57</td>
<td>Feel or act competent in my role as parent</td>
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<td>58</td>
<td>Let myself feel angry at somebody I like</td>
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<td>59</td>
<td>Respond sexually to another person</td>
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<td>60</td>
<td>Accept praise from another person</td>
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<td>61</td>
<td>Put somebody else’s needs before my own</td>
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<td>62</td>
<td>Give credit to another person for doing something well.</td>
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<td>63</td>
<td>Stay out of other people’s business</td>
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<td>64</td>
<td>Take instructions from people who have authority over me</td>
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<tr>
<td>65</td>
<td>Feel good about another person’s happiness</td>
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<td>66</td>
<td>Get over the feeling of loss after a relationship has ended</td>
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<td>67</td>
<td>Ask other people to get together socially with me</td>
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<td>68</td>
<td>Feel angry at other people</td>
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<td>69</td>
<td>Give constructive criticism to another person</td>
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<tr>
<td>70</td>
<td>Experience sexual satisfaction</td>
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<td>71</td>
<td>Open up and tell my feelings to another person</td>
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<td>72</td>
<td>Forgive another person after I’ve been angry</td>
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<td>73</td>
<td>Attend to my own welfare when somebody else is needy</td>
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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 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 too 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 too 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............................ 0 1 2 3 4
117. I am too envious and jealous of other people.............. 0 1 2 3 4
118. I keep other people at a distance too much............... 0 1 2 3 4
119. I worry too much about my family’s reactions to me..... 0 1 2 3 4
120. I let other people take advantage of me too much........ 0 1 2 3 4
121. I too easily lose a sense of myself when I am around a strong-minded person........................................... 0 1 2 3 4
122. I feel too guilty for what I have failed to do................. 0 1 2 3 4
123. I feel competitive even when the situation does not call for it................................................................. 0 1 2 3 4
124. I feel embarrassed in front of other people too much..... 0 1 2 3 4
125. I feel to anxious when I am involved with another
person.......................................................... 0 1 2 3 4
126. I am affected by another person’s misery too much....... 0 1 2 3 4
127. I want to get revenge against people too much.......... 0 1 2 3 4
Appendix K

Resolution Scale (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.

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<tbody>
<tr>
<td>Not at all</td>
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<td>Very much</td>
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2. I feel frustrated about not having my needs met by this person.

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<tbody>
<tr>
<td>Not at all</td>
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<td>Very much</td>
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3. I feel worthwhile in relation to this person.

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<tbody>
<tr>
<td>Not at all</td>
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<td>Very much</td>
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4. I see this person negatively.

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<td>Not at all</td>
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<td>Very much</td>
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5. I feel comfortable about my feelings in relation to this person.

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<tbody>
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<td>Not at all</td>
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<td>Very much</td>
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6. This person’s negative view or treatment of me has made me feel badly about myself.

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<tbody>
<tr>
<td>Not at all</td>
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<td>Very much</td>
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7. I feel okay about not having received what I needed from this person.

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<tbody>
<tr>
<td>Not at all</td>
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<td>Very much</td>
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</table>
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
Appendix L

Examples of EXP Ratings from the Present Study

Level 1 ratings were not detected in the present study.

Level 2. “I don’t know how it got to the point where she had the broom. I don’t know if I had broken something, but then I don’t, I don’t know. What I knew was scrambling under the table or chair.” “Yep, both verbally and physically.” “Yeah. We had to rely on ourselves for our own entertainment and that kind of thing. Uh, I guess we were thinking about some of those questions, being looked after physically. I remember being pretty cold at times. Being freezing at winter. I don’t know whether that was due to not having enough money for clothes or that the clothes weren’t very well made in those days, maybe a combination of the two.”

Level 3. “I used to just hate any kind of stuff done, like getting my hair done or something right before school. I used to just um not want to do it. I didn’t want her to do it. Let me do my own hair. Of course I didn’t do a good enough job that she had to do it, but um, mentally I didn’t want to get my haircut. It’s not that it was too much trouble.” “Oh yeah, crazy. I was really freezing doing chores. Really cold.” “Yeah yeah cause I think uh you shouldn’t even help yourself that way. I realize that she went through a hard time too, but I really think that she took the easy way out to deal with it and I’m really hoping that I took a more positive way, but by doing that, I have to shelf a lot of things and just go forward without you know, having to worry about them in my back pocket.”

Level 4. “Yes but our house was like it was just you would go home and that was what it was like and um. I don’t see it as afraid, I guess I was. I wouldn’t have thought to say that I was afraid, but obviously when I think about it I generally was at that time.”
“Oh yeah, it was alright. I don’t think that I even said too much. He explained a few things to me, but not that much, so I was always edgy when I was around him too. When am I going to make a mistake?” “That’s why I’ve been hiding most of my unresolved feelings. I have been kind of scared to tell my mother.” “I kind of feel lost without her, but it’s pretty easy to be angry about a lot of things too.” “Um, just a feeling of not being wanted and they were always screaming and yelling and everything was negative.”

Level 5. “I want to know why I have devalued myself, why I’m the one who feels guilty, why I am the one that feels worthless. Why am I the guilty one? Why do I take the responsibility for every negative thing? Is it because of all the put downs and never the praise and never being encouraged?” “Yeah, but maybe that was just too much to hope for. You know, at the time I didn’t think, oh, I wish my mother was. Well, of course, I did, um. I wished my mother was like, one of my friends’ mothers who was expecting me to go to someone else’s house. You know, you go to visit someone’s home and it’s a totally different. They get along with their mom. I still have a problem with that when I go to people’s homes. Like friends of mine who are adults and you go to their place just to visit and or not to their place, to their parents’ place, like one of my friends has a little boy and uh after school he goes over to his grandparents. So if a bunch of us are going out for supper or somewhere we can’t take him, then we stop in there and you know, her parents are there. Everybody else is fine with it. I’m just not fine with it. I just can’t handle going to family things where other people’s, it’s not that I don’t like them, but it just feels weird to be in a family situation.”

Level 6. “Yeah I mean, just, just become really blank. I was extremely depressed. And it’s like a black abyss that you’re falling into. And people talk about it,
but it really is like that. Your mind is like, you mind is falling into a black pit and you can’t really do much about it, I mean. And some people would kill themselves and some people would reach out to someone else, but the problem is each person is just human, so you can’t put too much hope in each person or you can’t put absolute faith in another person, because they’re human, they make mistakes… It’s just a very dark place. It makes it, it makes it very cold. Like I can physically feel it…. It’s hard. Because it’s kind of emptiness. Its kind of part of me. It’s kept me going. Another part of me just likes it there. And it’s really hard to find, but if you’ve ever been there you know. Well you start to understand what. Like I feel problems and you’re lookin’ at me sayin’ tell me about your problems, why are you so, why are they so depressed, why do they kill themselves, but if you’ve ever had that feeling, then you can understand that, like you can understand, you can have some understanding of what’s it’s like to of how difficult it is to deal with that.”

*Level 7 ratings were not detected in the present study.*
Vita Auctoris

Lori Robichaud was born in 1979 in Toronto, Ontario. She graduated from Michael Power St. Joseph’s High School in 1998. From there, she went on to the University of Guelph where she obtained a Bachelor of Science (Honours) degree in Psychology in 2002. Throughout this period, she obtained experience in the emergency services through Toronto Emergency Medical Services, Ontario Air Ambulance, Toronto Fire Services, and St. John Ambulance, which stimulated her interests in traumatic stress and fuelled her subsequent clinical and research interests. At this time, she was also able to obtain valuable experience working as a research assistant and teaching assistant in the University of Guelph Psychology Department. She moved to Windsor, Ontario in September 2002 to begin graduate studies in Adult Clinical Psychology, for which she was awarded a Canadian Graduate Scholarship from the Social Sciences and Humanities Research Council and a University of Windsor Tuition Scholarship. During the course of these studies, Lori Robichaud was afforded the opportunity to combine and further her clinical and research experiences in the areas of trauma, crime, and mental health through the Centre for Addiction and Mental Health, the Life Stress Centre at Detroit Receiving Hospital, and the Neuro-Biofeedback Wellness Centre. She will be graduating from the Master of Arts Degree in Adult Clinical Psychology in October 2004 and will continue graduate studies in Adult Clinical Psychology at the University of Windsor at the doctoral level, for which she has been awarded an Ontario Graduate Scholarship and University of Windsor Tuition Scholarship.