

**EMOTIONALLY FOCUSED INDIVIDUAL THERAPY FOR THE TREATMENT OF
TRAUMA-RELATED SYMPTOMS OF THE SELF**

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Abstract

Emotionally Focused Individual Therapy (EFIT) is an evidence-based and empirically supported therapy (Wiebe & Johnson, 2016). Although there is significant research on EFT for couples with trauma, there is limited research on the effect of the treatment for trauma of individuals. The study models change in trauma-related symptoms and emotional dysregulation over the course of 12-15 sessions of EFIT treatment with 40 individuals. HLM results confirmed a significant change demonstrating a decrease in trauma-related symptoms of depression, attachment difficulties, and impaired self-reference. The findings did not show any significant decrease in emotional dysregulation across therapy sessions. It should be noted that the Covid-19 pandemic impacted the study results and lead to limitations, such as incomplete data. The findings support the theoretic assumption that EFIT helps alleviate symptoms of trauma for individuals engaged in therapy.

Keywords: attachment theory, emotionally-focused, emotional dysregulation, and trauma

Dedication

This thesis is dedicated to the survivors of trauma.

To my family who continues to survive it.

And to my beloved dog, Wilson, whom I tragically lost while writing.

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Emotionally Focused Individual Therapy for the Treatment of Trauma-related Symptoms of the Self

According to the Canadian Psychological Association, it is estimated that 76% of Canadians have experienced trauma in their lifetime (Ameringen, Mancini & Boyle, 2008). After experiencing trauma many individuals are plagued with memories of the event and experience symptoms that impact normal functioning. The amygdala is one part of an individual's brain that could show changes in functioning as a result of trauma. The amygdala forms emotional memories based on experiences (Johnson, 2005). When traumatic memories are formed, an individual is more likely to experience activations in their nervous system, which leads to frequent responses to real or perceived threats. The individual in this situation experiences constant emotional flooding. When an individual's nervous system is constantly activated, it leads to symptoms of emotional dysregulation in clients that have experienced trauma (Briere, Hodges, & Godbout, 2010). Trauma has a powerful negative impact on an individual's life and relationships (Johnson, 2005).

The nature of trauma is multidimensional and survivors of trauma report feeling helpless with their complex symptoms (Johnson, 2005). Instances that could impact normal functioning through emotional dysregulation are, for example, being confronted with physical danger, significant loss, or another distressing situation (Briere et al, 2010). Trauma is a painful emotional experience; therefore, an argument can be made that treatments focused on emotion may be more likely to be effective over cognitive-based therapies. Ultimately, emotionally-focused therapy targets emotions in areas of the brain, such as the amygdala, to treat emotional processes which are beyond cognitive control (Johnson, 2019).

In psychotherapy, one of the major challenges for therapists is how to work on helping clients transform their dysfunctional emotional responses when these are no longer serving their

needs towards healthier emotional responses. As a result of learned responses, clients with emotional dysregulation feel reminded of painful experiences whenever they are faced with emotionally activating cues, such as a trauma trigger (Briere et al, 2010). One of the effects of trauma on emotional regulation is the loss of the ability to regulate anxiety, so individuals develop coping strategies to try and lessen feelings that they cannot control (Johnson, 2005).

It is also likely that depressive symptoms will arise for an individual who experiences trauma because of arousal de-activation that has formed to deal with the hyperarousal symptoms (Johnson, 2005). Major depression is one of the most prevalent psychiatric disorders world-wide (Nelson et al, 2017). Individuals who seek treatment for depression often have experienced some form of childhood trauma in their lifetime. Disengagement, avoidance, and numbing strategies are common coping mechanisms for trauma survivors, such as appearing absent in their relationships (Burgess et al, 2016). The avoidance of trauma triggers a natural response when an individual is feeling overwhelmed with symptoms related to their experience (Johnson, 2005).

Healthy adaptive orientations to these experiences are normally processed emotions and based on primitive human survival mechanisms. Emotional responses could become problematic, however, for individuals who perceive that they are under constant threat because of the memories that have shaped them (Briere et al, 2010). Dysfunction occurs when a client's normal adaptive responses affect their ability to process emotional information even in times where there is no real threat (Greenberg, 2004).

Trauma survivors often blame themselves for what happened and experience damages to their sense of self such as feelings of shame and helplessness (Johnson, 2005).

Therapy that focuses on emotions works on building emotional resilience, which ultimately helps individuals cope with traumatic experiences and emotional injuries (Pascual-Leone, Yeryomenko, Sawashima, & Warwar, 2019).

Emotionally Focused Individual Therapy (EFIT) focuses on the present process and explores a client's patterns and ways of processing (Johnson, 2019). This attachment-based individualized approach focuses on a client's emotional injuries and pain through compassion and exploration (Johnson, 2019). The process of EFIT involves discovering with a client how they experience depression and anxiety. Through the development of secure attachments, a client can foster resilience and confidence with their sense of self. EFIT works to help an individual uncover how their symptoms perpetuate responses and behaviours that shape their sense of self and emotional worlds. As these emotional experiences evolve throughout therapy, new meanings and responses are formed (Johnson, 2019).

EFIT offers a safe haven in the therapeutic relationship in which an individual is guided through a process of learning about their emotions and attachment needs, which helps them explore ways to create safety and connection in relationships, including a more integrated sense of self in the process (Wiebe et al, 2017). A secure connection is pertinent in the face of danger or threat for trauma survivors. Trauma leaves an individual with negative assumptions about themselves and insecure perceptions in their relationships (Johnson, 2005). Treatments like EFIT are constructivist and focus on creating meaning in relation to an individual's sense of self, which is particularly relevant for those who have experienced trauma (Johnson, 2005).

This thesis will present a literature review that will cover the gaps in trauma research findings, future directions, and effectiveness of EFIT treatment for clients. It will pose definitive research questions that lead to the working hypothesis that EFIT is effective in helping clients

reduce trauma-related emotion dysregulation and symptoms related to sense of self. The methodology section will outline the research design, procedures, measurements, data analysis, and findings. The thesis concludes with a discussion of potential limitations and implications for future research on effective treatment methods for trauma.

Literature Review

The Nature of Trauma

Trauma is the disturbance as a result of an unexpected event or repeated exposure to events that cause helplessness, intense fear, horror, and/or tremendous distress (Mlotek & Pavivio, 2017). For example, childhood maltreatment, including physical, emotional, sexual abuse, and neglect are considered traumatic events. Trauma also includes events of real or perceived threat of sexual violence or physical harm (American Psychological Association (APA), 2013). A traumatic event could be a singular event learned or witnessed by an individual or repeated exposure to an event. In particular, childhood maltreatment is associated with adult interpersonal difficulties and issues with emotional regulation because of repeated exposure to trauma over a period of time and usually impacts the brain at an early age of development (Mlotek & Pavivio, 2017).

According to Harte, Strmeli, and Theiler (2020) emotional pain is caused by both “large T” and “small T” trauma (p.43). “Large T” traumas are events like, assault, accident, abuse, or interpersonal violence, while “small T” traumas are stressful interpersonal experiences (Harte, Strmelj, & Theiler, 2020, p. 43). Traumatic emotional injuries in relationships could benefit from treatment methods that focus on resolving, healing, and rewriting emotional responses such as those offered by attachment-based interventions (Greenberg, Warwar, & Malcolm, 2008).

On some occasions, trauma is associated with symptoms of Post-Traumatic Stress Disorder (PTSD) that includes symptoms of hyperarousal, intrusive thoughts, avoidance, mood

disturbances, and cognitive issues (APA, 2013). For example, an individual in a chronic state of hyperarousal as a result of feeling unsafe and insecure within their relationships is more likely to have difficulty regulating emotions and responding in constructive ways (Johnson, 2019). Emotional dysregulation in individuals with childhood trauma may have one or more symptoms, such as self-destructive behaviour, self-harm, beliefs they deserved abuse, lack of self-awareness, and an unclear sense of self (Mlotek & Pavivio, 2017).

Complex trauma refers to a type of trauma that is intricate and occurs repeatedly within relationships over a period of time (Courtois, 2004), which has come to light in recent research. For example, there is evidence that attachment trauma and forms of domestic violence have a deep impact on interpersonal relationships and an individual's sense of self. Some of the more severe symptoms developed from complex traumas that have been discovered are, alterations in self-perceptions, alterations in perceptions of the perpetrator or abuser, alterations in relationships to others, somatizations of these symptoms or comorbid medical illnesses, and alterations in systems of meaning (Courtois, 2004).

According to Courtois (2004), prolonged exposure to trauma is more likely to lead to severe symptoms in adulthood and throughout an individual's lifespan. Specifically, alterations in perceptions of oneself is the most complex symptom to treat. An individual may feel a chronic sense of guilt, shame, and blame associated with their experience and these symptoms could be on-going, which impacts sense of self and feelings of self-worth. Some of the findings in the Courtois (2004) study discovered that the most common symptoms with complex trauma were lack of self-awareness in their symptoms, difficulties with trusting others, and challenges with emotional dysregulation. A noted realization and gap found in the study, however, was that when treatments focused on affect regulation alone, fears of abandonment and feelings of loss related to

safety of their relationships were often left unresolved. These unresolved attachment-related symptoms made it more likely that individuals would eventually return to treatment (Courtois, 2004).

Trauma and Attachment Theory

Trauma survivors often feel like they cannot count on being able to trust others, regulate their bodies, or rely on their emotions for safety. A survivor of trauma often feels a sense of being out of control and there is no firm sense of self (Johnson, 2005). Individuals rely on attachment styles that protect them from psychological pain and rejection (Rependa et al, 2018). Dismissive and avoidant styles, in particular, are common among trauma survivors who tend to avoid getting too close or going emotionally deep within their relationships and feel threatened if someone was to gain closeness to them. Avoidant styles rely on developed coping mechanisms to protect themselves from painful experiences (Rependa, et al, 2018).

Attachment theory suggests that individuals need to maintain closeness with others during times of real or perceived threat in order to feel safe and secure (Bowlby, 1979). According to this theory, it makes sense that individuals who avoid emotional connections as a result of their traumatic experiences can lead to individual and interpersonal dysfunctions throughout one's life (Muller, 2010).

Self-disturbance symptoms. According to attachment theory, healthy adaptations are a result of positive connections with others, which fosters emotional experiences that impact emotional regulation and perceptions of self (Johnson, 2019). In addition, the theory proposes that developmentally traumatic events such as experiencing childhood maltreatment, significantly effects a child's self-perception and perception of others through negative interaction cycles and experiences. In addition to developmental trauma, event trauma, such as exposure to war or a car

accident can also impact an individual's sense of self (Briere, 2004). These beliefs significantly impact interpersonal relationships and emotion regulation throughout one's lifespan (Bowlby, 1979).

Self-disturbance symptoms are primarily constructed of three core impaired self-capacities: 1) identity disturbances, which includes problems with accessing and maintaining a sense of self; 2) emotional dysregulation and/or inability to regulate negative emotions; and 3) relational disturbances, such as problems with forming and sustaining meaningful relationships due to feelings of insecure attachment (Briere & Rickards, 2007). Individuals with self-impairments may be more likely to lack self-awareness in terms of their needs and feelings. A lack of self-awareness puts an individual at risk for problems that include mood instability and difficulties with expressing themselves. An absent sense of self-reference may also lead to alternative learned responses for dealing with internal distress (Briere & Rickards, 2007).

Insecure attachment symptoms. Individuals with impaired sense of self may experience relational problems and have problems forming secure adult relationships. An individual with fears of abandonment, for example, may find themselves in chaotic relationships (Briere & Rickard, 2007). Emotional experiences that contribute to the development of avoidant and dismissing coping patterns occur throughout close interpersonal interactions. Children observe and experience emotional events with primary caregivers. These patterns can manifest into adulthood within intimate relationships (Johnson, 2019).

An adult's history of complex trauma can also be present in their parenting style through avoidant and dismissive attachment patterns (Foroughe, 2018). An individual who experiences a traumatic event in adulthood may also develop insecurity in their relationships (Johnson, 2005). EFT conceptualizes these experiences as negative interactions that impact emotional affect and

continue to perpetuate patterns of insecure attachment, disconnection from others, and distress within relationships (Wiebe & Johnson, 2016).

Attachment-related trauma symptoms are linked to identity disturbances and are associated with dysfunctional behaviours (Briere & Rickard, 2007). Compulsive self-reliance in relationships as a way of protecting oneself from threat or stress is one symptom which leads to distance in relationships and lack of intimacy (Mikulincer & Shaver, 2018). Problems with relatedness and unstable self-image sometimes leads to a Borderline Personality Disorder (BPD) diagnosis. Characteristics of BPD include disturbed object relations and childhood trauma as central risk factors to this diagnosis (APA, 2013). Attachment theory suggests that children need secure relationships with parents who are emotionally stable to help with the development of a positive sense of self (Bowlby, 1979).

Mood dysregulation symptoms. Symptoms of trauma are biopsychosocial in the sense that individuals experience somatic, behavioural, and interpersonal responses (Dalton et al, 2013). Childhood abuse, for instance, is linked to the development of insecure attachments, fears of abandonment and mistrust in others, avoiding intimacy and closeness, and other fears or developments of hypervigilance related to fears of harm (Dalton et al, 2013). Dysfunctional coping behaviours that could occur as a result of dealing with unstable moods, for example, include self-destructive behaviours like substance use, self-harming, and disordered eating (Briere & Rickard, 2007).

Later in life mood dysregulation symptoms manifest in relationship challenges, such as in the development of emotional bonds that are satisfying and when an individual is learning to assert their needs within a partnership (Johnson, 2005). Insecure attachment that develops in the context of trauma has negative impacts on mood, but more importantly may lead to symptoms of

depression (Ventimiglia, 2020). Insecure attachments present itself in interpersonal feelings of helplessness and loneliness, and fears of abandonment that perpetuate in an individual's future relationships (Johnson, 2014). Ultimately, difficulties with regulating emotions in adulthood related to childhood abuse has been found to lead to higher divorce rates in couples and impact the quality of relationships as an adult survivor (Whisman, 2006).

Researchers have found that attachment figures are immediately activated when an individual experiences threatening stimuli, which further suggests that attachment styles are an important factor to consider in the treatment for trauma (Mikulincer & Shaver, 2018). The early attachment experiences lead to difficulties in emotional dysregulation and interferes with the development of inner capacities for dealing with stress. Exposure to trauma at any point in an individual's lifetime requires treatment that actively seeks to confront the attachment symptoms (Mikulincer & Shaver, 2018).

Depression, anxiety, and PTSD

Trauma exposure is associated with the development of mood disorders (Ventimiglia, 2020). In a study by Ventimiglia et al (2020) of 107 participants, it was found that the manifestation of depressive symptoms as adults and emotional dysregulation is directly associated with an individual's history of trauma. In addition, Ventimiglia (2020) found that the severity of trauma exposure or whether it occurred in childhood or throughout a lifetime did not influence fluctuations in symptom severity. A key finding from this study was that an individual has a higher risk of depression if they experienced higher levels of stress, had a history of trauma, and reported negative feelings towards their sense of self (Ventimiglia et al, 2020). According to Bowlby (1979) regarding attachment theory, these risk factors shape interpersonal behaviours, which in turn, perpetuates depressive symptoms.

Mental health issues, such as, depression and anxiety disorders develop as a result of attachment insecurities and emotional dysregulation (Johnson, 2019). Bowlby (1979) suggests that the experience of loss, in particular, leads to feelings of hopelessness and other depressive symptoms. Individuals experiencing depression view themselves as failures and report having low self-worth. Experiences of loss and failure lead to feelings of self-criticism, which perpetuates depression and impaired self-references (Bowlby, 1979).

Individual experiences of trauma and threat lead to rejection sensitivities, as found in anxious and avoidant attachment styles (Bowlby, 1979). The function of anxiety is to warn an individual of a potential threat and when these systems are overactive or chronically triggered it can lead to self-defeating symptoms and perpetuate depressive symptoms (Johnson, 2019). The key factors of anxiety include frequent negative self-perception, vigilance associated with uncertainty, avoidant behaviours for coping with emotions, and fears. Sensitivities, as a result of heightened senses of threat, are a risk factor that contributes to the onset of anxiety and depression (Johnson, 2019).

Moreover, literature on Post-traumatic Stress Disorder (PTSD) and attachment found that children who were sexually abused are more likely to experience symptoms of traumatic stress because of the development of insecure attachments (Johnson, 2005). In addition, long-term studies on military veterans and sexual abuse survivors have shown that there is a relationship between attachment styles and symptoms of trauma. For instance, an individual with insecure attachments may be more at risk for PTSD and emotional dysregulation (Dalton et al, 2013). Individuals who experience trauma face the prospect of developing symptoms of affect dysregulation, which shows up within their relationships and further causes distress (Johnson, 2005). Furthermore, individuals who have symptoms of depression, anxiety, and stress have

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usually experienced traumatic events during development or throughout their lifespan (Johnson, 2019).

According to Nelson et al (2017), in a meta-analysis of 184 studies exploring the impact of childhood maltreatment on the development of depression, found that childhood trauma is a major risk factor for the development of depression in adulthood. In the meta-analysis, it was found that 46% of individuals with depression in the studies reported experiencing a traumatic event in their lifetime (Nelson et al, 2017). Since depression is the most prevalent psychiatric disorder world-wide, it is theorised that almost half of individuals with depressive symptoms have experienced some form of trauma, either in childhood or at some point in their lifetime (Nelson et al, 2017).

Trauma and Emotion Regulation

Emotional regulation is an individual's ability to manage and respond to an emotional experience (McRae, Dalgleish, Johnson, Burgess-Moser, & Killian, 2014). Emotional dysregulation is when an individual has difficulty using healthy coping strategies to defuse or control emotions. Interpersonal distress within intimate partner relationships has been found to impact individual wellbeing within the relationship (McRae et al., 2014). According to Johnson (2019) emotional regulation is the ability to access, identify, modify, and use emotions as a guide for how we act, think, and respond to situations.

Research suggests that significant or long-term traumatic stress is connected to symptoms of affect dysregulation and identity disturbances (Briere et al, 2010). In addition, chronic traumatic stress such as extended interpersonal abuse or violence is associated with symptoms of mood changes and dysregulation, such as dissociation and suicidality. The Diagnostic Statistical Manual of Mental Disorders 5 (DSM-V) characterises trauma as symptoms of hyperarousal and emotional

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numbing, or avoidance (American Psychiatric Association, 2013). Prolonged exposure to trauma overwhelms the emotional regulation system, which theorists suggest leads to avoidance behaviours to escape or cope with these distressing states (Briere, 2004).

Low affect regulation capacities are related to extreme affective experiences. According to research by Briere (2004) focusing on trauma-avoidance symptoms, the treatment methods that were determined to be most effective concentrated on emotional processing of trauma-related events that encouraged a growth in emotional regulation capacities. Healthy emotions, for example, were joy, surprise, and anger, which are emotions that educe actions towards goals, curiosity, and openness. Avoidance emotions, for instance, were shame, fear, and sadness that tend to conjure withdrawal responses, fight or freeze, and hiding (Johnson, 2019).

EFT uses practices that regulate and process emotions through creating bonds and developing an emotional equilibrium (Johnson, 2019, p. 26). In previous EFT studies, it was found that sessions with deep emotional experiencing exhibited the best results and the most progress in expanding emotional self-awareness and lowering emotional control related to insecure attachments (McRae et al, 2014).

Emotionally Focused Therapy for Individuals (EFIT)

EFT and Emotion

In EFT, emotion is considered a foundational construct of a person's orientation to the world. Emotions are a key element in human functioning that help people understand themselves and their environment (Johnson, 2019). The main concept of EFT is to assist clients in organizing their emotional experiences, thoughts, and feelings for optimal awareness and functioning (MacIntosh & Johnson, 2008). EFT utilizes emotional experiencing in the treatment of

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maladaptive functioning for distress by enhancing a client's understanding of their responses to experiences (MacIntosh & Johnson, 2008).

In general, EFT is recognised for focusing on the transformation of emotional experiences from dysfunctional or maladaptive emotions to more healthy responses with couples (Johnson, 2005). It has been found in recent research, for example, that EFT may be an effective form of psychotherapy for childhood sexual abuse survivors within couples (MacIntosh & Johnson, 2008). In treatment, trauma survivors use their emotional experiences in session to formulate new responses in a safe space with their partners (MacIntosh & Johnson, 2008). More recently, however, there has been interest in how EFT may encourage positive change in individual responses to trauma, largely as a result of success in couple's therapy that has shown positive outcomes for reducing symptoms of distress (Johnson, 2005).

Emotional regulation is the ability to lessen or control the intensity of a given emotion, depending on the situation, while making decisions on how to respond (Greenberg & Pos, 2006). The goal of EFT is to transform maladaptive emotions, such as fear and shame, to adaptive ones such as anger and sadness (MacIntosh & Johnson, 2008). From the perspective of EFT, therapeutic change means developing a sense of self-awareness and transformation occurring throughout the course of therapy (Johnson, 2005). Throughout EFT treatment, clients learn to identify their emotional experiences and make reflections on how their feelings impact themselves internally, which in turn supports the transformation of maladaptive emotions to adaptive ones for healthier functioning and secure relationships (Johnson, 2014).

In 2019, Johnson developed "Emotionally-Focused Therapy for Individuals" abbreviated as "EFIT" which is based on Johnson's EFT for couples. EFIT and EFT for couples have similar components with the major difference being that the secure relationship is modelled between the

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therapist and the client rather than between the two partners in therapy. Although Greenburg's EFT was also modelled on EFT for couples, it is not attachment-based and focuses primarily on emotion processes and changing emotions. Although emotionally-focused and emotion-focused are similar, there is a key difference in the nature of these two therapeutic realms. Emotionally-focused therapy uses an attachment-based perspective in understanding relationships (Johnson, 2005). In attachment theory, emotional connections are pivotal in the healing and treatment process in terms of creating a secure bond (Johnson, 2005, p.11).

EFT theory suggests that emotional injuries impact an individual's sense of self, safety in relationships, and fear responses. Attachment theory suggests that trauma results from attachment wounds leads to fears of abandonment and isolation, among other mental health issues (Johnson, 2005). Emotionally-focused interventions and therapeutic processes work on developing connections with others that, "...fosters emotional balance and regulation" that, ultimately, encourages healthy relationship patterns and responses as a result of feeling safe and secure in relationships (Johnson, 2019, p. 26).

EFIT in practice

The practice of EFIT focuses on emotional regulation and processing. EFIT is based on Bowlby's (1979) attachment theory, which states that human emotions are organized by and regulated within bonding experiences with significant others. The process of EFIT involves identifying an individual's attachment orientation through exploration of their experiences. The individual reformulates these experiences through validation and acceptance. In this process, the individual takes part in forming new emotional and interpersonal interactions. The goal in this process is to support the individual in formulating and understanding a sense of self and that in relation to others (Johnson, 2019).

The role of the therapist in EFIT is to engage in a safe therapeutic relationship. An EFIT therapist helps the client track steps in their internal and relational conflicts and tracks these dialogues. The therapist is a moment-by-moment co-regulator of emotions and helps a client translate these experiences. Typically, clients with PTSD or severely distressing trauma symptoms take longer in couple's therapy to alleviate relationship distress because of their complex symptoms (Johnson, 2005). EFIT focuses on developing a sense of safety that promotes healing these complex symptoms by taking a slower approach and practicing containment (Johnson, 2005).

On work with EFT for couples, two components in therapy for dealing with trauma-related symptoms are screening for violence between partners and evaluating safety at every stage to ensure a safe therapeutic environment for treatment (Johnson, 2005). Within couple's therapy for trauma, part of the treatment is for the client to share their traumatic experience to the non-traumatized partner. In individual therapy, however this experience is shared with the therapist. The general practice when dealing with trauma-related and emotional dysregulation symptoms is to take a slower step-by-step approach (Johnson, 2005).

EFIT Stages. EFIT consists of nine steps carried out over three stages. The three EFIT stages are stabilization, restructuring, and consolidation. The stabilization stage relates to discovering a client's strengths and vulnerabilities. The restructuring stage involves restructuring interactions, fostering withdrawer reengagement, and blamer softening. The final and third stage of consolidation involves problem solving, the consolidation of new positions and more flexible interaction patterns (Johnson, 2019).

Stabilization. In the first stage of stabilization individuals explore strengths and vulnerabilities. Step one in this process is identifying a client's presenting issues and creating a therapeutic alliance (Johnson, 2019). Step one includes exploring a client's stressors, supports,

copied, and safety. Step two involves identifying interpersonal and intrapersonal patterns of how a client relates to their own emotions and sense of self. In step three, the client explores self-awareness of their unacknowledged emotions within their relationships. Finally, the fourth step of stage one is reframing the problem in terms of underlying emotions and attachment needs. As these new emotional experiences form, the therapist validates and reinforces the experience. During this stage, a client may be more accepting of their emotions and become less numb or avoidant (Johnson, 2019).

Restructuring. In the second stage of EFIT, emotional experiencing is deepened, and more complex emotions are explored in imaginary encounters with the self and others. In step five, the client's awareness expands through dialogue with the therapist and imagining contact with others. In step six, attachment needs are accepted, and validation occurs between the therapist and client in reference to the self and with others. Finally, in step seven of this stage, positive cycles of a secure relationship are conditioned through the expression of needs. During this stage, a client may become more attune to their needs and responses, while experiencing a decrease in depression and emotional dysregulation symptoms (Johnson, 2019).

Consolidation. In the third and final stage of EFIT, the therapist collaborates with the client in translating their emotional discoveries and underscoring a client's new sense of confidence. Step eight requires a facilitation of new solutions to interpersonal and intrapersonal experiences outside of therapy. In step nine, new narratives are created with these new solutions and consolidated through the creation of positive interaction cycles in the client's world. The therapist in this stage, reviews the client's progress with specific emphasis on their emotional regulation, changes in avoidance responses, and connections with their self and others. The therapist reinforces the sense of security and safety the client experienced in therapy for future use after therapy (Johnson, 2019).

Mechanisms of Change. There are six components that are identified as mechanisms of change within EFIT. In one mechanism of change, an individual engages with their emotions through perception, sensations, motivations, actions, and meanings (Johnson, 2019). Once an individual's understanding and relationship of their emotions has changed, they take part in creating new experiences with this knowledge. Through these recognized mechanisms of change, an individual is equipped with newfound ways of regulating their emotions and shaping their experiences. The individual integrates these new emotional skills to develop a more positive sense of self (Johnson, 2019).

Another component of change in treatment occurs throughout the creation of a safe place in therapy for the exploration and processing of emotional experiences and injuries. The therapist alliance is a key part of therapy since it helps the client feel safe, seen, accepted, and heard (Johnson, 2019). The therapist's qualities in EFIT consists of compassion, nonjudgement, unconditional positive regard, and respect. Validation is the forefront of the alliance created which helps the therapist meet the client where they are at emotionally and ultimately, fosters self-awareness (Johnson, 2019).

A pivotal mechanism of change related to the self is achieved through focusing on the integration of the self and the individual's constructed reality – the dancer and the dance itself, Johnson states (2019). In attachment theory and EFIT, the self is a process and developed from a set of interactions with others. The individual engages in relational cycles with the therapist, who helps model healthy interactions and find meaning. These cycles help develop new affect regulation patterns that eventually become habitual for the individual (Johnson, 2019).

In addition, through the creation of healthy adaptations and understanding a mechanism of change can be identified. EFIT theory is that individuals with emotional regulation strategies are

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more equipped to accept feelings and assert their needs with vulnerability and ultimately feel more emotionally attuned to oneself (Johnson, 2019). At this point, an individual has experienced compassion and validation, and therefore, may develop healthier emotional adaptations. The secure attachments developed from these experiences foster growth and lessens an individual's symptoms of self-impairment and emotional dysfunction (Johnson, 2019). The therapist role in this mechanism of change is to model a secure attachment through emotional presence and by offering manageable challenges for the individual to process within the session (Johnson, 2019).

A fifth mechanism of change is the acknowledgment of a client's past learned experiences while staying present. The therapist recognizes the individual's experience of trauma and response to threat, which are brought into awareness. EFIT mechanisms of change theorize that past learned experiences return with self-interactions and with others. The therapist uses a moment-by-moment process of validation with the client that focuses on the emotional experience of the individual by asking questions that deepen their understanding of themselves. These changes are observable by the therapist in their interactions throughout the sessions (Johnson, 2019).

A final mechanism of change occurs in the deepening of the therapeutic experience that involves the client's commitment of these new interactions to be continued outside of therapy. EFIT theorizes that these pivotal moments and interactions in therapy are remembered because of their adaptive nature and empiricism (Johnson, 2019). To deepen the therapeutic experience, EFIT therapists engage in themes of trauma, abandonment, hope, fear, hopelessness, anxiety, isolation, and inadequacy. These experiences are explored and brought forth in therapy to realize the individual's responses to emotional injury and depth. Ultimately, an EFIT therapist follows an emotional map of an individual's life using core aspects of human nature and survival strategies to encourage change (Johnson, 2019).

The EFIT Tango

The EFIT tango refers to the dance between the therapist and the client, which occurs throughout all of the stages and steps of therapy. The first tango move in EFIT is mirroring the present process. The second EFIT tango move is affect assembly and deepening. The third tango move involves choreographing engaged encounters with significant attachment figures in the person's life. Move four embraces processing the encounter. Finally, the fifth tango move is to integrate and validate the experience. These five moves are repeated to help develop emotional safety and security (Johnson, 2019).

EFT and Trauma

Emotion in its nature, is a "...high-level system that integrates a person's awareness of innate needs and goals with feedback from the environment and the predicted consequences of actions" (Johnson 2019, p. 34). According to Johnson (2014), the function of emotion is that it orients, engages, shapes meaning, motivates, communicates, and sets up a response from others. Trauma and insecure attachments greatly influence an individual's ability to regulate emotions (Johnson, 2014). Chronic activation of the nervous system due to unsafety or distress increases an individual's likelihood to experience depression, an impaired sense of self, and emotional dysregulation, such as aggression (Ventimiglia et al, 2020).

EFIT offers promising results for clients with deep emotional wounds. One of the theories that recognizes the potential in attachment-based treatment options for individuals with trauma, is EFT for couples (Brubacher, 2017). Attachment theory is a foundational philosophy of EFT for couples (Johnson, 2019). Attachment fears of abandonment, responses to rejection, and feelings of trust and safety are all factors that are associated with clients that have insecure, anxious, or avoidant attachment styles. Attachment styles effect how an individual reacts and responds to the

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world (Bowlby, 1976). Hyperactivation and deactivation of emotions are specific emotional dysregulation issues experienced by trauma survivors because of early attachment bonds (Brubacher, 2017).

Other therapeutic interventions focused on client emotion related to EFIT, such as emotion-focused therapy as developed by Greenberg and colleagues, in many ways have been found to help treat symptoms of complex trauma related specifically to early childhood abuse or neglect (Paivio & Nieuwenhuis, 2001). A specific study by Paivio and Nieuwenhuis (2001) uses a quasi-experimental design of 46 participants between the ages 24-49, where the goal of the study was to evaluate the effectiveness of emotion-focused therapy on emotional change among people with complex trauma (Paivio and Nieuwenhuis. 2001). The participants engaged in 1-hour weekly emotion-focused sessions over approximately 28 weeks. The participants disclosed experiences that ranged from chronic verbal assault, repeated threats of harm, and family violence (witnessed and experienced) in their childhood.

The study found that most of their participants (66%) made significant improvements in emotional regulation and that just over half (54%) of participants indicated they had reduced feelings of distress in comparison to how they felt pre-therapy. The researchers determined from results on measurements of distress, pre- and post-therapy, that EFT was successful in addressing emotional dysregulation as a result of trauma associated with child abuse (Paivio & Nieuwenhuis, 2001). Moreover, they found "...no evidence that the type of abuse was a predictor of treatment response" (p. 130).

EFT for couples. EFT has been widely studied in the treatment of couples with a trauma-history (MacIntosh & Johnson, 2008). There is significant research on couples that were sexual abuse survivors, for instance, to help partners reconnect. Often, survivors of sexual abuse have

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symptoms of hyperarousal and emotional dysregulation as a result of their childhood experiences. Many survivors continue to seek out intimate connections later in life; therefore, much of the research evidence supports the use of EFT for unresolved trauma in adult relationships (MacIntosh & Johnson, 2008).

More specifically, MacIntosh and Johnson's (2008) study found that 5 of the 10 couples demonstrated an increase in relationship satisfaction, 5 couples recorded significant improvements in trauma symptoms, and 5 couples demonstrated a decrease in hyperarousal symptoms (MacIntosh & Johnson, 2008). This key finding indicates a gap in research on whether or not emotional dysregulation symptoms, such as hyperarousal symptoms, could predict the efficacy of EFT for the treatment of individuals with trauma. For example, research on changes in emotional regulation and the prediction of changes in trauma-related symptoms of the self could prove to be beneficial to the overall understanding of individual treatments (MacIntosh & Johnson, 2008).

Research in EFT reveals through exploration of attachment-based approaches finds that emotional injuries related to complex trauma are often manifested in adult interpersonal issues (Dalton et al, 2013). Trauma impacts the development of healthy intimate partner relationships because symptoms manifest in avoidance and withdrawal responses from partners with untreated emotional injuries. In a randomized control trial of 32 couples, researchers Dalton et al (2013) found that female partners disclosing a history of child abuse/neglect had improved marital functioning scores following EFT (Dalton et al, 2013). These results suggest that EFT for couples is an effective treatment for relationship distress in individuals who have experienced childhood abuse.

One theory for the effectiveness of EFT is that it addresses individual fears and insecurity commonly expressed by trauma survivors, such as feelings that they may never be able to connect

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or feel close to their spouses, and this translates to improvements in marital functioning of these couples (Dalton et al, 2013). Based on attachment theory, fears within relationships are related to insecure attachments and feeling a sense of unsafety (Bowlby, 1979). Trauma-related symptoms within a couple's present symptoms of an impaired sense of self related to the other means that these clients are likely experiencing symptoms of depression and emotional dysregulation (Johnson, 2019). EFT addresses insecure attachment through developing a safe therapeutic relationship and practicing new relational experiences within the therapy room (Johnson, 2019).

Emotionally Focused Individual Therapy (EFIT). There has not yet been any research conducted on the process and outcomes of EFIT of individuals for the treatment of trauma-related symptoms (Johnson, 2019). There is one approach, however, that shows promising results for treatment methods focused on emotion for trauma survivors, called Emotion-Focused Therapy (Greenberg, 2006). The main difference in emotion-focused versus emotionally focused treatments is that EFIT uses an attachment-based approach. In a randomized control trial by Paivio et al (2010), two emotion-focused interventions for the treatment of trauma were compared in order to explore changes in trauma-symptoms related to childhood sexual abuse. The interventions focused on client experiences and expression of feelings and needs. The researchers discovered from the comparison data that both emotion-focused interventions were equally successful treatment options. They concluded that the specific emotion-focused interventions used in therapy have no impact on the success of treatment, as long as the focus was on emotional and experiential processing (Paivio et al, 2010). One of the key discoveries in this study was that participants identified their developmental needs related to their attachment figures. Specifically, participants identified attachment figures and realized their impact on the development of adaptive emotions for survival at an early age. The identification and processing of these attachment discoveries were

reported to be key elements in treatment success (Paivio et al, 2010). This study finds that gaging emotional experience is the pivotal part of emotion-focused therapy in reducing symptoms of distress and developing healthy relationships outside the therapy room; however, it is ultimately the identification of attachment-related trauma symptoms that lead to improvements throughout treatment (Paivio et al, 2010).

A case study by Greenberg (2006) documents emotion-focused therapy with a client who experienced childhood emotional abuse. The client was experiencing low self-worth, had fears about vulnerability, and was not open to new interpersonal relationships. Greenberg (2006) used Rogerian methods of building rapport with the client over time and then worked on accessing primary adaptive emotions. The purpose of emotion-focused therapy in this case study was to replace feelings of fear with anger to empower the client. Therapy appeared to help this client feel more open to new relationships and demonstrate improvements in self-worth. One gap in this research, was the exploration of changes with insecure attachment styles in adulthood related to the emotional processing of their traumatic experiences. This case study validated Greenberg's (2006) previous studies that explored the efficacy of emotion-focused therapy for individuals with trauma.

Greenberg, Warwar, and Malcom (2008) conducted a study of 46 individuals with emotional injuries that ranged from feelings of abandonment, betrayal, neglect, and physical and sexual abuse. Approximately half of the clients underwent 1-hour of emotion-focused individual treatment while the control group received group psychoeducation sessions for the 12 weeks (Greenberg et al, 2008). The outcome of the study was that the clients in the emotion focused therapy group achieved significantly higher scores on the forgiveness scales and symptom reduction (Greenberg et al, 2008). One of the limitations Greenberg et al (2008) documented was

that the treatment methods (group psychoeducation and individual emotion-focused therapy) were too different to make any significant comparisons on effective individual treatment options. One mitigation strategy in this study could be to identify specific attachment-related symptoms of trauma and their changes over the course of treatment with an attachment-based orientation like found in EFT.

Pascual-Leone, Yeryomenjo, Sawashima, and Warwar (2019) have recently made headway in examining of emotion-focused therapy in fostering emotion resilience. The team used two separate longitudinal single case designs. Both cases exhibited instances of childhood trauma (abuse) and had positive treatment outcomes, which meant that the individuals were able to “...bounce back” quickly following emotional activation (Pascual-Leone et al, 2019). The micropatterns found in this recent study indicated future directions for researchers in terms of discovering how these patterns impact individuals’ long term and whether the continuous emotional activation contributed to the client’s ability to self-regulate emotions.

EFIT and emotion-focused therapy are similar in terms of their view of emotion as a primary mechanism of change; however, the key difference between the therapies is in how they recognize the process of emotional change. EFIT uses an attachment-based approach as an orientation of treatment, which makes this option more effective at addressing the impacts of trauma on an individual’s sense of self, insecure attachment, and symptoms of depression (Johnson, 2014). Considerable evidence on EFT for couples suggests that it could be an effective evidence-based treatment for individuals dealing with traumatic circumstances related to issues of childhood physical, emotional and sexual abuse (Holowaty & Paivio, 2012). Ultimately, attachment-based approaches like EFIT could lead to improvement of trauma-related symptoms

over the course of therapy because of the gaps found in research on emotion-focused therapy and treatment results of EFT for couples with trauma.

Purpose of Thesis

The purpose of the thesis is to explore the effectiveness of EFIT for alleviating trauma-related symptoms and emotional dysregulation for individuals seeking treatment for depression and anxiety. Individuals who have experienced trauma in their lifetime often seek treatment for depression and anxiety later in life (Wiersma et al, 2009). Moreover, depression is the most prevalent psychiatric disorder world-wide with almost half of individuals with depressive symptoms having experienced some form of trauma in their lifetime (Nelson et al, 2017). Specifically, treatment that focuses on impaired sense of self as a result of trauma could lead to improvements in symptoms of depression (Wiersma et al, 2009). To address this gap in research, this study engaged participants that self-reported symptoms of depression and/or anxiety and that agreed to undergo EFIT treatment.

According to the findings in each of the individual studies, focusing on the activation of a client's affective experience throughout therapy promotes resilience and decreases dysfunctional arousal responses (Pascual-Leone et al, (2019), Greenberg et al, (2008), and Paivio et al (2010)). Moreover, some of the studies that utilized an attachment-based approach concluded that emotionally-focused therapies in couples with trauma was an effective treatment for emotional processing and the development of healthy intimate relationships and improved sense of self (MacIntosh & Johnson's (2008), Dalton et al, (2013), and Johnson (2014 & 2019).

One of the frequently occurring limitations in the literature is that the studies conducting individual therapy report gaps in explorations of changes in trauma-related symptoms using attachment-based approaches. These studies focused primarily on emotional processing and

dysregulation symptoms of trauma. While the studies found significant evidence that emotion-focused therapies decrease trauma-related symptoms, the studies did not address underlying symptoms of trauma related to an individual's sense of self and insecure attachment style. The research on trauma indicates that frequency in exposure to traumatic events impacts an individual's sense of self through the development of insecure attachment, depression, and impaired sense of self symptoms (Briere et al, 2010).

This study explores changes in trauma-related symptoms involving sense of self. Participants seeking therapy for depression and anxiety participated in 15 sessions of EFIT, an attachment-based experiential psychotherapeutic approach that aims to alleviate a range of symptoms of emotional distress. Trauma symptoms related to the self were measured using the Trauma Symptom Inventory (TSI-II), which was developed to capture a broader range of trauma-symptoms, including a range of symptoms commonly found in complex PTSD responses and clinically relevant symptoms that may not meet criteria for a diagnosis of PTSD. The presentation of complex trauma symptoms and sub-diagnostic trauma symptomatology is common among individuals seeking treatment for depression or anxiety (Briere, 1995). The TSI-II subscale for self-disturbance (SELF) has three parts that focus on insecure attachment, depression, and impaired self-reference. This study on EFIT will afford more research data and more analysis on the effectiveness of treatment for trauma symptoms.

The Present Study

This study aims to examine the effects of EFIT on individuals' trauma-related symptoms pertaining to the self and emotional dysregulation over the course of 15 EFIT sessions. More specifically, the research focuses on measuring participants' trauma-related emotional regulation and trauma-symptoms related to the self over the course of therapy at the following timepoints:

baseline, midpoint 1 (session 5 of therapy), midpoint 2 (session 7 of therapy), and post-therapy. It examines changes in self-related trauma symptoms early in therapy as a predictor of emotion regulation across therapy sessions. The foundations of this study follow the EFIT theory that improvements in self-related symptoms leads to increases in trauma-related emotion dysregulation symptoms (Johnson, 2019). The basic theory is that an individual with a self-reported secure sense of self will experience decreases in trauma-related symptoms for the treatment of depression (Wiersma et al, 2009).

The rationale for the study is based on attachment theory and EFIT treatment processes, which theorize that an individual develops emotional regulation skills within the first step of therapy. By step two, the treatment will have impacted an individual's sense of self through various interventions and the use of the EFIT Tango. By the final phase of treatment, it is predicted that these changes will be integrated and fortified resulting in improved symptom scores.

Research Questions, Hypothesis and Rationale

Based on the literature review, the working hypotheses of this study are as follows:

1. Participants receiving EFIT will demonstrate significant linear decreases in trauma-related symptoms pertaining to the self and emotion dysregulation symptoms across baseline to session 7.
2. Greater reductions in trauma-related emotion dysregulation will be significantly associated with changes in self-disturbance symptoms.

The first hypothesis predicts that trauma scores, including emotional dysregulation, will decrease over time. Based on this hypothesis, self-related symptoms of impaired self-reference, depression, and insecure attachment will also decrease over the course of treatment. Specifically, the hypothesis predicts that participants will encounter improved perceptions of self through

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insight and contextual meanings of self. As a corollary outcome, participants may report feeling more secure in their attachments through bonding and re-experiencing. Based on results of the second hypothesis, participants may report decreased symptoms of depression, and decreased symptoms of emotional dysregulation because of emotional processing in EFIT.

Method

The goal of this study is to investigate the predictive value of key therapeutic change factors on trauma symptoms measured across therapy. These key factors include change in insecure attachment, self-disturbance, impaired self-reference, and depression scores as a result of emotional experiencing in EFIT. The Difficulties in Emotional Regulation Scale (DERS-36) is used to explore linear change in emotional dysregulation indicators from EFIT. The Trauma Symptom Inventory (TSI-2) is used to explore linear change in insecure attachment, self-disturbance, impaired self-reference, and depression reported symptoms. Since emotional dysregulation is a symptom of trauma, it is hypothesized that DERS scores will decrease and that TSI-2 scores will also decrease as a result of emotionally focused treatment overtime. The DERS scores will predict changes in TSI-II scores. These scales explore changes in trauma symptoms through a linear change model of DERS overtime and a linear change model of TSI over time, as well as whether or not the DERS predicts changes in the TSI-II.

Research Design

This study examined EFIT across four time points through 15 sessions of therapy with participants recruited from three cities: Ottawa (Ontario), Victoria (British Columbia), and Denver (Colorado). There were two study groups, treatment ($n=40$) and wait-list control ($n=40$). A total of 15 sessions of EFIT treatment were given by experienced therapists with EFIT training and each therapist worked with approximately 2-3 clients. It should be noted, however, that due to the

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Covid-19 pandemic treatment began as in-person therapy and transitioned to an online format at various timepoints for each participant. The sites where therapy took place were the Ottawa Institute of Couple and Family Therapy in Ottawa, Centre for EFIT Vancouver Island in Victoria, and Colorado Centre for EFT in Denver. For the scope of this study, only the EFIT treatment group of $n=40$ was used.

Participants

Participants were recruited through posters, university email, and social media accounts inviting people seeking treatment for symptoms of depression and/or anxiety. Those interested in participating in the study were encouraged to contact the research coordinator for more information. Participants, who reach out, were assessed for potential eligibility via a telephone screening process. Those selected had a second assessment to determine final eligibility for the study.

The inclusion criteria for the study were two-fold: participants were at least 18 years old and met a primary diagnosis of Major Depressive Disorder with co-morbid symptoms of anxiety. One exclusion criterion for the study was any changes in the participants' psychotropic medication 6 weeks prior to enrollment or anticipated during the study period because of potential impact on emotional regulation results. Another exclusion criterion was the client meeting DSM V criteria for bipolar disorder, schizophrenia-spectrum disorder, PTSD, substance abuse or dependence. These exclusion criteria protected against clients exhibiting symptoms of another disorder throughout the course of therapy.

Procedures

Study procedures included telephone screening to determine initial eligibility for the study and signing a consent form agreeing to further assessment. The diagnostic test used in the study

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was the Anxiety and Related Disorders Interview Schedule for DSM-V (ADIS-5) to assess participant inclusion and exclusion criteria related to diagnosis (Barlow & Brown, 2014). The assessment tests for symptom severity used were the Beck Depression Inventory (BDI-II) to assess depression symptom severity (Beck, Steer & Brown, 1996); and the Beck Anxiety Inventory (BAI-II) to assess anxiety severity criteria (Beck & Steer, 1990).

Measurements

DERS-36

The DERS scale is a measure of emotional regulation capacities. One of the popular features of the DERS is that it has test-retest reliability, validity, and internal consistency (Fowler et al, 2014). Research by Fowler et al (2014) measured the psychometric validated of the scale on 592 subjects with severe mental health symptoms. It was found that DERS was a strong measure with good construct validity. Specifically, the validity was demonstrated with symptoms related to impairments in emotion regulation that are common in individuals with depression (Fowler et al, 2014).

The DERS scale consists of 36 items. Negative changes or a decrease in scores on the DERS scale is indicative of improvement of emotional dysregulation symptoms. Alternatively, positive changes in DERS scores of an increase in scores indicates a worsening of emotional dysregulation symptoms (Gratz & Roemer, 2004). Likert scales with a 5-point system were used to calculate the means with the sum of the scores at each timepoint.

Emotional dysregulation reliability scores. The reliability scores for DERS is found at pre-, midpoint 1, midpoint 2, and post-therapy are found with N=37. The Cronbach alpha for pre-therapy = 0.84, midpoint 1 = 0.89, midpoint 2 = 0.87, and posttherapy = 0.71. The Cronbach alpha scores range from good to excellent for the DERS scores and are reliable for analysis.

TSI-II

The TSI-II is an empirically validated scale for investigating trauma-related symptoms (Runtz et al, 2008). The scale used to measure trauma symptoms is the TSI-2 (Briere, 1995). This scale is designed to explore a broad range of trauma symptoms, in particular, focuses on symptomology related to self-disturbances (Runtz et al, 2008). Research by Godbout et al (2016) collected data from 679 adults in the general population with a broad range of traumatic symptoms. It was found in this study that the assessment factors in the TSI-II significantly recognized symptomology and predictors of trauma which further supports the use of this particular scale in the investigation of trauma-related symptoms of self.

The TSI-II consists of 12 types of trauma-related symptoms and 6 of these have subscales. The scale consists of 136 items, where 4-5 items make up a factor. Each item is rated from 0-3, where 0 is a lower symptom experience. This study uses one scale, and three subscales that consist of the items to make up a full factor. The TSI-2 scale is used to determine trauma-related symptoms before and throughout treatment. For the scope of this study, the TSI-2 Self-Disturbance subscale (SELF) was used to determine changes in Insecure Attachment (IA), Impaired Self-Reference (ISR), and Depression (D).

Trauma-related reliability scores. The reliability score results for TSI-II pre-therapy N=37 offers Cronbach's alpha scores for depression, insecure attachment, and impaired self-reference. The scores were rounded to the nearest tenth for readability. The pre-therapy scores for depression finds a Cronbach alpha of 0.86. The insecure attachment scores find a pre-therapy Cronbach alpha of 0.77 and impaired self-reference has 0.81. On the Cronbach alpha scale, these scores ranging from good to excellent and were, therefore, determined to be reliable for analysis. Also, the midpoint scores were calculated to confirm the reliability. The Cronbach alpha scores

were the following for the midpoint TSI-II D, IA, and ISR scores: 0.92 (D), 0.78 (IA), and 0.84 (ISR). The midpoint scores are reliable according to the Cronbach alpha scale.

SELF scale. The self-disturbance factor is a sum of IA, ISR, and D subscales which ultimately measures disturbed and altered senses and perceptions of self. This combination, in particular, factors feelings of insecurity and ambivalence which can lead to a lack of self or identity and being easily influenced by others. This state of being can lead to depression and emotional dysregulation. In total, the SELF scale consists of 30 items in total. A high score in SELF may report difficulties in accessing a stable sense of self (Briere, 1995).

IA subscale. The IA subscale consists of 10 items on the assessment form and two factors. The IA indicator includes Insecure Attachment-Relational Avoidance (IA-RA) and Insecure Attachment-Rejection Sensitivity (IA-RS) scores. The IA scale measures early experiences of parental maltreatment, childhood abuse/neglect, and witnessing or experiencing frightening behaviour (Briere, 1995). The IA scale is made up of two parts. The first part is a participant experience of insecure attachment related to symptoms of intimacy avoidance. The second part records a participant's preoccupations with fears of rejection and abandonment.

ISR subscale. The ISR subscale consists of 10 items on the assessment form and two factors. The ISR subscale includes scores from the Impaired Self-Reference-Reduced Self-Awareness Scale (ISR-RSA) and the Impaired Self-Reference-Other-Directedness (ISR-OD). The ISR subscale explores a participant's lack of self-knowledge and sense of self and their personal beliefs. The two parts of this subscale tap into how influenced an individual is by others and if they are not valuing their own thoughts and feelings.

D subscale. The D subscale consists of 10 items on the assessment form. Moreover, the D subscale includes factors related to depressed mood and cognitions (D1 and D2). Negative changes

or decreases in TSI raw scores indicate an improvement of symptoms while positive changes or increases in raw scores indicate a worsening of symptoms (Briere, 1995). High scores on this scale reflects more frequent feelings of unhappiness and perceptions of worthlessness.

ADIS-5

The ADIS-5 screening interviews were administered to predict the inclusion criteria and need for treatment. This screening tool examines a broad range of psychiatric symptoms and therefore, can screen out comorbid disorders or diagnostic criteria that would impact the study (Brown & Barlow, 2014).

Plan of Statistical Analysis

SPSS creates a reliability score using Cronbach's alpha to test the results. Using SPSS, the scores were examined for missing information and screened for entry errors. SPSS was used for all descriptive and psychometric analyses. In addition, HLM was used to test the hypotheses.

The Residual Change Scores

The residual change score was used to estimate degree of change between the baseline and session 7 measurements. The residual change score accounts for the amount of change from baseline to session 7 while accounting for baseline scores. Therefore, it is a more reliable estimate of the degree of change from baseline to session 7 than a difference score. The residual change score is a reliable estimate of the amount of change that has occurred from baseline to session 7 taking into account the variance in session 7 scores that can be accounted for based on baseline scores. These scores were used to examine change in self-related trauma symptoms in the first half of therapy as a predictor of change in emotion dysregulation across the course of therapy. The residual change scores were used to predict change in trauma-related symptoms found pre- and mid EFIT therapy.

Missing Data

Hierarchical Linear Modeling (HLM) was used to investigate any patterns in the missing data across treatment periods of pre-, midpoint one, midpoint two, and post-therapy timepoints for the DERS, TSI SELF, and TSI subscales. A pattern-mixture model was conducted to examine whether missing data was related to linear trajectories of the dependent variables, SELF, D, IA, and ISR.

Hierarchical Linear Modeling (HLM)

HLM was used to test change in emotion dysregulation and trauma-related symptoms of self-disturbance across four timepoints over the course of EFIT (baseline, session 5, session 7 and post-therapy), and to examine the relationship between change in emotion dysregulation over the course of therapy and change in self-disturbance (i.e., insecure attachment (IA), Depression (D), and Impaired Self-Reference (ISR)) in the first half of therapy.

The analysis determines whether or not there are changes with the treatment variables, including finding standard deviations (SD) from the mean to determine if there is a significant change in trauma-related emotional regulation scores. The statistical analysis also takes into consideration any potential outliers by completing a data analysis to determine the homogeneity of the variance, including a linear analysis of the independent variables (EFIT over time) and the dependent variables (emotion regulation and trauma scores). Level one data is the measurement of TSI-II and DERS scores over time. In level one, the DERS scores are compared to the TSI-II level 2 data in order to explore any correlations between emotional dysregulation symptoms and trauma-related symptoms throughout EFIT.

Level two data takes into account the individual participant variables nested within the data. Level two data for trauma-related symptoms is the measurement of TSI-II scores for the subscales D, IA, and ISR across time with respect to individual participant scores. The individual

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variables in the SELF scale are explored across time in order to observe any self-disturbance patterns over the course of therapy. In both levels, HLM also takes into account the missing data in the study which is particularly important in respect to the study limitations.

The findings are presented in the results section of the report below. Analysis of data determines whether the hypotheses are supported and will potentially point to any gaps, limitations, and opportunities for future research.

Results

Data Screening and Cleaning

SPSS

SPSS screening results indicate 100% participation at pre-therapy timepoint, and the participation decreases at the midpoints and post therapy because the study is on-going. The participation for the DERS decreases from 100% to 45.9% at midpoints 1 and 2, to 32.4% post-therapy. The DERS scores required a reverse scoring method for questions 1, 4, and 6. Mean scores are calculated for DERS pre-therapy point, midpoint 1, midpoint 2, and post-therapy point. In addition, TSI-II scores are combined to calculate IA, D, and ISR, and totalled to determine SELF scores for each of the four timepoints.

Missing Data

The pattern-mixture models could not be examined because the models would not converge due to lack of variance in the dichotomous variable representing presence or absence of missing scores.

Statistical Analysis

HLM

HLM was used to examine the rate of change from pre-therapy through midpoints one and two, to post-therapy.

Changes across EFIT sessions

Emotion Dysregulation Linear Slope. DERS scores did not demonstrate statistically significant change, $\beta_{10} = 2.6$ (36), $t = -0.09$, $p < 0.17$. The coefficient was negative -0.09 so the scores were reducing from the starting point coefficient of 2.6; however, the amount was not a significant change. This model yielded a deviance score of 124.64, which was lower than the base model, indicating that adding the linear slope scores to the model appears to explain more of the variance in DERS scores as compared to the simpler model in which the linear slope variable was not included, which demonstrated a deviance score of 135.42.

TSI SELF Linear Slope. The TSI SELF model for exploring change in self-disturbance symptoms demonstrates a significant negative linear slope across the four treatment timepoints, $\beta_{10} = -6.90$ (36), $t = -3.9$, $p < 0.001$, demonstrating that participants reported significant decreases in self-disturbance symptoms across the four timepoints from pre to post treatment (see figure 1), representing average decreases of -6.90 in the TSI-self score at each time point. The linear model for TSI-SELF demonstrates a deviance score of 589.73, which is lower than the TSI SELF baseline model which has a deviance score of 634.50. Based on the deviance scores, it is evident that this model takes into account more of the variance in the data. The TSI SELF baseline model shows a deviance score of 634.50. The TSI SELF baseline model includes the total variables from the three subscales. The baseline models are used to compare data to more complex models.

Depression Linear Slope. The data is organized into three sections to show the subscale data for each of the subscales over time. The depression subscale model demonstrates a significant linear slope across the timepoints, $\beta_{10} = -2.67$, $t(36) = -3.78$, $p < 0.001$. The coefficient shows a

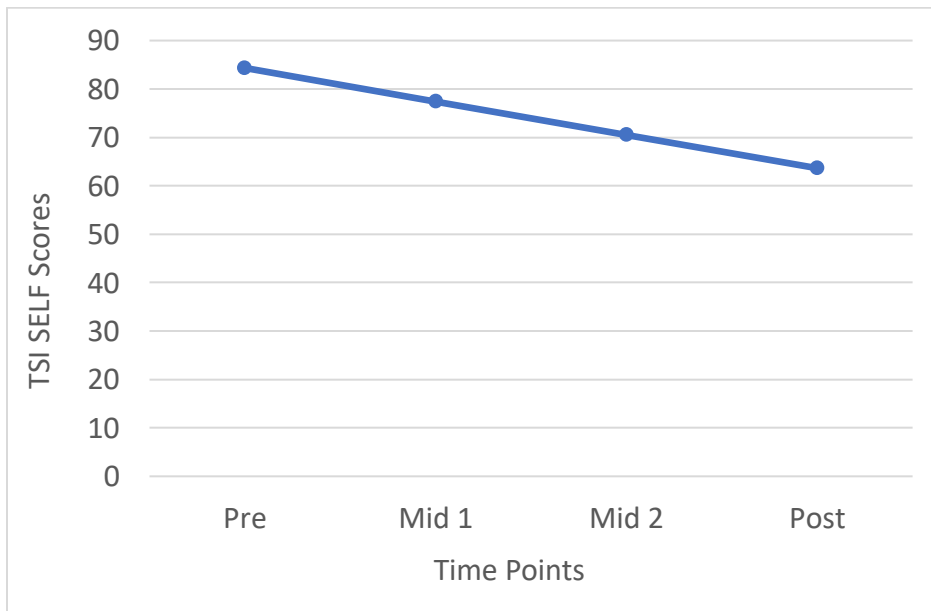
decrease in symptoms by - 2.67 at each timepoint, which is evident in the negative slope of the indicator D (see Figure 2).

Insecure Attachment Linear Slope. The insecure attachment subscale model demonstrates a significant linear slope across the time points, $\beta_{10} = -2.26$, $t(36) = -3.12$, $p < 0.004$. The coefficient displays a decrease in insecure attachment symptom indicators by - 2.26 at each timepoint, which is visible in the negative slope of the indicator IA (see Figure 2).

Impaired Self-Reference Linear Slope. In addition to the previous subscales, the impaired self-reference subscale model also demonstrates a significant linear slope across the timepoints, $\beta_{10} = -1.96$, $t(36) = -4.12$, $p < 0.001$. The coefficient exhibits a decrease in impaired self-reference symptom indicators by - 1.96 at each timepoint which is visible in the negative slope of the indicator ISR (see Figure 2).

Figure 1

TSI SELF Scores Over Time: Decreases in self-disturbance symptoms modeled from pre to post therapy.



Early change in TSI-SELF predicting change in DERS across EFIT sessions

The TSI-SELF residual change scores did not significantly predict linear changes in the DERS scores across baseline, session 5, session 7 and post-therapy over the course of 15 EFIT sessions, $\beta_{11} = 0.01$, $t(17) = 2.04$, $p=0.06$. The deviance score of this model was 80.19, which is lower as compared to the deviance score of the DERS linear model (124.64). Although the predictive model did not reach statistical significance, it appears to explain more variance in the data as compared to the linear model.

Figure 2

TSI SELF Subscale Scores Over Time: Decreases in depression, insecure attachment, and impaired self-reference from pre to post therapy.

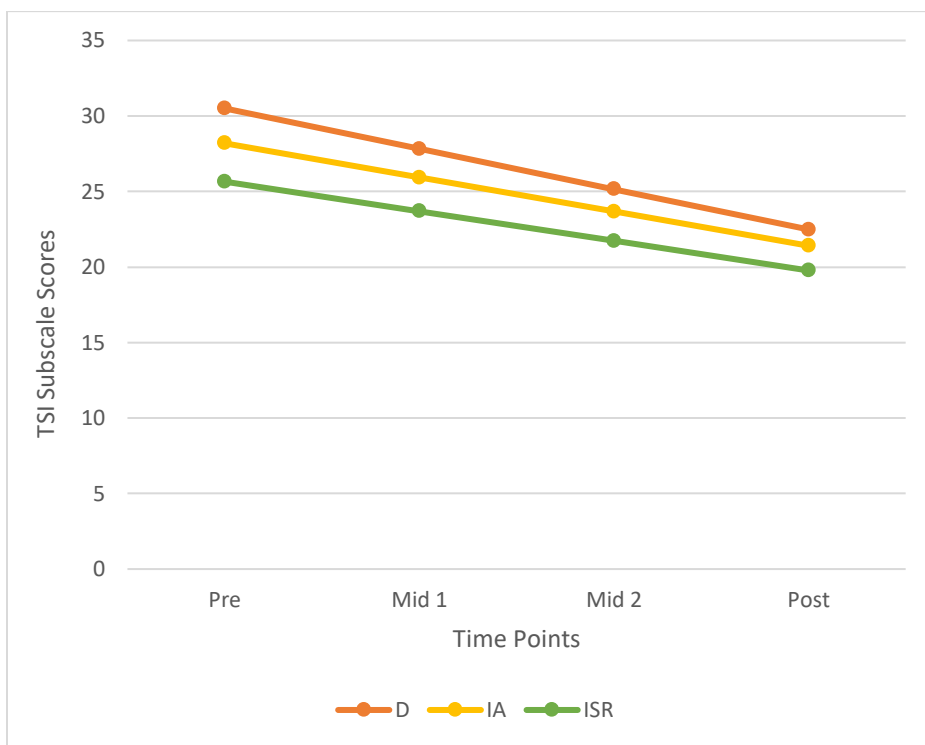


Table 1*Means and Standard Deviations of Treatment Variables over Time*

	Pre-Therapy		Mid-Therapy 1		Mid-Therapy 2		Post-Therapy	
	<i>n</i>	<i>M (SD)</i>	<i>n</i>	<i>M (SD)</i>	<i>n</i>	<i>M (SD)</i>	<i>n</i>	<i>M (SD)</i>
Emotion Dysregulation	37	2.63(0.58)	17	2.49(0.63)	17	2.45(0.61)	12	2.27(0.45)
Self- Disturbance	37	84.38(13.44)	19	77.32(6.51)	16	72.19(18.11)	5	53.40(12.95)
Depression	37	30.49(5.46)	19	28.37(6.87)	16	24.88(7.33)	5	19.60(5.90)
Insecure Attachment	37	28.22(5.46)	19	26.05(5.84)	16	25.19(6.94)	5	16.80(6.30)
Impaired Self- Reference	37	25.68(5.76)	19	22.89(6.08)	16	23.13(5.83)	5	17.00(5.15)

Discussion

This study investigated changes in trauma symptoms related to the self over the course of EFIT. The results demonstrated significant changes in trauma symptoms related to self over the course of therapy. Symptoms of insecure attachment, impaired self-reference, and depression display a significant gradual decrease over the four timepoints, which also signify improvements over the course of treatment. Though there were statistically significant changes in scores for the TSI-II scales, the findings present no statistically significant changes in emotional dysregulation. Emotional dysregulation reductions scores changed over the first few sessions of therapy; however, did predict reductions in self-related trauma symptoms across EFIT sessions.

Based on analysis, reductions in trauma symptoms related to the self in the first few sessions of therapy do not appear to significantly predict reductions in emotional dysregulation symptoms across EFIT sessions, however, is approaching significance. More data is needed to show whether the results could become significant. With this current data set it could be theorized

that improvements in self-related trauma symptoms in the first part of EFIT may play a role in reductions in emotion dysregulation across therapy sessions. Though these results are tentative and dependent on more data collection, the value is approaching significance at the preliminary findings level.

Changes in EFIT of trauma symptoms related to the self

The study's results provide support for the assumption that when individuals participate in EFIT they cultivate feelings of safety in their relationships, which ultimately improves attachments. EFIT helps an individual develop long lasting changes in attachment bonds which formulate into secure attachments with others (Wiebe et al, 2017). EFIT theory suggests that as individuals engage in more secure patterns, they experience less distress and increased self-awareness (Johnson, 2014). Attachment theory suggests that individuals with symptoms of insecure attachments with others need treatment that focuses on the client-therapist relationship to cultivate healthy attachment bonds (Bowlby, 1979). A decrease in insecure attachment symptoms as found in this study supports the theory that attachment-based approaches cultivate improvements in self-reported feelings of safety in relationships and secure connections to others (Johnson, 2019).

Moreover, feelings of safety and security in relationships correspond with sense of self in relation to the other (Briere et al, 2010). The current study provides evidence that throughout EFIT the participants self-reported decreases in symptoms, which maintains the assumption that key bonding experiences and self-awareness are fundamental components in improving attachment insecurity and avoidance (Johnson & Wiebe, 2016).

The findings in this study provide preliminary evidence to support the assumption that trauma-related symptoms may decrease when therapy is emotionally-focused and oriented with

attachment-based approaches. According to trauma theory, individuals who have experienced trauma may exhibit symptoms of depression, hopelessness, impaired sense of self, insecure attachments, and low self-worth (Johnson, 2005; Ventimiglia et al, 2020; & Briere, 2010). The self-disturbance symptoms in this study examined changes in self-reported symptoms of mood and impaired self-reference. The results of the study provide evidence that EFIT decreases symptoms of trauma related to the self may decrease over the course of EFIT sessions.

According to attachment theory, attachment bonds greatly impact an individual's sense of self and leads to symptoms of depression and anxiety (Bowlby, 1979). Specifically, attachment theory suggests that individuals who have experienced trauma develop symptoms of depression and anxiety related to feelings of insecurity in relationships (Briere, 2004). The study found that self-disturbances, such as, symptoms of depression, insecure attachment, and impaired self-reference decreased over the course of EFIT. The assumption that decreases in symptoms of self-disturbances coincide with decreases in symptoms of depression is shown in these results.

In addition, the results further support research by Briere (2004) and Johnson (2009) which suggest individuals who seek treatment for depression experience symptoms of impaired sense of self associated with their experience of trauma in their life. In addition, Bowlby (1979) theorized that depression was an inherent part of attachment difficulties and considered it a part of mourning the loss of attachment. The assumption that attachment-based approaches, such as emotionally focused therapies, increase symptoms related to an individual's sense of self is found in these results through decreases in these self-reported symptoms (Johnson, 2004).

EFIT is thought to improve perceptions of self through insight and contextual meanings of self in treatment (Johnson, 2019). The study further provides evidence that EFIT leads to greater reductions in self-impairments and depression.

The study found no changes in the emotional dysregulation scores throughout treatment. In addition, it is found that emotional dysregulation symptoms are not predictors of changes in self-related trauma-related symptoms. Theory suggests that emotional dysregulation generally decreases over the course of EFIT (Johnson, 2019). One theory as to why these symptoms did not decrease over the course of therapy is because the treatment was impacted by an external problem unrelated to the study itself. The results suggest that more research is needed to determine whether emotional dysregulation is a predictor of outcomes in EFIT.

Limitations

The study exhibits a few limitations worth noting for future studies, such as small sample size, delays in treatment, and participant emotional impacts related to the Covid-19 pandemic. The first limitation is the small sample size which is homogenous and, therefore, the results are not able to be generalized for the broader population.

An unexpected limitation of this study was the effect of the world-wide Covid-19 pandemic that caused a delay in the study and resulted in missing data and delays in participants completing the study. The study began its course in September of 2019. The possibility of a pandemic was an unexpected impact and occurred by March of 2020. In March, all treatments were paused and awaiting public health confirmations of safety regulations. One of the mitigating factors is that participants did not all begin and end therapy at the same time. For instance, when the pandemic occurred some participants were nearing the end of therapy. Other participants were at the midway point of treatment and some participants had not yet started treatment. Participants were stalled at various points of their EFIT treatment course; therefore, there is a possibility this incident impacted participation, missing data, and affected emotional-dysregulation/trauma-related scores.

There was a pivotal change in the way treatment was administered during this time and is another limitation. EFIT treatment was originally administered to be an in-person and changed to an online format. EFIT is an in-person psychotherapy treatment and more research is needed on its efficacy in a virtual or online format.

The pattern of missing data could not be examined; therefore, it cannot be assumed that missing scores have no relationship to the results. Ultimately, participants with missing data at particular time points may potentially differ from those who did complete the questionnaires at those time points. Therefore, the results must be interpreted with caution.

The potential impact of the pandemic on participant scores may have resulted in changes observed in the data, which could be related partly because of this world event as opposed to individual experiences within the EFIT study. Stress related to the pandemic may have significantly influenced the study results by impacting the mental health and wellbeing of the participants. One theory is that participants may have experienced increases in mental illness symptoms as a result of uncertainty and fear associated with the lockdown safety measures and health anxiety.

Theories on trauma, as exhibited in the literature review above, might propose that participants who have previously experienced traumatic events or have trauma-related symptoms are more likely to experience heightened state of arousal following a traumatic event (Briere et al, 2015). The emotional toll of a pandemic on an individual could lead to symptoms of emotional dysregulation as a result of feeling unsafe in one's environment. Feeling unsafe, as the research has shown, perpetuates symptoms of insecure attachment and emotional dysregulation (Briere, 2004). Another emotional impact could be that individual's may experience symptoms of depression and hopelessness related to worries about the future state of their individual life and/or

the long-term impact of the disease on the global population. These experiences are likely to impact the trauma-related and emotional dysregulation scores presented in the results.

Implications

As per the literature review, EFT has been used increasingly over the last decade for treating couples with trauma (Johnson, 2014). EFIT is a relatively new treatment in terms of individual therapy; however, the evidence found in couples therapy support EFT as one of the more empirically supported treatment plans for psychotherapists (Johnson, 2019). By nature, trauma is a deep emotional injury that creates wounds that have profound effects on an individual's well-being and orientation to the world (Harte, Strmelj, & Theiler, 2020). The emotional depth of trauma makes it one of the more challenging issues for psychotherapists to treat. The results presented in this paper could aid therapists in navigating the effects of trauma and encouraging exploration of evidence-based treatment options.

The current study reveals that trauma-related symptoms decreased over the course of EFIT despite the limitations involved over the course of therapy. One major clinical implication of the study is that clients are presented with a potentially effective treatment option for their trauma-related symptoms. The clinical implications related specifically to the use of the TSI-II subscales used are that this method did not account for individuals with PTSD and a broader range of trauma symptoms. Individuals with PTSD meet more criteria and could utilize the full TSI-II scale for investigation of treatment results.

One implication of the study is that it is unknown whether or not emotional dysregulation symptoms predict changes in trauma-related symptoms. Although theory on emotional dysregulation in EFIT suggests that emotional dysregulation symptoms improve over the course of therapy (Johnson, 2005), the lack of data in this study could suggest further research is needed

in this area in terms of predicting changes in symptoms related to trauma. Future research could explore this implication through longitudinal data using DERS as a predictor and investigating changes in TSI-II over the course of therapy.

Future research directions

The findings of this study hold a broader implication for future research on trauma-related emotional dysregulation symptoms in terms of exploring these concepts empirically and longitudinally for evidence-based practices and trauma-informed therapy. For example, future research could explore the predictability of emotional dysregulation symptoms on treatments for trauma-related symptoms.

In the final analysis, EFIT is a relatively new treatment that deserves recognition in the field of trauma-informed therapy because of these findings; however, substantial research is still needed to yield a broader understanding and knowledge base. Future studies could propose to investigate the correlation of emotionally focused treatments for trauma symptoms longitudinally and post-pandemic. Future studies could test the hypothesis that EFIT is an effective treatment for trauma-related symptoms and emotional dysregulation long-term, after following the course of therapy. This could be explored by including follow-up assessments to measure the treatment effect and whether or not participants experience a decrease in trauma-related symptoms related to self-awareness and self-disturbances. From the literature review, a high prevalence of individuals report that they have experienced a traumatic event in their lifetime. This finding signifies the need for future studies on the effectiveness of treatment methods and the further discovery and development of evidence-based psychotherapy practices, such as EFIT, that elicit long-lasting results. Ultimately, the intention of this study is to continue to broaden potential research avenues for future research on EFIT.

Conclusion

The current study provides evidence for the theoretical assumption that EFIT helps clients change trauma-related attachment security, depression, and self-disturbance symptoms that occur over the course of treatment. Specifically, decreases in trauma-related depression, insecure attachment, and impaired self-reference were found. Based on the results of the study, the assumption that emotional dysregulation decreases over EFIT therapy is not supported. This result could be explained by the limitation on the impact of the world-wide pandemic that occurred in March 2020 and is on-going. The scope of this study focused on the EFIT treatment group and trauma-related symptoms, however, the larger EFIT attachment-based project is still on-going and plans to provide more insights and findings on the effect of treatment for individuals. Ultimately, the study supports previous EFIT theories that attachment-based approaches improve symptoms of self-disturbance, insecure attachment, sense of self, and depression.

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