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**Emotionally Focused Therapy for Couples and
Childhood Sexual Abuse Survivors**

Heather B. MacIntosh

Dissertation submitted to the School of Graduate and Postdoctoral Studies
Of the University of Ottawa
in partial fulfillment of the requirements
for the degree of Doctor of Philosophy
(Clinical Psychology)

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DEDICATION

This dissertation is dedicated to survivors of trauma
who struggle against the odds to love again
and, in their loving, change the world.

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ABSTRACT

The purpose of this study was to explore the use of Emotionally Focused Therapy for Couples (EFT) with childhood sexual abuse survivors (CSA) and their partners. Ten couples participated in this exploratory study. In assessing outcomes the concept of the reliable change index was utilized to determine whether the treatment did have an impact on couples over the course of the therapy. Qualitative coding strategies were utilized to relate the process of change in couples to the identified outcomes. A case study replication methodology was utilized to examine the use of EFT with these couples thematically. Half of the couples in this study reported clinically significant increases in mean relationship satisfaction over the course of the therapy. Similarly, half of the CSA survivors reported clinically significant decreases in trauma symptoms on a self-report measure and a statistically significant decrease in trauma symptoms was identified on a standardized interview measure of trauma symptoms in the group of survivors. Very little change was identified over the course of therapy on a self-report measure of attachment. Thematic analyses identified numerous areas where trauma survivors were challenged in fully engaging in the therapy process. In particular, trauma symptoms such as affect dysregulation and hypervigilance, shame, anger, emotional numbing and dissociation were identified to play a role in the challenges that survivors experienced in fully engaging in the EFT therapy process. The EFT model and therapist behaviours were also analyzed observationally and results of these thematic analyses yielded clinical recommendations for working with CSA survivors and their partners in EFT for traumatized couples. Recommendations for future study were articulated.

Introduction

It is arguably one of the great miracles of our species that in the face of violation and terror, those who have been abused continue to seek out and long for connection with others. Researchers in psychology are only beginning to explore these miraculous connections and emphasize the need to assist those who have been violated in creating and maintaining these healing bonds.

Trauma researchers have historically focused on establishing empirical validation for individual therapies for trauma survivors. Couple therapy researchers have traditionally opined that trauma survivors should primarily focus on individual treatment with couple therapy only being offered at the completion of the individual work. This has left trauma survivors and their partners with nowhere to turn when their relationships are in distress. At the same time, therapists have been missing the opportunity to engage partners as allies in the healing process and to strengthen these important relationships.

There is however a growing awareness of the interpersonal context and impact of trauma. With this awareness has come a developing understanding of the importance of integrating systems of support into the trauma treatment process. It was the purpose of this study to explore the use of Emotionally Focused Therapy (EFT) for couples dealing with childhood sexual abuse (CSA). In particular the goals was to examine the ways in which EFT can aid couples in alleviating their relationship distress and help the CSA survivor in dealing with the after effects of their traumatic experience. This study was the first systematic evaluation of any clinical couples' therapy paradigm for CSA survivors and their partners.

The following literature review will focus on the sequelae of CSA on psychological functioning and on interpersonal relationships, attachment theory, available theories on CSA and couples therapy and the application of EFT for couples to CSA survivors.

Psychological Sequelae of CSA

The prevalence and impact of CSA is pervasive and extensive. Epidemiological studies suggest that one-third of women and one-sixth of men in North America have been sexually abused before the age of 18 (Finkelhor & Strapko, 1992). These individuals are disproportionately represented within the population of consumers of mental health services. Briere & Zaidi (1989) found that 50-60% of psychiatric inpatients, 40-60 % of outpatients, and 70 % of psychiatric emergency patients reported histories of sexual abuse.

Posttraumatic Stress Disorder (PTSD)

In the trauma literature, CSA sequelae are often understood within the diagnostic framework of posttraumatic stress disorder (PTSD, American Psychiatric Association, 2000). PTSD involves symptoms such as avoidance of reminders of the trauma, heightened arousal, memory and cognitive impairment and affect dysregulation. Trauma memories or flashbacks, and the attempt to avoid such memories or reminders, affect the survivor in many domains of functioning.

Complex Trauma

Clinical researchers and academics have proposed that survivors of chronic and severe trauma beginning in early stages of development are likely to demonstrate more severe sequelae than those encompassed within the diagnostic framework of PTSD. These sequelae are hypothesized to span both the intrusive and arousal symptoms of PTSD and are accompanied by severe alterations in affect regulation, identity and interpersonal functioning. The two primary proponents of this conceptual framework have suggested

that individuals who display this more complex and broad array of sequela are better understood within the framework of what they have termed Complex Posttraumatic Stress Disorder (Herman, 1992) or Disorders of Extreme Stress (DESNOS, van der Kolk, 1996).

In clinical settings these individuals exhibit pervasive difficulties with self-regulation, experience even minor stressors as overwhelming, have a loss of ability to focus on relevant stimuli and an inability to inhibit themselves when aroused (van der Kolk, Perry, & Herman, 1991). The putative diagnostic criteria consist of six different areas of distress: 1) deficits in the capacity to self-regulate, regulate affect and contain behavioural impulses including difficulty modulating anger, 2) deficits in attention and consciousness including dissociation and depersonalization, 3) alterations in sense of self, including pervasive and chronic feelings of guilt, self-blame, and shame, 4) significant challenges in being in relationships with others including being unable to trust or feel intimate with people, 5) feeling distress on a somatic level with no medical explanation, and 6) loss of sustaining beliefs and basic assumptions (van der Kolk, McFarlane, Alexander, & Weisaeth, 1996).

Methodological Issues

Methodological issues have been an ongoing problem in the CSA literature. The first twenty years of trauma research were characterized by cross-sectional studies that relied upon retrospective self-report. In particular, studies have been criticized for an over-reliance on clinical samples, excessive self-report and retrospective bias and the failure to statistically control for confounding environmental risk factors. For example, family dysfunction which often co-occurs with CSA has been associated with many of the same negative outcomes as CSA (Mullen, Martin, Anderson, Romans-Clarkson, & Herbison, 1993). Additionally, definitions of CSA are highly discrepant between studies and

statistical analyses are generally correlational in nature. These issues need to be considered while interpreting the findings of the early cross-sectional studies of CSA impact.

Meta-Analyses of Cross-Sectional Studies

Over the last twenty years, the literature on the long-term sequelae of CSA has expanded. A number of meta-analytic studies have recently been published that synthesize this vast literature. Neuman, Houskamp, Pollock, and Briere (1996) conducted a meta-analytic review of the relationship between CSA and psychological dysfunction in adulthood. They reviewed 38 studies. Individual symptom domains across studies were assessed for the degree of association with CSA. Anxiety, anger, depression, revictimization, self-mutilation, sexual problems, substance abuse, suicidality, impairment of self-concept, interpersonal problems, obsessions and compulsions, dissociation, posttraumatic stress responses, and somatization were included in their analyses. They found a significant association between CSA and adult symptomatology in all studies and across all symptom domains. These associations were stronger for participants recruited from clinical settings.

More recently, Paolucci, Genuis, and Violato (2001) conducted a meta-analysis of 37 studies examining the impact of CSA on adult psychological functioning. They compared studies on the basis of outcomes. These outcomes included PTSD, depression, suicide, sexual promiscuity, the victim-perpetrator cycle, and academic performance. Significant associations were found between CSA and all six outcomes with higher effect sizes for PTSD, depression and suicide than promiscuity, the victim-perpetrator cycle and academic performance.

Thus both of these meta-analyses clearly document the relationship between CSA and adult psychological distress. However, given the significant methodological short-

comings of these studies, further research of a longitudinal or prospective nature that assesses for potentially confounding environmental factors is required to make any kind of causal statements of impact.

Longitudinal Twin Studies

Some of the significant early methodological problems have been addressed by researchers who have undertaken controlled longitudinal studies. Two longitudinal twin studies have been recently published which attempted to control for the environmental moderators of CSA on long-term psychological impact. Kendler et al. (2000) and Nelson et al. (2002) accessed large samples through twin registries.

Kendler et al. (2000) accessed a sample of female twins (N=1411) from a population based registry. Initial interviews were carried out when the twins were on average 7.6 years of age. Three telephone interviews were later performed using DSM-III and IV structured interviews for lifetime psychopathology. The second of these interviews was initiated after the twins turned 16 at which time a question about CSA was added to the interview. The interviews were carried out over the course of ten years. Additionally, the twins provided the addresses of living biological parents who were then interviewed for lifetime psychopathology, substance abuse, parenting skills and attitudes, financial stress during the twin's childhood, family environment and parental education.

The co-twin analysis examined the pairs where only one of the twins had experienced CSA. Analyses confirmed the findings of other cross-sectional studies that CSA twins had a significantly higher likelihood of developing lifetime psychopathology. In fact, their effect sizes ranged between .24 and .35 which the authors reported were significantly higher than the mean effect sizes reported in previously published meta-analyses (.09). The authors hypothesized that CSA was associated with an increase of

lifetime psychopathology which could not be assessed in a cross-sectional study. When statistical analyses were carried out entering the reported familial factors, there was only a slight and non-significant decrease in the association between CSA and later psychological disorder. While the reports of CSA and potential confounding risk factors were retrospective, the authors made the case for a causal relationship between CSA and later psychological disorder on the basis of their findings and use of more rigorous methodology.

Nelson et al. (2002) assessed 1991 same sex twin pairs from the Australian Twin Registry. One comprehensive assessment of CSA, parental and family history and DSM-IV major depressive disorder (MDD), conduct disorder, and alcohol or substance dependence was administered through semi-structured interviews. These interviews were administered over the phone. Twins with a CSA history evidenced significantly increased levels of MDD, suicide attempts, conduct disorders, substance dependence, rape and divorce. Similar to other cross-sectional studies, penetrative CSA was associated with a higher degree of psychopathology. However, both CSA twins in pairs where only one reported a history of CSA did report higher levels of problems than CSA negative pairs. The authors questioned whether these represented false negative reports of CSA or the impact of environmental factors. Curiously, the researchers did not assess their participants for anxiety disorders including posttraumatic stress disorder. While this study did control for some of the confounding impact of shared environment there was still a heavy reliance on retrospective self reports. These limitations can only be addressed through prospective methodologies which are beginning to appear in the literature.

Prospective Studies

Currently, two prospective studies of CSA survivors into adulthood are in print (Horwitz, Widom, McLaughlin, & Raskin White, 2001; Spataro & Mullen, 2004). These studies addressed many of the limitations of the cross-sectional and twin studies.

Horwitz et al. (2001) compared the psychological outcome of a large sample (N=641) of children with court-substantiated abuse or neglect around 1970 in the United States. These children were matched by age, gender and race through school records with 510 children who did not have documented abuse or neglect. Two assessments were carried out 19 and 25 years following the abuse.

Using DSMIII-R semi-structured interviews participants were assessed for dysthymia, antisocial personality disorder and substance abuse. All participants also completed an extensive stressful life events inventory. Results indicated that male CSA survivors also experienced significantly higher levels of stressful life events along with increases in dysthymia, antisocial personality disorder and no difference from comparisons on substance abuse. Female survivors reported higher levels of dysthymia, antisocial personality disorder, substance abuse and reported lower socioeconomic status than controls. Analyses designed to control for other stressful life events suggested a decreased but still significant association between CSA and mental health in adulthood. Authors suggested that CSA may act as a stress factor that amplifies the impact of later stressful life events.

While authors were attempting to confine their assessments to long-term mental health problems in a prospective methodology, this study was limited by the failure to assess for symptomatology that has been identified through cross-sectional studies to be

associated with CSA. In particular they did not assess for PTSD, dissociative disorders, anxiety disorders or major depression.

Most recently, Spataro et al. (2004) developed a prospective cohort design assessing the impact of CSA on 1612 CSA survivors (1327 female, 285 male) over the course of approximately 20 years. This sample was obtained through accessing a large database of documented sexually abused children in Australia. These cases were then run through another register of consumers of mental health services provided by the state on both an inpatient and outpatient basis. A diagnostic hierarchy (schizophrenia, major affective disorders, organic pathologies, somatoform disorders, PTSD, disorders of childhood, Axis II disorders, conduct disorder and substance abuse) was developed whereby each participant could only be coded with the disorder that was at the highest level of the hierarchy.

Significant associations were found between CSA and anxiety disorders and acute stress disorder with male and female CSA survivors evidencing a three times greater risk of developing these disorders than controls. Major affective disorders were also significantly more likely to be diagnosed in CSA survivors at a two times higher rate in women. CSA survivors were diagnosed with five times higher rates of personality disorders than controls. No differences were found in rates of schizophrenia, substance dependence and somatoform disorders. Male survivors were found to have higher levels of psychological disorder than female survivors. This was accounted for by significantly higher levels of conduct disorder and authors suggested that this may be due to evidencing more significant levels of distress and externalizing behaviours that resulted in referral to a public treatment facility.

Using a diagnostic hierarchy limited the veracity of these findings given the high level of comorbidity often found in CSA survivors (Herman, 1992). This study was also limited by the use of diagnostic information from public mental health facilities. Male survivors were found to have higher levels of psychopathology but this may have been related only to more extreme presentations that were treated in public facilities versus more minor mental health distress treated in the community. Additionally, there was no assessment of CSA in controls; and assumption of discordance was made.

Summary

These more recent longitudinal and prospective studies of the impact of CSA on adult psychological functioning have provided more rigorous support for the argument that CSA is associated with significant risk for psychological impairment. Researchers have not coordinated their definitions of CSA, measurements and analytical approaches, their approach to confounding risk factors and come to a consensus on the appropriate methods for measuring psychological functioning in survivors. Thus we have a body of literature that is progressing methodologically but needs to take the next step towards agreeing upon measurement and analyses so that studies can be more rigorously compared. Additionally it will be important for researchers to begin replicating these more recent prospective studies in different regions.

The relationship between CSA and adult functioning is not simple and more sophisticated statistical methodology needs to be incorporated into these prospective studies to allow for the development of a structural model of CSA impact based on the incorporation of moderator and mediator variables that can be measured over the transition from childhood trauma to adulthood (MacIntosh & Whiffen, 2005). Beyond assessing psychological functioning within the CSA survivor, it is also essential to understand how

the impact of the CSA extends to the survivor's social system. Thus assessment of interpersonal functioning is also critical to understanding the experience of the survivor.

Interpersonal Sequelae of CSA

Even in light of significant interpersonal violation, CSA survivors display a remarkable longing for relations with others and for stable attachment relationships (Allen, Huntoon, Fultz, & Stein, 2001). However, these relationships are not without significant struggles. Research has suggested that interpersonal relationships are potential moderators and mediators of the relationship between CSA and long-term distress (Feinauer, Callahan, & Hilton, 1996; Lynskey & Fergusson, 1997; Runtz & Schallow, 1997; Whiffen, Judd, & Aube, 1999) and the clinical literature has documented long-term and significant impairments in interpersonal functioning in CSA survivors. For instance, based on clinical case studies, authors have asserted that couples where one or both partners are CSA survivors are more likely to develop relationship distress and to evidence more severe distress than other distressed couples (Johnson & Williams-Keeler, 1998; Nelson & Wampler, 2000).

Experiential Avoidance

One theoretical conceptualization has been put forward to explain the challenges that survivors face interpersonally (Polusny & Follette, 1995). Authors used Hayes' (1987) concept of experiential avoidance in the context of CSA to understand this phenomenon. Essentially they argued that attempts to avoid negative thoughts, feelings and memories result in coping mechanisms such as dissociation, substance abuse, casual sexual behaviours and an avoidance of interpersonal relationships. While these mechanisms work in relieving pain in the short term by allowing for the avoidance of negative emotions there are negative long-term consequences such as feelings of isolation, dissatisfaction with

relationships and sexual dysfunction. This conceptualization has not been empirically studied but provides some rationale for the findings of empirical study of the interpersonal distress of survivors.

Qualitative Studies

Qualitative research has suggested that CSA survivors' report distress in their interpersonal relationships. For example, Pistorello and Follette (1998) assessed CSA survivor's perceptions of their couple relationships in the context of group therapy. Five different therapy groups for female CSA survivors were taped and comments related to interpersonal relationships were thematically analyzed. The two most prominent themes were related to problems with emotional communication or intimacy, and the approach to power and control in the relationships. Sexual difficulties were also frequently noted and were found to be correlated with the survivors' current level of trauma symptoms. Many survivors reported that their partner often blamed the survivor's CSA history for the couple problems.

Review of Cross-Sectional Studies

Empirically, interpersonal functioning in CSA survivors has only recently been incorporated into studies of CSA survivors and their functioning in adulthood. Some cross-sectional studies assessing the long-term impact of CSA have examined the interpersonal relationships of CSA survivors but primarily in the context of larger studies where other realms of functioning were assessed. The same methodological issues need to be kept in mind when interpreting these studies as were discussed above.

Three exhaustive reviews of this literature have been published within the last four years (Davis & Petretic-Jackson, 2000; DiLillo, 2001; Rumstein-McKean & Hunsley, 2001). There is some overlap between these reviews in the studies that were incorporated.

All of the authors approached the literature critically and made distinctions between clinical and community samples and assessed the degree of representativeness of studies. Efforts were made to focus on empirical studies but some qualitative studies were included given the salience of their findings.

In total between 23 and 42 unique studies were contained in each review. There was a high level of consistency between studies in the findings related to the couple relationship. CSA survivors reported more current relationship problems than non-survivors and were likely to have had a prior divorce, marry younger, perceived their relationships to be more isolating and of lower quality than controls, and felt that they were unable to depend on their partners. Survivors were also found to have a significantly higher risk of maltreatment by partners. However, it was noted that in cross-sectional controlled studies, fewer CSA survivors got married than controls. (Davis et al., 2000; DiLillo, 2001; Rumstein-McKean et al., 2001).

Partners

Given these significant detriments in interpersonal relationships it is surprising that only two studies to date have looked at the impact of loving a CSA survivor on the partners. Most treatment approaches for trauma primarily address the needs of the survivor. Expectations from the survivor and perhaps his/her therapist are high in terms of the supporting role that the partner should play yet the partner is often alienated from the process.

Isolation, pain, anger, frustration and dissatisfaction are high on the list of concerns of partners of trauma survivors arising out of the results of two qualitative studies (Reid, Mathews, & Liss, 1995; Reid, Wampler & Taylor, 1996). In the first study (Reid et al., 1995) authors articulated some of the themes identified in a support group for partners of

CSA survivors. These partners reported feeling isolated from their partner's recovery, angry, frustrated and dissatisfied with their relationships. In the second study (Reid, Wampler, & Taylor, 1996) data was collected through in-depth interviews with 17 partners of survivors. These partners reported that they had ongoing problems with communication with their partners. They reported feeling that their partners were inconsistent, confusing, and frustrating in their attempts to communicate with them. They indicated that they felt left out of the therapy process, that therapists did not help survivors develop intimacy with their partners, that they were treated like perpetrators and that they were left waiting for the therapy to conclude to continue their relationship.

Survivor's perceptions of their partners are similarly negative. DiLillo's (2001) review consolidated survivors' reports in 23 studies about their partners. Partners were perceived as more controlling, less caring, less well adjusted, less supportive, more insecure, dependent, immature and exploitative than the partners of controls. Both survivors and partners reported significant communication problems especially related to being open and honest about emotions and needs and resolving frustrations.

Summary

Thus both survivors and their partners consistently report significant interpersonal distress in their relationships citing low levels of satisfaction and trust and high levels of discord and communication problems. While these studies suggest ongoing interpersonal distress they do not address questions such as why are some survivors able to develop stable, healthy interpersonal relationships while others experience maltreatment and distress and still others are unable to develop relationships at all. Nor do these early studies validate any theoretical conceptualization of the development of these interpersonal problems or begin to articulate a causal pathway.

While strong interpersonal relationships may have a moderating impact on the relationship between CSA and adult emotional distress, CSA can have a significant effect on survivors' ability to engage in healthy supportive intimate relationships and on their partners (Feinauer et al., 1996). Thus, while the majority of treatment modalities for CSA have focused on the individual, an alternative and effective therapy for CSA survivors may be one that is able to integrate the partner into the process to create an ally in the healing process and allow the partner to be an active participant in the therapeutic process rather than an outside observer thus it is important to develop clinical interventions for couples that are based upon a strong theoretical understanding of possible pathways from CSA to interpersonal distress.

Attachment Theory

One theoretical conceptualization of the relationship between CSA and later interpersonal dysfunction in survivors that has received preliminary empirical support is attachment theory (Alexander, 1992). As such it may be an important area of consideration for those seeking to understand the experience of CSA survivors in their relationships. Over the last 10 years a vast quantity of research has been undertaken to understand human attachment. Given the scope of this paper this review will be limited to the following questions: what is attachment theory, how is it applied to adult romantic relationships, can attachment change and how is attachment theory applied to CSA survivors?

John Bowlby

The first researcher to examine behaviours between an infant and its caregiver was John Bowlby a British psychoanalyst (Bowlby, 1969). He became intrigued by the distress of infants separated from their caregivers and developed a developmental evolutionary theory to understand this phenomenon. Having seen that these behaviours were present in

both humans and primates Bowlby set about observing these responses to understand their purpose. Bowlby hypothesized that infants were born with an innate attachment behavioural system that ensured proximity to the primary caregiver and thus ensured maturation to reproductive maturity. These behaviours such as crying, smiling, clinging, moving and looking all served to achieve proximity to the caregiver and increased survival and thus were potentiated by natural selection (Bowlby, 1969; Bowlby, 1973).

Bowlby further hypothesized that the infant would seek to ascertain whether the attachment figure would be available and attentive to them. It was only when this availability was assured that the infant would explore their environment with comfort and confidence. Bowlby suggested that these ideas about the availability of the caregiver developed into an internal system of thoughts and feelings about relationships or internal working models of attachment that guided the infant's expectations of the caregiver, others and themselves.

Bowlby, (1973, p. 204) identified two key features of internal representations of these working models of attachment: a) whether or not attachment figures could be trusted to be there when needed and to respond to calls for support and protection and, b) whether or not you felt worthy of being loved, comforted and cared for. These working models include one's expectations. These expectations are the cognitive components of attachment which determine how incoming interpersonal information is attended to and perceived both cognitively and emotionally.

Mary Ainsworth

Mary Ainsworth was a student of Bowlby's who developed a paradigm for the empirical study of attachment in infants (Ainsworth, Blehar, Waters & Wall, 1978). She developed a laboratory paradigm referred to as the strange-situation where infants were put

in situations of separation and reunion with their mother. Based on these infants' behaviours in the strange situation Ainsworth suggested a three category model of attachment in infants. These three categories were Secure, Anxious/ambivalent and Avoidant.

Securely attached infants were found to use their caregiver as a safe based for exploration, to be upset upon separation from the caregiver and to be soothed by physical contact upon reunion. These caregivers were noted to be sensitive and responsive to their infant's cues. Anxious/ambivalently attached infants were observed to seek proximity from their caregiver upon reunion after separation but to be angry and resistant to this contact and more difficult to comfort than secures. The caregivers of these anxious/ambivalent infants were observed to be unpredictable, intrusive and inconsistent. The avoidantly attached infants ignored and avoided interaction with their caregivers and these caregivers were observed as being rejecting and rebuffing.

These studies represented the first empirical observations of the differences in attachment behaviours in infants in response to frightening and safe experiences and the first taxonomy of infant attachment.

Attachment in Adult Romantic Relationships

Given the profound impact of early caregiving relationships researchers have sought to identify the connection and pathways between these early attachment experiences and adult romantic relationships. Hazan and Shaver (1987) made the first extension of attachment theory to adult romantic relationships. They hypothesized that the emotional bond in adult romantic relationships served a similar function to that of the infant caregiver bond. In fact they suggested that these relationships were driven by the same motivational system; the attachment behavioural system and that both had similar characteristics. These

characteristics included feeling safe when the other was nearby versus feeling insecure when the other was unavailable, engaging in close bodily contact, sharing discoveries with each other and playing with each other.

Categorical Three Category Model

Hazan et al., (1987) suggested a continuity of attachment from childhood to adulthood and developed a questionnaire of adult romantic attachment based on Ainsworth's three category system. They conceptualized three categories of attachment corresponding to the attachment styles of childhood. Their self-report measure instructed participants to choose one of three paragraphs describing different ways of being and feeling in adult intimate relationships. Securely attached adults described themselves as being comfortable with closeness and able to trust that their partner will be there for them when they need them. Avoidantly attached adults described themselves as finding closeness and intimacy uncomfortable and having difficulty believing that their partner would be there to support them when they needed them. Anxious-ambivalently attached adults described themselves as needing high levels of intimacy yet fearing abandonment

They found that 55% of adults' responses were suggestive of a secure attachment style, 25% avoidant, and 20% anxious, which was a similar breakdown to Ainsworth's findings in infants (Hazan et al., 1987).

Dimensional Four Category Model

Hazan and Shaver's (1987) adult attachment conceptualization contained a single avoidant-detached category which other researchers felt might obscure conceptually separate patterns of avoidance in adulthood. Bartholomew and Horowitz (1991) developed a four category model of attachment where the model of self was dichotomized as positive or negative (the self worthy of love and support or not) and model of other dichotomized

into positive or negative (people seen as trustworthy and available vs. unreliable and rejecting). This culminated in four attachment patterns derived from a combination of these two dimensions.

Brennan, Clark and Shaver (1998) followed this line of inquiry with an exploratory factor analysis in which all of the items from the various self-report measures of adult attachment were included. This research identified twelve specific factors which formed the two global factors Anxiety and Avoidance. This research aided in the development of their 36 item measure which yields continuous scores along these dimensions which can then be further analyzed into the four categorical attachment styles of secure, preoccupied, dismissing avoidant and fearful avoidant.

Descriptions of Attachment Styles in Adult Romantic Relationships

Researchers have begun to investigate how adults experience their romantic attachment relationships and they have found a high level of consistency between studies in these descriptions. It was consistently found that securely attached adults reported more positive views of themselves and others, comfort with closeness and lower anxiety about their relationships. They described themselves as being lovable and worthy of the care of others and felt that others would be there for them when they needed them to support and comfort them. Their relationships were found to last longer and be more satisfying. Additionally, these adults reported using their partners as a safe base, to seek comfort when distressed and to be more likely to provide comfort to their distressed partners than adults with other attachment styles (Feeney, Noller, & Callan, 1994; Simpson & Rholes, 1994; Simpson & Rholes, 1998).

Preoccupied adults reported more negative views of their own worthiness and lovableness while maintaining a cautiously positive view of others' accessibility and

support. This was represented by high anxiety about their relationships and low avoidance of closeness and sharing. Dismissing/avoidantly attached adults reported positive views of themselves and negative views of others. These people endorsed discomfort with intimacy, and feelings of hostility and loneliness. This was represented by low anxiety about their relationships and high avoidance of closeness and sharing. Fearful/avoidant adults reported negative views of themselves and others. This was represented by high levels of avoidance of closeness and sharing and high anxiety about their partner and their relationships (Feeney et al., 1994; Simpson et al., 1994; Simpson & Rholes, 1998).

Relationship Between Attachment and Relationship Satisfaction

The relationship between attachment and couple satisfaction has been well established in the literature. A review of these studies suggested that couples comprised of individuals with secure attachment styles had fewer marriages, higher levels of relationship satisfaction, and less relationship strain (Carnelley, Pietromonaco, & Jaffe, 1996; Hibbard, 2001). Securely attached couples were characterized by higher levels of trust, commitment and higher dyadic satisfaction (Kobak & Hazan, 1991; Levy & Davis, 1988; Simpson, 1990). Fuller and Fincham, (1997) in their study of 53 married couples found that secure attachment styles were related to more positive emotional responses to traumatic and stressful events. These couples offered each other the support and security to explore their environment in self enhancing ways.

Continuity of Childhood Attachment

Given the extension of attachment theory to adult relationships, researchers have begun to examine whether attachment is continuous or stable from infancy into adulthood. Hazan et al. (1987) and Feeney and Noller (1990) examined the stability of retrospective self-reported attachment relationships from childhood and found that those who identified

themselves as securely attached in adult romantic relationships were more likely to report having had childhood relationships with attachment figures that were affectionate, caring and accepting. This provides some preliminary support for the continuity hypothesis but prospective studies will need to be performed before any definitive statements can be made.

Can Attachment Styles Change?

Given the preliminary findings that attachment styles are fairly stable from childhood into adulthood researchers concerned with understanding the nature and process of attachment change have begun to assess whether attachment can change in adulthood and in particular, in romantic relationships.

A series of longitudinal studies of married couples has found support for some fluctuation in attachment. Up to 30% of adults in these studies reported some change in attachment over the course of eight months to four years (Baldwin & Fehr, 1995; Feeney et al., 1994; Fuller et al., 1997; Kirkpatrick & Hazan, 1994; Scharfe & Bartholomew, 1994). These changes were related to cognitive factors such as beliefs about partner's trustworthiness and emotional factors such as relationship satisfaction and contextual factors such as change in relationship status. However, these early studies primarily utilized categorical single item measures of attachment and one researcher suggested that in fact the construct of categorical attachment was potentially flawed and responsible for these high levels of change (Baldwin et al., 1995).

Two recent longitudinal studies (Davila, Burge, & Hammen, 1997; Davila, Karney, & Bradbury, 1999) utilizing a dimensional multi-item measurement of attachment assessed the question of whether attachment can change in adulthood. They assessed specific models of change based on contextual factors and individual differences. The first model was a contextual model initially proposed by Collins and Reed (1990) whereby working

models of attachment were changed in response to salient contextual factors. In particular, interpersonal events and circumstances were hypothesized to be the most likely contextual factors related to change. The second model was postulated by the authors as an individual differences model which argued that some people were more likely to experience fluctuations in attachment as a result of specific testable vulnerabilities such as psychopathology, personality dysfunction, family of origin dysfunction and psychopathology.

In the first study (Davila et al., 1997) 155 women were followed through the transition to adulthood. This time was hypothesized to be a significant transition period where participants would be open to changes in attachment in response to both individual and contextual factors. These women were assessed in face to face interviews upon graduation from high school and were then followed at six month intervals via telephone interviews over the next two years. Up to 28% of participants changed their attachment ratings at six months and 34% reported some attachment change at the two year assessment. The results supported both the contextual and individual differences model. In terms of individual differences, those who fluctuated in attachment, even from insecure to secure, were more likely to have a personal history of psychopathology, family history of psychopathology, come from non-intact families and have reported higher levels of personal distress throughout the study. In support of the contextual model, those women who fluctuated into insecure attachment style ratings were those who reported higher levels of romantic relationship stress and interpersonal stress. However, the identified individual factors were stronger predictors of attachment fluctuations.

In the second study, Davila et al. (1999) also sought empirical support for the context and individual differences models. Researchers followed 172 first-time, newly

married couples over the first two years of marriage. They hypothesized that these first two years of marriage were ideal for studying potential change in attachment given the salience of the marital attachment and what they suggested was a transfer of primacy of attachment to the partner. They interviewed couples at the beginning of the study in person and then every six months for the next two years through mailed questionnaires. Well validated measures were used to assess variables that the authors defined as being individual vulnerabilities such as personality pathology, psychopathology, interpersonal skills and behaviours and family of origin characteristics.

Consistent with the first study, the results of this investigation provided further validation for both the individual difference and contextual models. Using hierarchical linear modeling, contextual and individual factors were assessed for their ability to predict fluctuations in attachment over the course of the study. Both male and female participants became less anxious over time and self reported attachment styles were correlated with relationship satisfaction. Additionally in women, increased levels of individual vulnerabilities predicted higher levels of fluctuation over the course of the study and lower relationship satisfaction for both partners in a couple. As the male partners of women with higher levels of individual vulnerabilities became more secure over the course of the study their female partners became more anxious. Authors suggested that this may have been due to their vulnerable partner's interpretation of increased security as a decrease in their partner's level of need for them.

Both of these longitudinal studies utilized the continuous dimensional model of attachment and provided empirical support to early research that suggested that attachment could change over time. In particular, fluctuations in attachment were predicted by changes in the context of the relationship and variables that these authors defined as stable

individual vulnerabilities. These authors did not assess for CSA. However, given the associations between CSA and psychopathology, dysfunctional family of origin characteristics and low relationship satisfaction which were assessed it would be reasonable to suggest that CSA survivors may fall into the category of individuals who would be more likely to fluctuate and to report changes in attachment in response to contextual factors. Researchers are only beginning to assess the relationships between CSA and attachment and to put to empirical test, the question of whether the pathway from CSA to interpersonal distress is through attachment.

Attachment and Child Sexual Abuse

Attachment has also been described as a “theory of trauma” (Atkinson, 1997) to denote that isolation and separation are extremely aversive experiences to humans, especially in times of vulnerability. Several studies have indicated that adults who were traumatized in childhood tended to report insecure attachment orientations.

Bartholomew et al. (1991) assessed attachment styles of CSA survivors and found proportions of attachment styles of 60% fearful, 21% preoccupied, 11% dismissing, and 9% secure. Similarly, Alexander, (1993) studied the impact of CSA on attachment in a non-clinical group of 112 women drawn from the community. She found proportions of attachment styles of 58% fearful, 14% secure, 13% preoccupied, and 16% dismissing. A relationship was not identified between adult attachment styles and psychological functioning as measured by trauma symptoms. The measure of trauma included the Impact of Event Scale (IES) short scale, which has not been shown to reliably discriminate between CSA survivors and other trauma groups. Neither has it been validated to measure the chronic psychological effects of CSA nor to assess relationships and interpersonal or intrapersonal problems which may be significant factors in the long term sequelae of CSA.

Roche, Runtz, and Hunter, (1999) in a study of 85 female CSA survivor undergraduates, found that with intrafamilial abuse the majority of participants evidenced a fearful/avoidant attachment style followed by secure, preoccupied, dismissing. The intrafamilial CSA survivors were more fearful than those who had experienced extrafamilial abuse. They reported a strong predictive relationship between attachment style and trauma symptoms. CSA characteristics no longer predicted psychological adjustment when attachment style was partialled out. They concluded that adult attachment style mediated the relationship between CSA and psychological functioning as measured by trauma symptoms.

While this may appear to be a contradictory finding to Alexander, (1993) these researchers measured trauma sequelae with the Trauma Symptom Inventory (TSI) (Briere, Elliott, Harris, & Cotman, 1995) which has been empirically validated to reliably discriminate between CSA survivors and other traumatized populations and is designed to measure chronic and acute trauma symptoms (Briere et al., 1995). The TSI has a broad normative sample of CSA survivors and asks questions about relationships. Given the large differences between the measurement instruments in these two studies, it is possible that they were not measuring the same construct or different facets of the same construct. These findings need to be replicated before any conclusions can be drawn.

Allen et al., (2001) assessed attachment in a clinical sample of 99 women who had experienced trauma compared to a community sample of 154 non-traumatized women. They compared responses on a single item categorical self-report measurement to a dimensional multi-item measure. In the clinical sample, proportions of attachment styles were 37% fearful/avoidant and only 17% secure. Conversely they found proportions in the community sample of 43% secure and 17% fearful/avoidant. CSA survivors reported fewer

attachment figures than community control participants and a higher number of attachments to professionals than the non-traumatized comparison participants. Optimistically though, most trauma survivors reported being able to find some comfort and security in attachment relationships.

Very little agreement was found between the two attachment measures with the single-item categorical measure demonstrating very little psychometric or predictive validity. This finding emphasizes that the early studies of attachment based on the single item categorical attachment measure require replication prior to accepting their findings of high levels of attachment change over time. None of these studies listed the CSA survivors' status in relation to intimate relationships and once again very divergent definitions and measures related to CSA were used.

Attachment as a Mediator of the Relationship between CSA and Interpersonal Distress

More recently, researchers have begun to examine the specific role that attachment insecurity plays in the relationship between CSA and later interpersonal distress and dysfunction. Whiffen and MacIntosh (2005) reviewed the literature examining mediators of the relationship between CSA and emotional distress in adulthood. Four studies examining attachment were assessed in this review. However, two of these studies did not meet the basic conditions for the statistical assessment of mediation (Baron & Kenny, 1986). In the two studies with the most heterogeneous samples that did fulfill the requirements for mediation there was some evidence that attachment insecurity may be associated with both emotional distress and difficulties in developing and maintaining adult interpersonal relationships. However, the reviewers noted that these studies were cross-sectional and thus the findings must be interpreted with caution given the potential for competing hypotheses. For instance, based on these studies it is impossible to identify the

direction of these relationships. For example, whether it is the insecure attachment to parents that places children at risk for sexual abuse or whether sexual abuse results in an insecure attachment to parents.

Attachment Theory and Relationship Distress in Couples

In a recent theoretical proposal of how attachment can be understood to impact the relationship between CSA and relationship distress Johnson (2002) expanded upon her clinical experience to suggest that relationship distress results from the failure of the attachment relationship to provide a secure base for one or both partners.

Johnson (2002) argued that when no secure base is available to a partner in a relationship, attachment behaviours such as protest and clinging, avoidance or withdrawal would be provoked and exaggerated. She further argued that this process would evolve until neither partner would be able to be responsive or accessible to the other. This unresponsiveness would then continue to provoke increased insecurity until both partners became unable to sustain emotional engagement and couples would then become emotionally misattuned with each other.

Johnson expanded upon the concept of attunement in parent child dyads by suggesting that in adult relationships attunement is the sensitive moment-to-moment being with a partner as he/she experiences and expresses an emotion. This attunement would be demonstrated through the exhibition of behaviours that suggest the ability to empathize and share their partner's emotional experience. In conclusion, Johnson argued that as insecure attachment styles become rigid and polar the insecurity would manifest itself in the inability to be open and trusting with their partner whom she argued, represents the foundation of the secure bond with others. This insecurity would then result in avoidance from engagement with each other which would then make modification of attachment

styles difficult until eventually, both partners withdraw and the relationship is in jeopardy. This argument rests upon the validity of the contextual model of attachment change.

Summary

Empirical evidence has provided support for the extension of attachment theory to adult romantic relationships. Similarly, early studies have suggested that insecure attachment has been associated with low relationship satisfaction. While there is some evidence to suggest that attachment is a stable construct from childhood to adulthood more recent empirical evidence has been found for the ability of individual factors such as psychopathology and family of origin functioning and contextual factors such as relationship status to predict fluctuations in attachment. This prediction was particularly strong in individuals who reported insecure attachment styles.

CSA survivors have consistently reported a predominance of fearful avoidant attachment styles and low relationship satisfaction. Researchers assessing individual factors that predict fluctuations in attachment did not assess CSA but did assess variables that have been associated with CSA such as family of origin dysfunction and psychopathology. This may suggest that survivors would be more prone to attachment fluctuations and this warrants further empirical investigation. This could be seen as an advantage in the context of developing an attachment oriented intervention for CSA survivors' relationship. There is some evidence that attachment insecurity mediates the relationship between CSA and interpersonal distress. Guided by Johnson's (2002) theoretical understanding of attachment, CSA and relationship distress, it may be possible to create the context for change and target the potential for change in the survivor.

Understanding how pivotal the role that attachment patterns can play in the maintenance of relationship satisfaction and how relationship distress arises when

attachment relationships fail to provide a secure base for partners it behooves clinicians to integrate an awareness of attachment related processes into the couple therapy process.

Couples Therapies and CSA Survivors

Clinical and empirical evidence have begun to converge in the CSA field. In particular, the research on the long-term impact of CSA on psychological functioning, interpersonal relationships and attachment has consistently identified the association between CSA and distress in relationships. This confirms the long-held clinical observation that CSA survivors struggle with maintaining healthy and satisfying relationships. At the same time, this convergence has only occurred within the last five years and thus clinical research is only now beginning to catch up to clinical wisdom and non-clinical research. Currently, there are no published empirical clinical studies of the use of couple therapy with CSA survivors. The literature that does discuss couples therapy for CSA survivors and their partners is primarily based on theoretical discussions or case study descriptions. These few conceptualizations will be discussed here.

Behavioural Treatments

Two theoretical chapters by Compton and Follette, (1998, 2002) have attempted to articulate the application of Behavioural Marital Therapy (BMT) to couples where one partner is a CSA survivor. The two chapters are essentially the same theoretically; however, the second chapter attempts to extend their application of BMT to survivors of all forms of trauma including combat veterans and rape survivors. Additionally, the second chapter included a case study. No outcome studies of BMT with CSA survivors have been published to date. The authors articulated some suggestions for applying treatment interventions with these couples. They emphasized the importance of maintaining a close relationship with the individual therapist and avoiding triangulation.

The concept of emotional avoidance was hypothesized to play a large role in the relationship distress of CSA survivors and their partners. These authors suggested that this behaviour could be gradually decreased through training around issues such as dissociation, affect regulation and learning to minimize tension reducing behaviours such as substance abuse or self harm concurrently with the development of communication skills and psychoeducation.

The crux of their application of a behavioural approach to CSA couples was in the use of behavioural exchange strategies. In particular, they focused on the development of communication skills and intimacy through gradual exposure exercises and increases in positive reinforcement. It was advised that topics of conflict be introduced slowly as skills developed and that it was important to avoid blaming the survivor and approaching therapy as though she/he were broken.

The case illustration summarized the couple therapy process of a female CSA survivor and her male partner. This couple had a long history of very little emotional intimacy and high levels of conflict avoidance. The early phases of therapy for this couple included supporting the survivor in disclosing her abuse to her partner and in helping her partner integrate and respond to this new information. The individual and couple therapists worked closely together and skills developed in both realms were utilized in the other. The couple therapy occurred over a period of one year and focused on the development of communication skills, helping the couple learn to stop avoiding conflict and teaching the couple to work together to solve their problems. The authors noted that as the therapy progressed, the survivor's trauma symptoms increased and the therapy focused on helping her turn to her partner for support rather than withdraw. The therapy was faded out more

slowly than in traditional approaches due to concerns about the couple's ability to maintain their gains.

Psychoanalytic Interventions

Buttenheim and Levendosky (1994) presented a case study of a CSA survivor and her partner. Their theoretical orientation utilized objects relations theory as directed by trauma theory (Cole & Barney, 1987; Herman, Russell, & Trocki, 1986; Herman, 1992; van der Kolk, 1996). In line with Polusny et al.'s (1995) theory of emotional avoidance in CSA survivors, they articulated that their understanding of the impact of trauma on couples was a cycle of arousal and avoidance due to overwhelming experiences that overrode basic ego capacities and sense of safety, resulting in intrapsychic and interpersonal distress. Object relations theory was integrated into trauma theory in terms of reenactments, recreative repetitions, projective identifications or enactments of past trauma onto the present relationship, resulting in a cycle of reliving past relationships and a lack of introspection. They theorized that the traumatic reenactments were an attempt at communication and resolution of past traumatic relationships with the consequence that reparation was threatened given the confusion of the past and present objects.

Avoidance and fear of sexual intimacy was validated as a protective strategy in the past. However, as the clinician pointed out, the avoidance reenactment protected the survivor from guilt, fear and shame at a price; increased interpersonal isolation and emotional numbing. This case of couple therapy occurred over the course of three years while individual and group therapy was ongoing. No pre, post or process measures were administered and no attempts were made to empirically validate this approach to treatment.

Maltas (1996) also offered a conceptualization of a treatment of a CSA survivor from the psychoanalytic perspective. This author contended that early trauma perpetrated

by persons upon whom the child depended, would be reenacted in adult intimate relationships and cause the survivor to feel vulnerable due to the combination of intimacy, dependency and sex. It was argued that many of these reenactments were unconscious and therefore interpreted as viable present experiences. In addition, the author hypothesized that trauma symptoms in one partner have the potential to cause a secondary traumatization in the other partner as a result of feeling that they are living in a minefield and of the challenges to beliefs about the fairness and the predictability of life.

Avoidance, arousal, intrusion and other trauma symptoms were not integrated into the couples' treatment. Neither did their use of psychoanalytic theory integrate knowledge of trauma to guide the recommended intervention. Their work involved interpretations and education geared towards assisting the couple in moving out of old reenactment patterns and into a new way of being in relationship, where the past was understood and kept separate from the present. This author emphasized the importance of integrating couples therapy into the recovery process for CSA survivors.

Summary

This is a literature that is early in its evolution. While there is recognition of the extent and intensity of distress that can be caused to an individual as a result of traumatic experiences, clinicians are still at the theoretical stage in finding ways to address this distress in the context of the couples' environment. These theories have been illustrated, for the most part, in case studies and vignettes.

There is a common thread among these interventions that couples therapy may be an important element in the treatment of survivors of trauma who are in relationships. The rationale for this differs between interventions. For the behaviourist it is so that the partner can be educated about the effects of trauma to better understand his/her partner, that they

can learn to be emotionally engaged with each other and to relearn their ways of behaving toward each other to begin to build the ratio of positive to negative interactions and reorient their relationship. Psychoanalytic perspectives see the couples' environment as a context for the reenactment of traumatic memories as the trauma survivor begins to feel vulnerable due to a combination of intimacy, dependency and sex and past trauma is transmitted into the present. The role of the therapist is to assist the couple through interpretation and insight, to clarify their relationship cycles and refocus them in the present.

All of the recommended therapeutic interventions for trauma survivors recognized the disabling effects of trauma related symptoms such as avoidance, arousal and intrusions. While the behaviourists saw those symptoms as issues to be dealt with in the context of individual work through desensitization and exposure therapies, the psychoanalytic theorists considered avoidance and arousal/numbing as protective and requiring interpretation to break through the defensive cycle.

Of note, none of these interventions clarified whether the purpose of their proposed interventions was for the treatment of relationship distress in couples where one or both partners was a CSA survivor, or for the treatment of the distress of the CSA survivors within the context of the couple relationship.

The Present Study

Emotionally Focused Therapy (EFT)

EFT was developed in the early 1980s in response to an absence of standardized and validated non-behavioural clinical approaches to couple distress. Primarily, the field up to that point had focused on behavioural and cognitive change while leaving the role of emotion largely unexplored both in theory and practice. EFT is a form of couple therapy

which integrates experiential and systemic approaches in the process of therapeutic change. EFT has been empirically validated and presently is recognized as one of only two empirically validated extant couple interventions (Alexander, Holtzworth-Munroe, & Jameson, 1994; Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998).

Numerous studies have validated EFT through outcome based clinical research methods. Couple distress has been the primary focus of these studies as measured by the Dyadic Adjustment Scale (DAS, Spanier, 1976). In a review of the EFT research it was found that in nine studies there was significant improvement in DAS scores compared to both waiting list controls and to couples' pretreatment DAS scores (Dessaules, 1991; Dandeneau & Johnson, 1994; Greenberg & Johnson, 1985; Johnson & Talitman, 1997; Gordon Walker, Johnson, Manion, & Cloutier, 1996). In 70- 75% of the EFT treated couples, criteria for recovery were met, i.e. they were no longer relationally distressed. It has demonstrated both clinical effectiveness and relatively high and stable treatment effects (Johnson, Hunsley, Greenberg, & Schindler, 1999).

EFT has been investigated extensively and has been found to be effective with diverse populations including depressed women (Dessaules, 1991; Johnson, 1998), families experiencing chronic stress or coping with a chronically ill child (Gordon Walker et al., 1996). Case studies have been presented on the use of EFT with couples coping with one partner who has survived severe trauma and has symptoms of PTSD (Johnson et al., 1998).

The Process of Change

EFT emphasizes the role of affect in therapeutic change. Additionally, the role of communication and rigid interactional cycles such as blame/defend or pursue/withdraw in maintaining dysfunctional interactions are emphasized. Critical elements in relationship distress are hypothesized to be the absorbing states of negative affect such as anger or fear

(Johnson & Whiffen, 1999). EFT melds experiential (intrapsychic), systemic (interpersonal) and humanistic theoretical approaches (Johnson, 1996).

Through unveiling the shrouded emotional needs and identifying negative interactional cycles that maintain each partner's interactional stance, these interactional patterns can begin to change (Johnson, 1998). Not only is the expression of needs facilitated, but there can be the creation of new responses on the part of the partner. Johnson (1998) has suggested that emotional expression and communication are primary forms of self-regulation which enable us to identify that which is important to us and to our partner, thus allowing couples to more adequately meet each other's emotional needs. Emotional expression is also a regulator of behaviour both towards oneself and one's partner (Tronick, 1989).

The process of change in EFT has been demarcated into three stages and nine treatment steps. In EFT Stage One; De-escalation, has four steps. Step 1 delineates the conflict and includes an assessment of the core issues and conflict using an attachment perspective. The therapeutic alliance is developed and the unveiling process is begun. Step Two involves identifying the negative interaction cycles such as pursue-withdraw or attack-defend. Both of the individual's presenting concerns are made relational through the identification of these cycles. Step Three involves delving into the unacknowledged emotions underlying these self-reinforcing interactional patterns. The therapist begins to identify and validate the primary emotional responses. Step Four reframes the problems in terms of the cycle, the underlying emotions, and attachment needs.

Stage Two; Re-engagement/Softening, has three steps. Step Five promotes identification with disavowed needs and facets of the self that have been withheld in relationship interactions, and integration of these elements into the relationship. Step Six

involves the promotion of acceptance of the partner's new ways of being and responding in the relationship. Step Seven is the facilitation of the expression of specific needs and wants and creating emotional engagement. During the Re-engagement/Softening stage, key interventions support the couples in expressing vulnerability with the result of the emergence of new relational cycles which create a large shift in the relationship positions. Partner A expresses needs and vulnerabilities, trusts the other more, feels that the other can be accessible and responsive and accepts limitations. Partner A is more empathic, less hostile and is able to ask for comfort from the other. Partner B is also more engaged and empathic, trusts the other more and accepts limitations. Partner B is more accessible and responsive and feels that the other is more approachable (Johnson, 1996).

Stage Three, Consolidation/Integration, has two steps. Step Eight develops new solutions to old problem relationship issues and Step Nine involves consolidating new positions and new cycles of attachment behaviour (Johnson, 1996).

Stage	Step & Description
I Assessment & Delineation Of Problematic Cycles/De-escalation	1. Create an alliance and delineate conflict issues in the struggle 2. Identify the negative interactional cycle 3. Access unacknowledged feelings and attachment needs. 4. Reframe problem in terms of underlying emotions and needs.
II Re-engagement/Softening	5. Promote identification with disowned needs and aspects of self. 6. Promote acceptance of partner's experience. 7. Facilitate the expression of unmet needs and wants.
III Consolidation	8. Facilitate the emergence of new solutions. 9. Consolidate new positions

EFT and Attachment Theory

The proponents of EFT view attachment as a theory well suited to adult love relationships and one which addresses the gaps in existing paradigms of adult love. It

allows for the needs and emotions of partners in such relationships to be understood within a framework that has received strong empirical support. Attachment theorists postulate that humans are innately driven to develop and maintain strong affectional bonds to significant others (Bowlby, 1988). In couple relationships, secure attachments are represented by relationships that are reciprocal and affectionate, and where both partners feel close, safe and nurtured (Johnson, Makinen, & Millikin, 2001). Secure bonds are characterized by accessibility and responsiveness of partners towards each other. These secure bonds allow couples to help each other with the regulation of emotional distress.

EFT clinicians and researchers then envision the couple relationship as an attachment bond whereby distressed relationships are viewed as insecure bonds (Johnson et al., 1999). It has been suggested that these insecure bonds do not allow for the satisfaction of each partner's attachment needs for comfort, security and closeness, due to compelling negative emotional responses and constricted interactional patterns that arise and block emotional connection and engagement between partners. Thus the main focus of the EFT approach to couple therapy is on underlying emotional patterns, and on relational interactions with the goal of reorienting, resolving and transforming negative interactional patterns which will then allow for the fostering of a secure attachment between partners.

Emotionally Focused Therapy and CSA

The first extension of EFT to CSA can be found in Johnson (1989) which was a case study of a traumatized couple in which the female partner was a CSA survivor. In this case the traumatized woman requested couples therapy for relationship distress. This couples' therapy was integrated with individual therapy with the same primary therapist. In this early writing, Johnson did not directly attempt to understand trauma from within the EFT theoretical framework. She did, however, identify couple therapy as being a crucial

element in the healing process for CSA survivors given the significant interpersonal impairments evidenced by many survivors. Johnson suggests that these impairments would be primed and available for change within the couples' context. In addition, issues such as ambivalence about intimacy and emotional disclosure, feeling worthless and lacking trust in one's partner can lead to self-defeating relationship patterns which can be addressed directly in the relational context where they are enacted. Further, issues around sexual dysfunction and traumatic numbing secondary to intrusions and flashbacks, were also hypothesized to be important elements that could be more directly addressed in the couples' therapy context. As such, the EFT paradigm was used to directly address the effects of the CSA on both the individual and the relationship.

In a later presentation of EFT and CSA, Johnson et al. (1998) discussed another case study to illustrate the use of EFT in traumatized couples. This paper made a direct attempt to mesh the underlying theoretical foundations of EFT with trauma theory, and addressed avoidance, arousal and intrusive symptoms and their effects on relationship interactions. The authors indicated that trauma victims' marriages are more likely to develop distressing cycles of interactions which self-perpetuate distance, defense and distrust.

The individual treatment in the case study was offered to the CSA survivor through another therapist who was the referral source for the couples' therapy, and this therapy continued throughout the couples' therapy process. In this case study excerpt the wife was dealing with recovered memories of trauma accompanied by self-injury, severe affect dysregulation, avoidance, arousal and sexual avoidance. Her husband was feeling despondent and inadequate in the relationship, overwhelmed by her sudden shifts and his own apparent inability to do anything right. The process in the session described involved

reprocessing trauma-laden emotional responses within a relational context where the survivor partner was supported in asking for comfort from her partner. The authors suggested that the result of this experience was the expansion and restructuring of the couple's interactions around basic attachment needs (Johnson et al., 1998).

This conceptualization provided an example of an intervention which addressed the impact of the trauma on the survivor and the couple that was guided by a strong theoretical integration of trauma theory and couple therapy process. It addressed avoidance, arousal, and intrusive symptoms, attachment trauma and their effects on the relationship in a way that created a context and a safe haven for healing. The authors articulated that the nine steps of EFT paralleled the three stages of trauma treatment as identified by McCann and Pearlman (1990). These three stages divide the treatment of the trauma survivor into clearly defined sections. In the first stage, Stabilization, the survivor works to become stabilized enough to be an active participant in the therapeutic process. This includes decreasing tension reducing behaviours such as self-injury and substance abuse. The second stage, Building Self and Relational Capacities involves developing skills such as affect regulation and building new healthy coping mechanism for dealing with stressful situations. The survivor and therapist work on building trust in a working therapeutic relationship. Traumatic memories are processed in this stage and mastery of these memories enhances the building of self and relational capacities. The third stage, Integration, consolidates the new skills developed and integrates the traumatic material that has been processed into the survivor's self concept and autobiographical construction of self.

The first stage and four steps of EFT, De-escalation, parallel the stabilization stage of trauma treatment. The second stage, Changing Interactional Positions and can be viewed

as paralleling building self and relationship capacities. The third stage, Consolidation/Integration can be seen to parallel the integration phase of trauma treatment.

While this article provided a strong theoretical base for the extension of EFT to a trauma survivor, there has yet to be any empirical investigation of the use of EFT with CSA trauma survivors.

In a recent theoretical exploration of how EFT can be successfully applied to treatment of couples where one partner is dealing with CSA, Johnson (2002) theorized potential goals and processes of change for trauma focused EFT therapy with couples. Johnson suggested that the therapeutic process may create a holding environment. The goal of therapy would be to help clients increase the permeability and complexity of working models of attachment by revising them both cognitively and affectively on the basis of new information which is carefully choreographed within the therapeutic milieu. A more secure bond with a partner may create a safe haven that can help the CSA survivor regulate her grief, anger and fear in a positive self and relationship enhancing way. This safe haven with a partner helps the survivor deal with emotionally loaded re-experiencing symptoms such as nightmares, intrusive thoughts and flashbacks in a constructive way.

Echoes of past attachment relationships that create specific sensitivities in a present relationship would be acknowledged in therapy, but are not considered in a deterministic frame. Attachment styles, learned in past relationships, can be modified in new ones. Turning to one's partner for comfort then begins to replace other negative affect regulation strategies such as self-mutilation or dissociation. If the taming of fear is the most basic goal in the treatment of trauma (Foa, Hearst-Ikeda, & Perry, 1995), the natural inborn antidote to fear in primates is contact comfort (Bowlby, 1988). The availability of the spouse in the treatment process lessens the need for numbing and dissociation and allows

fear to be confronted. Spouses then become allies against the incursions of trauma rather than cues for traumatic memories and secondary victims.

Through EFT, it is argued that therapists assist couples in creating corrective emotional experiences where working models of attachment concerning others can be revised. The therapist directs the couple's attention to events that disconfirm old working models of attachment, blocks discounting attributions and tracks and clarifies how the partner is processing each element of the event. Beliefs about the responsiveness of others are challenged and the acceptance and reassurance of the partner increases the CSA survivor's sense of self worth. These new dialogues may allow working models to be updated and revised, and the facilitation of new cycles or behaviours will confirm these new expanded models. Once this safe base is established, the safety that has been achieved may facilitate the continued reprocessing and integration of traumatic experience. Affective states can be used as cues to attend to incoming information rather than alarm signals that prime hyper-arousal or numbing. Fight and flight responses are contained and the survivor becomes able to confide in and receive comfort from the partner. This process facilitates cognitive reorganization, and survivors can begin to find new meaning in traumatic events, integrate the acceptance of their partner who can legitimize and validate pain. This powerful process uses the partner as an ally in the healing.

This theoretical model of EFT for trauma survivors suggests that it will be necessary to take small steps, to focus the therapy process on helping the survivor to regulate affect, to provide more explicit direction in interactional tasks and to help facilitate new formulations of key emotional responses. The EFT therapist plays a pivotal role in this process; by choreographing interactions, supporting new ways of being in relationships and helping partners articulate their underlying attachment needs. EFT for trauma couples

is theorized to facilitate stability and safety through offering the couple the normative process of EFT with the addition of extensive psychoeducation about the nature of trauma and the role of trauma in the couple interactions. Additionally, Johnson proposes that EFT for trauma couples will require between 30 and 35 sessions of therapy.

Rationale for the Study

There is an increasing interest in the literature of the need for effective and time limited treatments for CSA survivors. Similarly, there is an increasing understanding of the pervasive interpersonal sequelae that hinder the ability of many CSA survivors in developing strong and healthy relationships. Consistently, survivors report higher levels of relationship distress and divorce and lower levels of intimacy and communication in their relationships. Additionally, since there is preliminary evidence that strong interpersonal relationships mediate the impact of CSA, it behooves clinicians to develop empirically validated treatments that address the interpersonal distress of CSA survivors.

Alexander (1992) suggested that if therapists fail to integrate a survivor's partner into the therapy process, the relationship distress and the failure of the partner to feel an integral part of the process may threaten any changes that might have begun in individual therapy. A therapy approach focused specifically on the sexual abuse misses much of the client's most pervasive experiences of loss, rejection, and abandonment experiences within the family. Therefore it was the goal of this study to explore the use of EFT with CSA survivors and their partners.

A central tenet of EFT for CSA survivors is that assisting the couple in the creation of a secure attachment bond in their relationship will assist the CSA survivor in dealing with her traumatic experience within the context of the relationship, and improve both her psychological functioning and the couple's satisfaction and security in their relationship.

The role of the partner in the treatment of CSA has historically been overlooked. It is the goal of this study to bring the partner in to the therapy process and assess the possible therapeutic benefits for both the survivor and the couple relationship.

METHOD

Research Strategy: Case Study Replication

In recent years there has been an insurgence of awareness that the nomothetic approach to psychotherapeutic research fails to address the intricacies of the process of therapeutic change. Although treatment efficacy can be confirmed through comparative treatment outcome studies, the ability of these studies to detect and clarify the constructs upon which the treatment are based are limited (Jones, 1993). It was the goal of this study to explore the extension of EFT to CSA couples through intense analyses of clinical cases and to understand the process of the EFT model with CSA couples. Specific themes that arose in the treatment of couple distress in EFT for CSA survivors were identified through a thematic analysis and the modifications of the application of the EFT model were observed qualitatively.

Thematic analysis is a qualitative methodology which can be utilized to organize clinical data into patterns with the goal of eventually developing theories or models for change (Taylor & Bogdan, 1984). A basic approach to a thematic analysis modified to be applicable to the audio-taped sessions of couple therapy can be performed in four steps. The first step in a thematic analysis is to develop a coding framework which is guided by the theoretical approach and research questions. The second step in this process is to identify basic themes which are lower-order themes that can be derived from the clinical material. An example of a basic theme would be issues of clinical focus related to sexual intimacy such as pleasure, sharing, understanding, partnership and communication. The

third step in this process is to organize these basic themes into a global theme. An example of a global theme related to the previous examples of basic themes would be “sexual companionship brings enjoyment of pleasurable sensations” (Attride-Stirling, 1999). Following the organization of global themes researchers can begin to build theories and models of change.

As this was the first systematic study of couples’ therapy for CSA survivors and, in particular, the use of EFT with these couples, it was important that an exploratory stance be taken to allow for a broad base of discovery. The original EFT is a short-term therapy of approximately 15 to 20 sessions in community clinical practice but is theorized to take up to 35 sessions in traumatized couples. Previous EFT research studies have been able to demonstrate treatment efficacy in approximately half the number of recommended sessions due to the high level of supervision, focus and the incisive treatment offered by highly trained EFT therapists (Johnson, 1996). Based on these past studies utilizing abbreviated treatment length it was determined that a maximum of 20 sessions would be offered to couples with the option of having more sessions if required and the therapist was available. Given the exploratory nature of this study and the qualitative foci of the analyses, it was determined a priori that a sample size of 10 couples would be sufficient. Similarly, based on findings from one of the original EFT studies indicated that 8 sessions was the minimum number of sessions in which treatment efficacy could be demonstrated it was determined a priori that if a couple completed a minimum of eight sessions they would be included in analyses (Johnson & Greenberg, 1985).

Particular measures were implemented to minimize the threats to internal validity that can accompany qualitative methodology (Kazdin, 1981). To fully explore the use of EFT with CSA survivors, the use of case study replication methodology was necessary.

The same case study protocol in a replication series of cases, each of which was designed to provide data on outcome and on the pattern and process of change associated with the treatment, was utilized. Various authors have listed recommendations that will decrease the threats to internal validity when using case study methodology. Based on these recommendations, specific hypotheses were developed to guide the investigation. Data was gathered at specifically identified intervals in a systematic fashion. An assessment was carried out before, throughout and after treatment using clear, objective, psychometrically valid and sensitive measures collected systematically from baseline (Hayes, 1981; Kazdin, 1981). All sessions in the study were audio-taped, all therapists were supervised by the principle originator of EFT and a well conceptualized and easily authenticated treatment manual was followed (Johnson, 1996; Moras, Telfer, & Barlow, 1993). Additionally, EFT has been demarcated clearly and implementation checks were carried out.

Factors that support the ability of a researcher to draw causal influences from results of a study also guided the analyses. These included assessing the degree of change relative to the chronicity and resistance of the clinical problem being treated. As CSA sequelae are often chronic and resistant to change (Herman, 1992), the ability to infer that clinical change was related to EFT was heightened. When change is slow or resistant in a particular population, improvement supports the efficacy of the treatment because it counters what is expected (Kazdin, 1981). Clinically significant change then, was defined based on the concept of the reliable change index, where the former factors are taken into consideration and a clinically significant cut off is set based on an a priori determination (Jacobson & Truax, 1991). Given the chronicity of trauma symptoms, and based on clinically significant change markers suggested by the authors of the measures being utilized, clinically significant change was defined as an improvement or deterioration of

one standard deviation, or a change that led to movement out of the clinical range on a measure. Immediacy and magnitude of change also assisted in determining whether or not EFT caused the change. External validity of single case research depends on systematic replications of effects in many clients and as such ten couples were selected for inclusion in this study.

Hypotheses

Outcome

The first set of hypotheses was designed to examine whether the treatment process had an effect on the outcome measures. It was predicted that there would be the following post-treatment effects:

1) It was hypothesized that survivors of child sexual abuse and their partners in EFT would display a clinically significant increase in levels of relationship satisfaction from pre-test to post-test as measured by the Dyadic Adjustment Scale (DAS, Spanier, 1976).

2) It was hypothesized that survivors of child sexual abuse would display a clinically significant decrease in traumatic symptomatology from pre-test to post-test as measured by the Traumatic Stress Inventory (TSI, Briere, 1995) and the Clinician Administered PTSD Scale (CAPS) .

3) It was hypothesized that survivors of child sexual abuse in EFT would display a decrease of anxiety and avoidance dimensional scores on the attachment measure (ECR-R, Brennan, Clark & Shaver, 1998).

Process

As this was the first study of any couples therapy with CSA survivors, exploratory qualitative analyses were performed on key sessions. Key sessions were identified by couples on the Post Session Resolution Questionnaire (PSRQ) and these ratings were confirmed by therapists. Interactions were coded using psychometrically validated clinical coding instruments the Structural Analysis of Social Behaviour (SASB) and the Experiencing Scale (ES).

Based on previous clinical studies it was predicted that the two couples with the greatest amount of change in their relationship satisfaction as measured by the Dyadic Adjustment Scale (Spanier, 1976), would reveal higher levels of experiencing as measured by the Experiencing Scale, and more autonomous and affiliative interactions as measured by the SASB, than the two couples with the least amount of change as measured by the Dyadic Adjustment Scale (Johnson & Greenberg, 1985; Johnson & Greenberg, 1988).

Thematic Analysis

A purely exploratory stance was taken to discover the experience of CSA survivors and their partners in this first systematic exploration of EFT therapy. Thus no specific hypotheses were generated. These exploratory observations were analyzed thematically on a case by case basis through case study replication.

Participants

The 10 couples in this study were recruited through advertisements in local media and posters placed at the offices of therapists and community agencies that described the research project. These posters and advertisements indicated that a research project examining the effectiveness of couples' therapy for CSA survivors and their partners was being undertaken, and that selected participants would have an opportunity to engage in

therapy free of charge. All respondents were screened using a standardized telephone screening procedure (see Appendix A for media advertisement and the telephone screening procedure). In selecting the pool of participants for this study, couples were required to meet the following inclusion criteria:

- The couple must have been living together for at least one year.
- Homosexual or heterosexual couples were welcome with no more than a ratio of 2 in 10 given the representation in the population.
- One partner reported an experience of child sexual abuse defined as unwanted sexual touch before the age of 18 by a person more than two years older than the child.
- There was no self-reported physical violence in the relationship.
- Neither partner self-reported having drug or alcohol problems.
- Neither partner self-reported current and active suicidal or self-injurious thoughts.
- The CSA survivor partner met criteria for PTSD on the CAPS.
- Average couple score on the Dyadic Adjustment Scale (DAS) had to be in the mild to severely distressed range (i.e. scores between 70 and 97).

Therapists and Setting

A total of seven therapists were involved in this research. All received training in EFT at the Centre for Psychological Services (CPS) of the University of Ottawa or at the Ottawa Couple and Family Institute. Two of these therapists were senior level practicum students in clinical psychology and one was a clinical psychology intern at CPS at the University of Ottawa. The remaining four therapists were members of the Ottawa Couple

and Family Institute and included one clinical psychologist in supervised practice, one clinical psychologist in independent practice and two licensed social workers. Therapy sessions were conducted at CPS which is an APA accredited doctoral training facility providing psychological services to the Ottawa community or at the Ottawa Couple and Family Institute. The therapists received weekly supervision by Dr. Sue Johnson, who is an academic faculty member at the University of Ottawa, the director of the Ottawa Couple & Family Institute, and one of the originators of EFT. All of the therapists offered their services on a voluntary basis.

Measures

Process Measures

These measures were selected on the basis of their utility to analyze change processes qualitatively within couples (Johnson et al., 1988).

Structural Analysis of Social Behaviour (SASB, Benjamin, 1974). The SASB codes behaviour from an interpersonal perspective. It is based on a circumplex model of interaction. Each interaction is rated on two independent axes. The horizontal axis is an affiliation scale, and the vertical axis is an interdependence scale. Combinations of these two axes encompass a wide range of behaviours. The axes divide the space into four quadrants numbered 1 to 4 based on descriptions of behaviour. Affiliation (measured by the horizontal axis) intersects with autonomy (measured by the vertical axis) and combinations of these two axes represent a full range of behaviours.

The measure provides two interpersonal grids. "Other" is the label of the first grid and focuses on the behaviour of one person towards the other. "Self" is the label of the second grid and focuses on the responses that are to, for, or about the self. This measure will be used to code specific interactional segments as identified by the therapist to measure

the changing quality of interaction between the couples. The author has reported high inter-rater reliability and has yielded kappas between .70 and .85 for difficult material containing multiple and complex messages (Benjamin, 1974).

The Experiencing Scale (ES, Escobar et al., 1983). The ES is a 7-point rating scale that measures in-session levels of emotional engagement and is very sensitive to changes in the couple's involvement in therapy. Moving up the scale, there is a gradual progression from superficial, interpersonal self-references to simple, limited, or externalized self-references, to a synthesis of newly emerged feelings and new awareness that leads to problem solving and better self-understanding.

The validity of the scale has been supported by its correlation with client variables such as introspectiveness and cognitive complexity (Klein, Mathieu, Kiesler, & Gendlin, 1969; Klein, Mathieu-Coughlan, & Kiesler, 1986). The scale has been used to predict client change, especially in client-centered therapy (Orlinsky & Howard, 1986). The scale has been shown to be highly reliable in terms of measuring client involvement or "experiencing" in therapy (Greenberg & Foerster, 1996). Inter-rater reliability coefficients from several studies were in the high .80s and .90s.

Rater Selection and Training

Two graduate students from the department of psychology were selected to rate the process data utilizing the process measures. All raters were trained EFT therapists and were able to demonstrate facility in correctly identifying the specific components of the process of change in EFT. They also received formal training on the SASB and the ES.

Outcome Measures

These measures were selected for their psychometric validity, clinical sensitivity and ease of comparison to other studies assessing the process and outcome of EFT.

Post Session Resolution Questionnaire (PSRQ, Orlinsky & Howard, 1975). The PSRQ measures levels of in-session change as reported by the couple. This measure was utilized to identify best sessions as rated by the couples. This questionnaire was adapted from the Therapy Session Report questionnaire, and consists of three 5-point and one 7-point session evaluation scale (Orlinsky & Howard, 1975). Couples report on how resolved they feel they are in relation to the particular issues that brought them into therapy. The questionnaire has face validity and has been used in previous studies to successfully identify best sessions (Greenberg et al., 1996; Greenberg, Ford, Alden, & Johnson, 1993). The first scale asks the couple to identify whether the issue dealt with in the session was related to the issue identified at the beginning of therapy. The remaining three scales are grouped together to derive a single PSRQ change score. High scores are indicative of no change and low scores are indicative of high levels of change.

The Dyadic Adjustment Scale (DAS, Spanier, 1976). The DAS is a widely used self report index of global couple adjustment. Recent studies confirm the validity of the DAS as a measure of couple adjustment (Eddy, Heyman, & Weiss, 1991). The measure contains four subscales: Consensus, Satisfaction, Cohesion and Affectional Expression. A reliability of .96 (Cronbach's alpha) has been reported by the author (Spanier, 1976). A Likert-type scale of 5-6 points is used to assess agreements and frequency of events.

Content validity was assessed by comparing the relevance of each item to contemporary relationships, its consistency with nominal definitions of adjustment and its components (i.e. satisfaction, cohesion and consensus) and its careful wording with the fixed choice responses. Criterion-related validity was established by assessing the difference of each item with the external criterion of marital status (divorced vs. married couples). On the total score, divorced and married couples differed significantly ($p < .001$).

Factor analysis was performed to ensure construct validity and by correlating the scale with the Locke-Wallace Marital Adjustment Scale, which was one of the most frequently used scales. Correlations between these scales were .86 for married and .89 for divorced respondents.

The DAS is scored by summing the weights of each fixed response. The scale score has a theoretical range of 0-151. Higher scores are associated with less distress and better adjustment. The mean total scale scores were 114.8 for happily married couples and 70.7 for divorced couples. The distress cut-off point for 97 has been set at one standard deviation below the mean for the married sample (Spanier, 1976).

Trauma Measures. Two measures of traumatic sequelae were selected to provide a high level of validity to the assessment of clinical change in trauma symptoms. The Trauma Symptom Inventory is a self-report measure of trauma symptomatology while the Clinician Administered PTSD Scale is a structured clinical interview designed to yield a diagnosis of PTSD. It was hypothesized that these two measures with different foci and administration would complement and support each other to provide a well-rounded picture of the clinical change in trauma symptoms.

Trauma Symptom Inventory (TSI, Briere, 1995). The TSI is a test of psychological functioning which contains 100 items that measure posttraumatic stress and other psychological sequelae of traumatic events. It was devised to be used in the assessment of acute and chronic traumatic symptomatology, following traumas such as rape, physical assault, spouse abuse, major accidents, combat trauma, natural disasters and the enduring effects of childhood abuse and early childhood trauma (Briere et al., 1995). Higher scores are indicative of greater distress and a T-score greater than 50 is considered to be in the

distressed range and a T- score greater than 60 is considered clinically distressed. Critical items identify self-harming tendencies and suicidal ideation.

The TSI has 3 validity scales and 10 clinical scales that assess a broad range of psychological symptoms including those related to Posttraumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD), plus intra and interpersonal difficulties associated with chronic psychological trauma. The test is self-administered and is intended for a fifth grade and above reading level (Briere, Elliott, Harris, & Cotman, 1995). Items are scored on a four point scale with 0 = Never through to 3 = Often, and are rated in terms of frequency of occurrence over the previous six months.

Reliability of the validity scales range from .51- .80 and for the clinical scales .82-.91. These scales include validity scales: Response level (RL), Atypical Response (ATR), Inconsistent Response (INC), and Clinical Scales: Anxious Arousal (AA), Depression (D), Anger/Irritability (AI), Intrusive Experiences (IE), Defensive Avoidance (DA), Dissociation (DIS), Sexual Concerns (SC), Dysfunctional Sexual Behaviour (DSB), Impaired Self-Reference (ISR) and Tension Reduction Behaviour (TRB).

Briere (1995) states that the mean intercorrelations of the 10 clinical scales for the TSI are internally consistent with mean alpha coefficients of .86 for the standardization (N=836), .87 for the clinical (N=370), .84 for the university (N=279), and .85 for the military samples (N=3659). Runtz and Roche (1999) in their study of a group of 775 previously victimized Canadian university women calculated internal consistency reliabilities for the clinical scales of the TSI. They found that the TSI internal consistency is strong as all reliabilities were above alpha = .80, except for TRB. Convergent and discriminant validity were assessed through comparing scales on the TSI to scales measuring similar constructs in other measures (Briere et al., 1995).

The Clinician Administered PTSD Scale (CAPS, Blake et al., 1990). The CAPS addresses the 17 core symptoms of PTSD that comprise the DSM-IV diagnosis. Further questions assess symptoms that are not in the formal PTSD diagnosis, as well as the influence of these symptoms in interpersonal and work-related domains. Separate ratings of frequency and intensity for each symptom are made on 5-point (0-to-4) scales with precise example comparisons to capitalize on standardization and consistency between interviews. Both past-month and lifetime presence of the disorder are measured. Higher scores are indicative of greater distress. The most conservative clinical cut-off set by researchers is 65 with a standard deviation of 17 (Blake et al., 1990).

The CAPS has been extensively validated psychometrically. Blake et al. (1990) reported that test-retest reliability ranged from .90 to .98, and internal consistency was .94. Criterion validity was achieved through comparisons with the SCID. Sensitivity was found to be high at .84, as was specificity at .95. Convergent validity was also demonstrated by a strong correlation between the CAPS-1 total severity score and scores on the Mississippi Scale for combat related PTSD ($r=.91$) and the MMPI K scale ($r=.77$) (Blake et al., 1990). High inter-rater reliability in clinical samples has been reported with ranges from .90-.97 (Blake et al., 1990; Weather, Ruscio, & Keane, 1999).

Experiences in Close Relationships-Revised (ECR-R, Brennan, Clark, & Shaver, 1998). The ECR-R is a 36-item attachment measure. The items are derived from a factor analysis of 60 constructs derived from 482 items extracted from most of the existing self-report measures of attachment. The measure can be used to measure attachment along two attachment dimensions; avoidance and anxiety. Each question is scored on a 7 item Likert scale. Results yield scores on both dimensions: avoidance and anxiety and can be conceptualized in terms of the four attachment styles: secure, preoccupied, fearful-avoidant

and dismissing-avoidant. Because this measure yields scores that are continuous on both dimensions, it is more sensitive to change than measures that yield categorical results. It also provides a higher level of statistical power which is essential with such a small sample size. Reliability of the items on both dimensions is high, with alphas of .94 for the avoidance dimensions and .91 for the anxiety dimension.

Implementation Check

Two procedures were carried out to ensure that the EFT interventions stipulated in the treatment manual were implemented consistently. A checklist of therapist interventions used in previous studies was used to assess adherence to treatment guidelines (Dandeneau et al., 1994; Gordon Walker, Johnson, Manion, & Cloutier, 1996). First, the supervisor reviewed segments of therapy sessions played during group supervision to monitor that the therapists were implementing the model faithfully. Secondly, the researcher audited all therapy sessions with a full checklist of EFT therapist interventions and assessed the degree of adherence to the model. It was established a priori that therapy sessions would be representative of EFT if 75% of therapist statements could be coded on the checklist.

Clinical Procedures

Telephone Screening

Couples who responded to advertisements in local media and community agencies by telephoning the EFT research lab were provided with a description of a free program of therapy for couples, where one partner was a CSA survivor and the couple was in distress. The researcher screened interested couples by telephone to assess whether they met the initial criteria. Verbal informed consent was provided to both partners prior to asking the prospective participants the screening questions. Couples that met the inclusion criteria

were invited to an intake interview with the researcher at the University of Ottawa EFT research laboratory to complete the intake questionnaires and for the CSA survivor to complete the CAPS interview.

Intake Interview

The researcher conducted all of the intake interviews. These interviews took approximately two hours. During this interview, procedures for the study were described, the limits of confidentiality were reviewed and each prospective participant signed a consent form (see Appendix A). The process of maintaining the confidentiality of their clinical information was explained to couples and they were given an opportunity to ask questions about the process of participating in the study. At the end of this interview couples expressed their ongoing interest in participating in the study and were informed that they would be contacted following the scoring of the measures to notify them of their eligibility to participate in the study.

Assessment

During the intake session, both partners were asked to complete a questionnaire package including a demographic questionnaire, the Dyadic Adjustment Scale (DAS), the Experiences in Close Relationships Scale (ECR-R) and the Trauma Symptom Inventory (TSI). Couples completed pre-therapy questionnaires at the intake session as a part of the initial screening procedure. Additionally, the CSA survivor partner participated in the CAPS interview.

Assessment measures were scored following this interview given the lengthy process of scoring the CAPS interview. Couples who did not meet the inclusion criteria were informed that they did not meet the requirements for the study. These couples were given a list of community resources for couple therapy (see Appendix A). Couples meeting

all of the inclusion criteria were informed by telephone that they would be contacted by a therapist and offered up to 20 sessions of EFT couple therapy.

Treatment

The couples participating in this study received an average of 19 sessions of EFT with a focus on understanding the role of the history of CSA on the survivor and the couple relationship and resolving relationship distress. At the end of each of the sessions, both partners were asked to complete the PSRQ.

Exit Interview

After the final session couples were invited to return to the EFT research laboratory to complete the DAS, ECR-R, and TSI again. CSA survivor partners were asked to complete the CAPS interview within two weeks of terminating therapy. Post-treatment interviews were also conducted to obtain couples' perspectives on how EFT helped the couple deal with the effects of CSA in the life of the survivor and in the couple relationship (see Appendix D). The exit interviews for members of Couples 9 and 15 who terminated their relationships over the course of therapy, were held individually at the suggestion of the therapists, and for the comfort of the participants to openly discuss their experience in therapy and the resulting end of their relationships.

All post-treatment exit interviews were conducted by the principal researcher with the exception of two couples. These two couples were those for whom the researcher was the therapist. A clinical psychology intern carried out these interviews to ensure that couples felt comfortable discussing their positive and negative impressions of the therapy process.

Plan of Analyses

Outcome Measures

Clinically significant change was defined as having been achieved if either of the following conditions were met: a) the self-reported rating of scores on the variables of interest fell within the scores of the non-clinical population as defined by the measurement authors or b) the self-reported rating of scores increased in the direction of functionality by more than one standard deviation. This approach to qualitative analysis of clinical outcome data is known as the reliable change index (Jacobson et al., 1991). Hypothesis one was considered supported if the CSA survivor and partner's DAS scores increased beyond one standard deviation (16 points) which was articulated by the author to represent a clinically significant decrease in couple distress (Spanier, 1976). Hypothesis one was also considered supported if couples' DAS scores increased to above the cut-off for distressed relationships (98).

Hypothesis two was considered to be supported if a clinically significant decrease of traumatic symptomatology was reported in CSA survivor's pre and post scores on the TSI or the CAPS. Clinically significant decreases on the TSI were defined as decreases of greater than one standard deviation (10 points) in T scores. Clinically significant decreases on the CAPS were defined as decreases of greater than one standard deviation (17) or movement into the non-clinical range (<65).

Hypothesis three was considered to be supported if CSA survivors decreased their self-reported levels of attachment related anxiety and avoidance on the ECR-R more than one standard deviation (1.19 anxiety, 1.33 avoidance) (Fraley, Waller, & Brennan, 2000).

Process Measures

As this was the first study of any couples therapy with CSA survivors, exploratory qualitative analyses were performed on key sessions. The two couples who demonstrated the greatest amount of change on the DAS were compared to the two couples who demonstrated the least amount of change or greatest deterioration to allow for the highest level of differentiation between positive and neutral or negative outcomes. One baseline session and one key session was analyzed for each couple. Key sessions were identified by the couples on the PSRQ and interactions were coded using psychometrically validated clinical coding instruments. Based on previous clinical studies, it was predicted that the two couples with the greatest amount of change in their relationship satisfaction as measured by the Dyadic Adjustment Scale, would reveal higher levels of experiencing as measured by the Experiencing Scale, and more affiliative interactions as measured by the Structural Analysis of Social Behaviour than the two couples with the least amount of change as measured by the Dyadic Adjustment Scale (Johnson et al., 1985; Johnson et al., 1988).

Selection of Transcripts for Rating

Participant identification of key sessions for the analysis of change processes was identified by scores on the PSRQ. A post-session rating of 5 or above on the 7-point resolution subscale of the PSRQ was considered a key session. The researcher reviewed the taped sessions and indicated segments of significance during which a softening event had taken place or been attempted and received verification of this assessment from the assigned therapist. These segments were then transcribed and analyzed with the SASB and ES.

Case Study Replication: Thematic Analysis

Thematic analysis was chosen as one approach to understanding the therapy process of CSA couples and their partners because of the exploratory nature of this study, and the dearth of existent systematically reviewed studies of any couple therapy with CSA survivors. As such, a purely exploratory stance was taken to discover the experience of CSA survivors and their partners in EFT therapy.

In line with the case study methodology the thematic analysis began with the onset of treatment of the first couple. The researcher was the therapist for this first couple and basic themes were identified throughout the course of the therapy through supervision and review of the audio tapes following therapy sessions. A basic theme was identified if it appeared to be a factor related to trauma sequelae which was observed to have an impact on the CSA survivor's ability to fully engage in the EFT process. Additionally, the process of EFT was observed and compared to the normative EFT model to provide further articulation and clarification of EFT.

At the end of therapy for each couple, the researcher reviewed all audio tapes for these themes using a coding sheet developed following the identification of basic themes for couple one. This coding sheet was adapted again following the review of the tapes for the second couple with the inclusion of two previously unidentified themes. No further basic themes were identified following this second couple. Tapes were reviewed to identify a case by case replication of the presence, absence and nature of the identified themes.

Segments of five randomly selected tapes were reviewed by two independent raters to ensure agreement of the themes.

Data Analyses

All statistical analyses were carried out using the SPSS 12 statistical software package. The preliminary analyses included demographic characteristics, clinical characteristics and the psychometric properties of the measures. Descriptive statistics were provided for all variables and reliability analyses were conducted using Chronbach's coefficient alpha.

RESULTS

Preliminary Analyses

Descriptive Characteristics

Ten couples completed the treatment study. Twenty two couples responded to the recruitment campaign. Of these, twelve couples met the full inclusion criteria and were invited to participate in the study. One couple was referred to a community trauma treatment centre for pro-bono services as the CSA survivor in this couple had not disclosed during the initial assessment that she had been diagnosed with Dissociative Identity Disorder. During the first therapy session her level of dissociative switching and affect dysregulation were too severe to allow for active participation in a couple therapy process. One couple attended four sessions over a period of four months, decided to terminate their relationship and withdrew from the study. The remaining ten couples completed an average of 19 sessions, completed the pre- and post-treatment questionnaire packages and were included in the current analyses. A total of 190 therapy sessions were carried out over the course of one calendar year. The range of the number of therapy sessions ranged from eleven to twenty six.

Demographic characteristics

All of the CSA survivors were female. The average age of the CSA survivor partners was 40.50 with a range of 22 to 58. The average age of the non-CSA partners was 43.00 with a range of 23 to 60. Couples had been together for an average of 14.90 years with a range of 2 to 37 years. The average number of children per couple was 1.5 with a range of 0 to 2. Family Incomes ranged from \$10,000 to \$100,000. The range of educational levels of the CSA survivor partners was from grade 12 or less to a Community

College Diploma. The range of educational levels in the non-CSA partners was from grade 12 or less to a Bachelor's Degree. Table 1 summarizes the demographic characteristics.

Table 1

Means, Range and Standard Deviations for the Couples on Demographic Variables at Pre-Treatment

Variable	Mean	Range	Standard Deviation
Age of CSA Partner	40.50	22-58	11.78
Age of Non-CSA Partner	43.00	23-60	11.36
Years Together	14.90	2-37	13.57
Number of Children	1.50	0-2	.71
Family Income	4.00	2-5	1.05
Level of Education (CSA)	3.60	2-4	.84
Level of Education (non-CSA)	3.30	2-5	1.34

n = 10 couples

Psychometric Properties of the Measures

Preliminary analyses were conducted to test the assumptions regarding the reliability of the self-report measures. Cronbach's Coefficient Alpha, an estimate of internal consistency, was used to calculate the reliability of the total scales. The sample consisted of all 20 participants and was conducted on pre and post-treatment scores for the Dyadic Adjustment Scale (DAS), the Experiences in Close Relationships Revised (ECR-R) and the Trauma Symptom Inventory (TSI).

As seen in Table 2 the reliability coefficients for the self-report measures ranged from .74 to .90. These reliability coefficients are comparable to those reported for these measures in the research literature.

Table 2

Reliability Statistics for Self-Report Measures at Pre-treatment and Post-treatment

Measure	Pre-treatment	Post-treatment
DAS	.74	.85
ECR-R	.88	.76
TSI	.94	.92

n = 20 Note: DAS = Dyadic Adjustment Scale, ECR-R = Experiences in Close Relationships, TSI = Trauma Symptom Inventory

Data Screening

Prior to computerized analyses, the data file was visually examined to ensure the accuracy of data entry. For four of the ten couples, each item of the questionnaires (pre- and post-treatment) was compared to the computerized data file. There were very few occurrences where the value differed from the value on the questionnaire. No data was missing for any of the couples on any of the measures.

Given that each couple served as their own control in the assessment of clinically significant change, it was not necessary to statistically assess for pre-treatment differences between those couples who reported positive versus negligible or negative change. These differences were assessed qualitatively in comparing process to outcome. Additionally, due to the qualitative nature of the analysis of the reliable change index of the outcomes, the data was not assessed for univariate or multivariate assumptions.

CSA Trauma

The original focus of this research was to explore the use of EFT with CSA survivor couples where the couples were dealing with trauma in only one partner, and that partner was experiencing the impact of that trauma in the form of simple PTSD. This was assessed utilizing the TSI and the CAPS. However, the majority of the CSA participants had experienced severe, chronic and intrafamilial sexual abuse. In fact, based on their clinical profiles, eight of the ten CSA survivors' sequelae might have been more aptly understood within the framework of Complex PTSD (1, 5, 7, 9, 13, 15, 16, 18). Three of the CSA survivors experienced sexual abuse by multiple intrafamilial perpetrators at an early age (1, 9, 14). For the CSA partner in Couple 1, the sexual trauma was inflicted upon her by many of her older male siblings and her father. Additionally there was severe neglect, maternal and sibling mental illness and alcohol abuse by her father and a number of her siblings. In the CSA partner in Couple 14 there was also severe sexual abuse by her father and her older male siblings. Additionally, this CSA survivor became pregnant by her father and had an extremely traumatic birthing that was not attended by medical professionals and which was followed by the death of her baby from complications. The CSA survivor in Couple 9 experienced repeated sexual abuse prior to the age of four, with the addition of severe neglect and physical abuse. This survivor was repeatedly locked in cupboards and forced to protect her younger siblings from beatings when she was only four or five years old. Following this, she was apprehended by child protection services and placed in a home where she experienced emotional deprivation.

For six of the CSA survivors (5, 7, 13, 15, 16, 18), the sexual abuse was severe, chronic and perpetrated by their fathers. All of these women reported that they could not remember when the abuse began, but that it ended at some point during their adolescent

years, except for the CSA survivor in Couple 16 whose father continued to violate her sexually until he died when she was well into adulthood.

For one CSA survivor (6) the sexual abuse was a one time rape when she was in early adolescence. She was not believed by her family or friends when she disclosed the assault to them. This was the only survivor participant who did not have a history of severe, chronic and developmentally early sexual abuse.

Prior Individual Therapy in CSA Survivors

The majority of the CSA survivors in this study had received some form of individual therapy prior to beginning their couple treatment. Four of the CSA survivors (7, 13, 14 & 18) had each received over ten years of therapy in total. This ranged from ten to twenty-seven years. Three CSA survivors (1, 6, & 9) had undergone between one and two years of individual therapy and two CSA survivors (5 & 16) had begun individual therapy at the start of the study but dropped out of this therapy over the course of the couple treatment. One CSA survivor (15) had not received any prior individual treatment.

The modalities described by these women could be characterized as primarily insight oriented, supportive psychotherapy. Two women in the study reported that they had been receiving Eye Movement Desensitization Reprogramming (EMDR) therapy. One woman had received hypnotherapy and three reported that they had participated in groups as an adjunct to their individual therapy at some point. One woman reported that she had received a behavioural treatment designed to teach her stress management techniques such as breathing and relaxation.

Trauma in non-CSA partner

The aim of this study was to explore the use of EFT in couples where one partner was a survivor of early trauma. However as therapy progressed it became clear that five of

the non-CSA partners had experienced difficulty life events that they defined as traumas (1, 5, 7, 13, 14). The non-CSA partner in Couple 1 reportedly experienced physical and emotional abuse during childhood, was physically abused by her first romantic partner and then witnessed the tragic death of her two-year old son when his stroller was crushed by a delivery truck that went up onto the curb. The non-CSA partner in Couple 5 reported that he was physically and emotionally abused by his alcoholic father who was unpredictably violent and humiliating. The non-CSA partner in Couple 7 was abandoned by his mother at the age of twelve. As a young adult his fiancé broke up with him by leaving the engagement ring on his desk without an explanation. He reportedly attempted suicide following this loss and has continued to feel shame and grief about these incidents. This partner did not ever disclose this loss to his partner through the therapy process, even though his partner had already been told about this suicide attempt by a family friend. The non-CSA partner in Couple 14 was abandoned by his mother at age eight and was subsequently and regularly beaten at school. Additionally, his first wife had an affair with his best friend. The non-CSA partner in Couple 13 indicated that his father was an emotionally cold alcoholic. Additionally, he reported that his CSA survivor partner frequently rose violently from nightmares and would cover his face with a pillow until he would be able to push her away and fully awaken her. Five of the non-CSA partners did not disclose any trauma over the course of therapy (6, 9, 15, 16 & 18).

Prior Individual Therapy in Non-CSA Partners

Two of the non-CSA partners had received individual therapy (1 & 18). The non-CSA partner in Couple 1 had been receiving individual therapy to process traumatic experiences from childhood, and was continuing in this therapy throughout the couple therapy process. The non-CSA partner in Couple 18 had been receiving individual therapy

for approximately one year to help him deal with distress related to his relationship difficulties.

Outcome Hypotheses

Relationship Satisfaction

It was hypothesized that survivors of child sexual abuse and their partners in EFT would display a clinically significant increase in levels of relationship satisfaction from pre to post-treatment as measured by the Dyadic Adjustment Scale (DAS, Spanier, 1976).

Relationship Satisfaction was measured by the DAS (Spanier, 1976). Clinical change in relationship satisfaction was determined by comparing partners' change scores from before and after therapy with the normative standard deviation of 16. Increases or decreases in DAS scores of greater than one standard deviation were pre-determined to indicate clinically significant change. In partial support of the prediction, half of the couples (6, 7, 14, 16 & 18) reported clinically significant improvements in mean relationship satisfaction on the DAS from pre to post-treatment. The overall mean relationship satisfaction for the CSA survivor sample rounded to the nearest whole number was 78 at pre-treatment and 94 at post-treatment which represents an overall improvement in relationship satisfaction of one standard deviation and would then represent clinically significant change for the overall sample of survivors.

Individual scores reflected further changes in relationship satisfaction. Half of the CSA survivors (6, 7, 14, 16, 18) reported clinically significant improvement from pre to post-treatment. Three non-CSA partners (6, 14, 18) reported clinically significant improvement in relationship satisfaction. One CSA survivor (1) had a change in score that exceeded the clinical cut off. Additionally, two further non-CSA partners (7 & 16) reported a change in score that moved past the clinical cut off of 98.

Three couples terminated their relationships over the course of therapy. Two CSA survivors (9, 15) reported clinically significant deterioration in relationship satisfaction on the DAS over the course of therapy. Couple 5 did not report clinically significant mean deterioration but the CSA partner evidenced a significant deterioration in her reported relationship satisfaction. Over the course of therapy both of the non-CSA male partners in Couple 9 and 15 became increasingly emotionally abusive. The male partner in these couples responded to the process of identifying underlying emotions and attachment needs with emotionally abusive behaviour towards their partners and, in some instances towards the therapists. In Couple 5, the CSA survivor partner developed a high level of anger and verbal aggression towards her partner over the course of the therapy process in response to efforts to access underlying emotions, which did not diminish with treatment. The emotionally abusive behaviours of these partners were not evident or reported at the time of intake, and would have been considered a contraindication for EFT. All three of these couples terminated their relationship after ending therapy. Table 3 summarizes these findings.

Trauma Symptoms

It was hypothesized that survivors of child sexual abuse would display a clinically significant decrease in traumatic symptomatology from pre to post-treatment as measured by the Traumatic Stress Inventory (TSI, Briere, 1995) and the Clinician Administered PTSD Scale (CAPS).

One measure of trauma symptoms was the Trauma Symptom Inventory (TSI, Briere, 1995). Clinical change in TSI trauma symptoms was determined by comparing partners' change scores over the course of therapy with the normative standard deviation of 10. Increases or decreases of greater than one standard deviation were pre-determined to

indicate clinically significant change. Partially supporting the prediction of change, half of the CSA survivors reported clinically significant improvement from pre to post-treatment (5, 6, 7, 9, 13). The mean overall TSI scores for the CSA survivors rounded to the nearest whole number was 66 at pre-treatment and 58 at post-treatment. This represented an improvement of 8 points for the total sample, 2 points lower than our a priori determined cut-off for clinical significance. A summary of individual scores both at pre and post-treatment can be found in Table 3.

Trauma symptom change was also measured by the CAPS. Clinically significant change in CAPS trauma symptoms was determined by comparing partners' change scores over the course of therapy with the standard deviation of 17. Increases or decreases of greater than one standard deviation or, no longer meeting the cut-off for a diagnosis of PTSD (>65), were pre-determined to indicate clinically significant change. Supporting the prediction of change, all of the CSA survivors reported clinically significant improvement from pre to post-treatment. Nine of the survivors' CAPS ratings decreased by more than 17 points and eight of the CSA survivors no longer met criteria for PTSD at the end of the study, encompassing all of the CSA survivors between the two definitions of change. The mean CAPS scores for CSA survivors at pre-treatment was 83 and this mean decreased to 46 at post-treatment representing a mean improvement in the sample of 37 points; greater than two standard deviations of positive change in trauma symptoms. A summary of individual scores both at pre and post-treatment can be found in Table 4.

Table 3

Clinical Change on Relationship Satisfaction and Trauma Symptom Inventory at Pre-treatment and Post-treatment

Couple Number	Partner Number	Relationship Satisfaction			Trauma Symptoms		
		T1	T2	DIF	T1	T2	DIF
1	1	90	89	1	52	53	-1
	2	90	104	14*			
	x	90	96.5	6.5			
5	1	83	83	0	74	56	-18*
	2	92	62	-30**			
	x	87.5	72.5	-15			
6	1	95	127	32**	70	58	-12*
	2	69	107	38**			
	x	82	117	35**			
7	1	97	108	11*	75	61	-14*
	2	80	107	27**			
	x	88.5	107.5	19**			
9	1	97	97	0	77	67	-10*
	2	63	42	21**			
	x	80	69.5	-10.5*			
13	1	88	96	8	64	49	-15*
	2	81	93	12			
	x	84.5	94.5	10			
14	1	83	137	54**	50	44	-6
	2	60	112	52**			
	x	71.5	124.5	53.0			
15	1	110	102	-8	73	72	-1
	2	84	76	-8			
	x	97	89	-8			
16	1	90	100	10*	55	52	-3
	2	99	133	34**			
	x	94.5	116.5	21.5**			
18	1	79	106	27**	69	65	-4
	2	61	100	39**			
	x	70	103	33**			

x = couple mean. Relationship Satisfaction (DAS): ** = clinically significant means change over normative sd of 16.00; * = clinically significant change over normative clinical cutoff (<98) or in to the divorce range (>70). Trauma Symptoms (TSI): * = clinically significant change over the normative sd of 10.

Partner 1 = Non-CSA, Partner 2 = CSA Survivor.

Table 4
Clinical Change on Clinician Administered Posttraumatic Stress Scale (CAPS) in CSA Survivors at Pre- and Post-treatment

Couple Number	Time 1 CAPS	Time 2 Caps	Difference
1	83	44	39*
5	100	66	34*
6	87	51	36*
7	67	21	46*
9	90	67	23*
13	98	48	50*
14	66	19	47*
15	89	50	34*
16	76	24	52*
18	80	64	16*

n = 10. * = clinically significant change over diagnostic cut-off (65) or greater than one sd of 17.

Attachment

It was hypothesized that survivors of child sexual abuse in EFT would display a clinically significant decrease of anxiety and avoidance dimensional scores on the attachment measure (ECR-R, Brennan, Clark & Shaver, 1998).

Attachment was measured by the Experiences in Close Relationships-Revised (ECR-R). Clinically significant change on attachment was determined by comparing partners' change scores from before and after therapy with the normative standard deviation (1.19 anxiety, 1.33 avoidance). Increases or decreases of attachment scores of greater than

one standard deviation were pre-determined to indicate clinically significant change. Two CSA survivor partners (6, 14) displayed a clinically significant decrease in attachment avoidance over the course of therapy. One non-CSA partner (6) demonstrated a clinically significant decrease in attachment related anxiety from pre to post-treatment providing minimal support for the prediction of change. The change scores for all participants on the ECR-R can be found in Table 5.

Table 5

Change in Attachment Dimensions from Pre to Post-treatment

Couple	Partner	Attachment Anxiety			Attachment Avoidance		
		T1	T2	DIF	T1	T2	DIF
1	1	4.44	4.11	0.33	2.06	2.06	0.00
	2	4.61	4.83	-0.22	1.83	1.44	0.38
5	1	5.00	5.22	-0.22	2.11	2.06	0.06
	2	3.44	4.44	-1.00	4.56	4.39	0.17
6	1	2.50	1.22	1.28*	2.22	1.78	0.44
	2	4.94	5.44	-0.50	4.28	2.78	1.50*
7	1	3.33	4.06	-0.72	1.83	2.44	-0.61
	2	3.61	2.83	0.78	5.78	5.00	0.78
9	1	1.44	1.56	-0.11	2.00	2.28	-0.28
	2	5.56	5.44	0.11	3.39	4.22	-0.83
13	1	4.11	4.39	-0.28	2.72	3.44	-0.72
	2	4.33	3.94	0.39	4.17	3.78	0.39
14	1	4.78	4.39	0.39	1.83	1.61	0.22
	2	2.50	1.67	0.83	4.06	2.22	1.83*
15	1	1.72	1.56	0.17	2.11	1.39	0.72
	2	4.35	4.06	0.30	4.72	4.33	0.39
16	1	2.50	1.83	0.67	3.44	3.50	-0.06
	2	2.28	2.67	-0.39	2.44	1.33	1.11
18	1	3.56	2.44	1.11	3.50	2.50	1.00
	2	6.22	5.22	1.00	4.22	3.28	0.94

Normative SD: Avoidance 1.33 Anxiety 1.19 * = clinically significant change over the normative SD

Partner 1 = Non-CSA; Partner 2 = CSA Survivor

Process Hypotheses

The Process of Change in Best Sessions

It was predicted that the two couples with the greatest amount of change in their relationship satisfaction as measured by the Dyadic Adjustment Scale (Spanier, 1976), would reveal higher levels of experiencing as measured by the Experiencing Scale and more affiliative interactions as measured by the Structural Analysis of Social Behaviour than the two couples with the least amount of change as measured by the Dyadic Adjustment Scale (Johnson et al., 1985; Johnson et al., 1988).

To test the hypothesis related to the process of change, the Structural Analysis of Social Behaviour (SASB) and the Experiencing Scales (ES) were used. Every utterance in a ten-minute segment, ten minutes in to the first session and from the beginning to the end of an attempted softening in a client-rated best session on the PSRQ, was rated on the ES and the two focus dimensions and four quadrants of the SASB for comparison from pre to post-treatment and between couples. Couples 6 and 14 showed the greatest positive change on relationship satisfaction. However, given that three couples showed deterioration in satisfaction over the course of the therapy, this hypothesis was tested utilizing Couples 5 and 9 who were the two couples who showed the greatest negative change in satisfaction over the course of the therapy.

Two trained independent raters coded a total of 222 utterances each. There was very little divergence between raters. Coding on the ES was analyzed for inter rater reliability and yielded a kappa of .865 ($p < .001$). Coding on the SASB was analyzed by focus and quadrant and yielded kappas of .978 ($p < .001$) and .931 ($p < .001$) respectively.

First Session Differences

Mean SASB and ES ratings at pre-treatment were compared between the two greatest positive change couples and the two greatest negative change couples. These were assessed to determine if there were any differences between these two groups of couples at the beginning of the EFT process. There was a mean frequency difference on sulking and appeasing, affirming and understanding, belittling and blaming and ignoring and neglecting. The greatest positive change couples exhibited higher levels of affirming and understanding, belittling and blaming, and ignoring and neglecting. The greatest negative change couples exhibited more sulking and appeasing. Thus, these couples may have been different from each other at pre-treatment. In particular, it is possible that while the two couples that demonstrated the greatest positive change were those who appeared to be exhibiting higher levels of both positive and negative interactions, this may have represented a pre-treatment difference in the ability to express and experience a broader range of emotion in their interactions.

There were no noticeable differences on the mean ES ratings or the range of ES ratings in the marker sessions.

Post-treatment Differences

Mean SASB and ES ratings at post-treatment were compared between the two greatest positive change couples and the two greatest negative change couples. These were assessed to test the prediction that couples showing the greatest level of positive change would reveal higher levels of experiencing as measured by the Experiencing Scale and more affiliative interactions as measured by the Structural Analysis of Social Behaviour. In support of the prediction, the greatest positive change couples had a higher level of mean experiencing in the best session and had a peak ES rating that was twice that of the greatest

negative change couples. On the SASB the greatest positive change couples evidenced higher affiliative ratings (Disclose & Express, Trusting & Relying and Helping & Protecting) than both themselves at pre-treatment and the greatest negative change couples at post-treatment. The greatest negative change couples evidenced higher hostile responses (Walling off & Avoiding, Belittling & Blaming) than both themselves at pre-treatment and the greatest positive change couples at post-treatment. These findings are summarized in Table 6.

Table 6

Pre-treatment to Post-treatment Mean Response Frequencies for the Greatest Positive Change and Greatest Negative Change Couples on the Process Measures

Response Categories	Greatest Positive Change		Greatest Negative Change	
	Pre	Post	Pre	Post
Disclose & Express (SASB)	7.5	14.5	8.5	3.0
Trusting & Relying	3.9	5.5	2.0	2.0
Sulking & Appeasing	5.0	1.5	8.5	1.5
Walling of & Avoiding	6.5	1.5	6.0	6.5
Affirm & Understand	0.5	0.5	3.0	1.5
Helping & Protecting	1.5	3.0	0.5	0.5
Belittling & Blaming	5.5	3.0	2.9	7.5
Ignoring & Neglecting	0.0	1.0	2.5	1.0
Level of Experiencing (ES)	2.47	2.96	2.36	1.9
Range ES	1-4	1-6	1-4	1-3

Note: Disclose & Express Needs (2-1), Trusting & Relying (2-4), Sulking & Appeasing (2-3), Walling of & Avoiding (2-2), Affirm & Understand (1-1), Helping & Protecting (1-4), Belittling & Blaming (1-3), Ignoring & Neglecting (1-2)

ES High Experiencing = ≥ 4 .

Thematic Analysis

A purely observational stance was taken for the thematic analyses. Identified basic themes were organized based on how trauma appeared to have impacted upon a survivor's capacity to be an active and engaged partner in EFT therapy. A number of these basic themes were cross-referenced due to reciprocal connections. A number of these basic themes were present in the non-CSA traumatized partner or were amplified by the presence of trauma in both partners in the couple. Basic themes were organized into global themes and will be presented here. For consistency in transcribed segments of sessions "Tx" will refer to the therapist, "CSA" will refer to the CSA partner and "P" will refer to the non-CSA partner. Because of the small sample size any disclosing material has been altered to protect participants' confidentiality.

Affect Regulation Difficulties

The predominant group of global themes was related to challenges with regulating affect, in particular, within therapy sessions.

Emotional Flooding: *Feelings are dangerous and overwhelming*

Nine of the CSA survivors (1, 5, 6, 7, 13, 15, 16, 18) and four of the non-CSA trauma partners (1, 5, 7, 14) evidenced significant emotional flooding in sessions which had an impact on their ability to actively participate in the EFT process. The global theme that emerged was that feelings were dangerous and overwhelming. Survivors repeatedly indicated that they could not tolerate, regulate or accept their emotions.

These trauma survivors were easily triggered by their partners' discourse about relational issues, and their dysregulation frequently derailed the EFT process due to the necessity to stop processing work to contain the survivor's affect. Additionally, these survivors were challenged to put their own affect on hold to engage in the process of EFT

within sessions, in particular when their partner was directed to reach out to them and ask them to help in meeting a relational goal or attachment need.

Essentially, these survivors both demonstrated and acknowledged that their ability to process affectively laden material was compromised by their dysregulated affect. The quotations below illustrate the basic themes identified by CSA partners' as their subjective experience of this phenomenon.

It's internal madness, I can't control myself. I am stuck and can't control my emotions. They are so intense and I lose my ability to understand and I can't connect my feelings to my thoughts. I am afraid that that part of me will just take over the world.

I can't talk about my feelings and think at the same time.

It feels like cerebral abandonment!

The wounded child takes over from the capable adult and I just fire at him.

I get so angry that I just sizzle. I just can't think, my mind gets crazy and I can't remember anything. We argue and I don't even know what it is about.

Emotional Numbing: *I can't let myself feel; I will lose control.*

On the opposite side of affective dysregulation that leads to overwhelming states of affect, was the emergent global theme of emotional numbing as a result of fearing emotional overwhelm and loss of control. Emotional numbing and over control was characteristic of many trauma survivors' responses to emotionally challenging situations in the therapy. Numbing was differentiated from dissociation in the thematic analysis.

Dissociation was coded if the response or way of being described memory loss, identity distortion or experiences that could be classified as depersonalization or derealization.

Many of the survivors in the study experienced emotion in sessions in an all or nothing way being either dysregulated and flooded with affect or numbed out and not present. Eight of the CSA partners (1, 6, 7, 9, 14, 15, 16, 18) evidenced substantial numbing of affect in

therapy sessions. The only CSA survivor who evidenced severe hyperarousal who did not also evidence numbing was from Couple 5; the only CSA survivor who exhibited her dominant affect as anger rather than shame. Examples of quotations that illustrate basic themes of the survivors' experiences of numbing follow.

I'm afraid of letting myself feel anything. I will turn into a little child and be overwhelmed with this feeling of shame and fear.

I'm protecting myself from my own emotions. Being sad or angry won't accomplish anything.

If I actually let go I would lose control and hurt someone. I won't be able to regain control of myself. When I get anxious I feel like I'm going to die. I just can't let myself feel.

In Couples 9 and 15 who ended their relationship over the course of therapy, the therapy began with substantial and intractable numbing in the CSA survivor partner. As the therapy went along and the therapist continued to draw them out and support them in staying present emotionally in the sessions, their partners became emotionally abusive towards them both in and out of the therapy sessions. This emotional abuse was not reported or evident in the intake process, but both survivors acknowledged in the exit interviews that their partners had not been kind or supportive throughout their relationships, but that they had tolerated this due to not feeling entitled or worthy of love and caring. The therapy process supported the CSA partner in bringing down a veil of emotional numbing that had likely served a protective purpose for them in their relationships. When both survivors became less numb they were able to acknowledge the abuse and left the relationships. Therapists addressed the emotionally abusive behaviour in sessions by placing limitations on the attacking partners. In Couples 9 and 15 the therapist supported the survivors in terminating therapy.

In the exit interview the CSA partner from Couple 9 indicated that seeing her husband be rude, contemptuous and hostile towards the therapist woke her up to what she was living with. She indicated that it was hard for her to see that how he was treating her was not because of her damage and worthlessness, but when she saw the well educated and very kind therapist being treated the same way, this helped her make a change in her life.

In six couples (1, 6, 7, 14, 16, 18) where numbing was a substantial issue for the CSA partner and who reported having made gains in therapy, a developmental process occurred over the course of therapy that was similar to that of the changes that were observed in hyperarousal and affective flooding in some positive change couples. By approximately the half-way mark in the therapy, the CSA survivors had begun to take risks in sharing their fear of becoming emotionally overwhelmed and that they were managing through numbing. Therapists coached their partners to respond in soothing and supportive ways. Non-CSA partners were also coached in identifying when their partners were numbing and to check in with them. Couples began to learn how to support their partner in regulating their affect. Non-CSA partners were supported in moving forward towards their traumatized partner and drawing them back into the relationship. These non-CSA partners expressed a sense of empowerment and capability to help their CSA survivor partners that had been absent in their experience in the relationship before the therapy. These findings suggest that this global theme may also be amenable to clinical change over the course of therapy.

Dissociation: *I just can't stay here.*

In six couples (1, 5, 6, 7, 9, 14) the CSA survivor partners evidenced clinically relevant dissociative symptoms in the therapy and a global theme was organized from the basic themes of the CSA survivor's unwillingness, fear of and stated inability to stay

present in emotionally challenging situations. In all of these cases, the dissociation of the CSA partner had been occurring over the course of the relationship, and was intricately tied in to the negative interaction cycle in which the couple had become entrenched. This phenomenon will be discussed further under the heading Trauma in the Cycle.

Examples of quotations that illustrate the CSA survivor's experience of dissociative disconnection and escape follow.

I go to a place where I lose myself and I can't hold on to the part of myself that is grounded and healthy, I just go away and I can't get myself out of it.

I feel guilty that I just shut if off. I should be able to conquer it and stay present.

I just can't stop it when it happens, I lose touch of myself. I lose my voice, I can't speak. I can't tell him how afraid I am.

Examples of quotations that illustrate the basic themes related to the non-CSA partner's experience of their partner's dissociation follow.

She seems to go so numb and just disappear. I don't get any feedback on what I am saying. It's like she's on cloud 10; she's never around.

I can't get to her. She isn't really present emotionally, I don't feel her there and...I don't trust her.

In Couple 14 the CSA partner disclosed over the course of therapy that she had been treated over many years of therapy for a dissociative disorder. While she had developed a strong sense of self and had a clear understanding of her internal self system through her own ongoing therapy, this phenomenon did play a role in how the therapy was structured and added additional elements for the couple to work with. In particular this CSA survivor had multiple experiences of her partner especially when he was angry or when they were being sexual. She had an internal self state that was very young and who responded to

situations by becoming fearful and withdrawn. A quotation that illustrates this experience follows.

Sally is just very young, under 10. She is very vulnerable and went away during the abuse and now she feels like she has to go away with P because of how angry and pokey he gets. When she is gone I just can't feel present and connected and she is missing the time that I used to spend with her.

On two occasions during therapy, this younger self state came into the therapy sessions. The CSA survivor partner switched into this younger self state in response to two difficult discussions regarding how to negotiate sexual touch in the relationship, and how to give her enough time to communicate with her inner child self state such that she could go away during sex to avoid retraumatization. Additionally, her partner's ongoing disavowal of the degree of his unspoken anger in the relationship was challenging for this inner self state to tolerate. The CSA survivor was able to report to the therapist that she was "sitting with Sally" and to continue to process in the session. She stated in a small voice:

CSA: I have to run away from anger... (she curls up and looks very little), P scares me when he gets that angry look on his face. People hurt you when they are angry.

P: I'm not going to hurt you, I promise.

CSA: (huddling in her chair) When you get that angry face I get scared. Everyone wants to hurt L (adult part). I have to run away. I can't watch.

Tx: Do you believe P when he says he's not going to hurt you?

CSA: I know that P is not going to hurt me but he scares me.

Five additional CSA survivor partners (1, 5, 7, 9, 13) made reference to child-like internal states of feeling, or to other parts of themselves that were experienced internally but which were not as delineated and separate as the fragmented self state of the CSA partner in Couple 14.

Over the course of therapy CSA survivors evidenced lower levels of reported dissociation outside of sessions and observed dissociation within sessions. Therapists needed to slow down the process to assist the survivor in staying present in the same way as the affective hyperarousal was managed. Additionally, therapists continued to draw survivors out of their dissociative withdrawal, overtly monitored them for their degree of presence in session, and used explicit grounding techniques such as breathing, focusing and kinesthetic awareness exercises. Partners were coached to help their partners when they were threatening to dissociate, in the same ways as with the emotional numbing. These observations suggested once again that this global theme might be amenable to clinical change over the course of treatment.

Constricted Range of Affect and Affect Dysregulation

In session, the expression of needs and relational distress by the non-CSA partner was observed to trigger affect dysregulation in CSA survivor partners. In particular, it was apparent in both the CSA trauma survivors and the non-CSA trauma survivor partners that they had one particular affective state that was dominant, unregulated and tied to their trauma. The two global themes related to affective constriction were associated with dominance of shame and anger. This dominant affect would arise regardless of the content or affective tone of the discussion and be highly dysregulated, appearing as an overwhelming flood of feeling. This constricted range of affect and dysregulation derailed the EFT process in that communication between partners was halted, and processing needed to stop for containment of the trauma survivor's affect. Additionally, the affect did not match the current context of the therapy thus resulting in a failure of empathy and lack of attunement to the partner and potentiating their negative interactional cycle. Over the course of the therapy it became clear that this dominant affect was tied to the trauma. For

instance a number of the CSA survivors had been shamed and humiliated by their abusers, taught that they were damaged. Any need or desire was somehow bad and shameful. Thus, in situations requiring them to respond to their partner's unmet need or state a need of their own, they became flooded with shameful thoughts and feelings rather than simply responding to the stated need in the present situation.

Shame: *I am damaged and unlovable.*

Shame was the most prominent dominant affect, with six of the CSA partners and two of the non-CSA trauma partners evidencing the tendency to become immediately flooded with shameful thoughts and feelings in response to any emotional trigger (CSA: 1, 6, 7, 13, 14, 15, 16, 18; non-CSA trauma: 5). The global theme that emerged was one of survivors feeling that their damage and woundedness rendered them culpable for relationship distress and unlovable. At the beginning of therapy affect in these trauma survivors was constricted and dysregulated such that trauma survivors were either flooded with intense shame or numbed and disconnected in sessions.

The quotations that follow illustrate the basic theme of the tenacity and overwhelming nature of the experience of shame, and how these partners experienced the relationship distress as being their fault.

It's all about me. I try to hold back my feelings and needs. It's me. I don't have normal responses and needs. I'm too much. I'm too fucked up and can't have a normal relationship. Why can't I get it right?

I don't want him to have to suffer because of my problems. He has a right to me because I married him. I'm not good enough. I'm a burden. There is something wrong with me. I should be over this by now. He does so much already. I don't want to ask him for more.

I am expected to fail. I am dumb. I can't do it. Every time I leave here I realize that I am wrong, that I am mean. I've never measured up to what it takes to be in a family.

My head tells me it's not my fault but my heart knows that I'm a freak. He's going to find someone who's not so damaged. If he really sees me...I'm abnormal. If I reveal my feelings he will see how abnormal and damaged I am.

This shame was pervasive and went beyond an affective experience and into a way of defining the self. There was a sense from these partners that they were somehow permanently damaged and unfixable. The following quotations illustrate the basic theme of the self defining nature of the shame experienced by these partners.

I will never have a healthy relationship no matter how much therapy I have.

I am damaged goods and it's never going to be enough so what's the point.

It's hard to believe that it's possible to fix this. I should be able to put this behind me but I just can't. Maybe I will never be happy so I should be alone.

This experience of shame was accentuated by 7 non-CSA partners (1, 6, 7, 9, 13, 15, 16) who tended to make blaming and shaming statements and beliefs. The quotations below are taken from early sessions and demonstrate the reinforcing impact of the basic theme of the partners' beliefs that the CSA survivor is to blame for their relationship problems or that they are in some way worthy of shame.

It's hard to have an emotional relationship with someone who's not there. I want to be held and cared for. I don't want anymore of this. She is simply not available. I don't see all of the changes she says she has made.

You are obviously not over it if you find that difficult!

Before we can heal our relationship she needs to get over her own stuff. I don't feel good about how she is dealing with her issues. She is overly concerned with herself and obviously has not gotten over her experiences.

You solve your problems and come back then I'll let you know if I'm still interested. Until you came along my life was stable. It's your problem. It's your past.

The clinical implications of this global theme for partners who evidenced shame as the dominant affect at the beginning of therapy was that sessions were often stilted and slow and frequent pauses in the process were required to allow for restabilization,

containment and for the therapist to focus on the survivor to help her process some of her shameful ideations in the context of the present.

A key intervention in EFT is the heightening of affect and the supporting of partners in expressing underlying attachment needs through enactments. An enactment is a directed intervention which occurs when the therapist asks a partner to turn to their partner to tell them about a relational need, fear or past trauma. They are designed to assist the receiving partner in attending to their partner's experience in the relationship on an affective and attachment level, and to help engage this partner in a different, more compassionate, mutual stance. Neither of these techniques were successful in these couples in early sessions due to the tendency of the shamed trauma survivor to become easily flooded and derail the unfolding in session process. Attempts to heighten affect as a method of accessing emotions underlying the couples' negative interaction cycles frequently failed due to the tendency of the trauma survivor to become flooded with shame in response to their own or their partner's distress.

It was common in early sessions for therapists to coach couples towards enactments three or more times with each one being blocked by the trauma survivor's flooding with shame. These enactments needed to be stopped. The therapist then needed to help the survivor contain their affect so that the focus of the therapy was shifted from the process, to affect containment strategies.

The following is a transcript example of this theme from a session with a couple that was not able to maintain de-escalation between sessions. The CSA survivor is talking about her experience of feeling left out of her partner's family life with her step-son.

CSA: She treats me like that sometimes, like I'm in the way.

Tx: It feels like there is a theme there of feeling like you aren't important, that you always feel second to someone else or something else.

CSA: Yeah, I think that I'm realizing it now, I've not really understood it for years.

Tx: You're realizing that that is something you have felt?

CSA: I think I am only feeling it now somehow, like I'm feeling like...and that's why my reaction to it is to try to close myself down and protect myself.

Tx: So you're sort of starting to understand things that have been bothering you for a long time and starting to see some of the deeper issues.

CSA: Yeah,

Tx: And you're closing in to yourself. (lowers voice, slows down) "I'm not going to show P how I feel because that's just going to make it worse or that's just going to make her more upset or send her farther away from me".

CSA: It really upsets me. I feel really...what's the point...you can not, you know (starting to cry). I can't get through. I can't.

Tx: What can't you get through?

CSA: I just want to be a part of what's going on in the family.

Tx: Can you tell her that? "I want to feel important; I want to feel like I am a part of the family".

CSA: (long pause, turns away from partner, crying) It's hard. I mean, I feel really...

Tx: Just that little bit, just turn to P and tell her how important it is for you to feel like you are a part of things in your family.

CSA: (long pause) I need...I don't know why it's so hard. I feel like it's over the top.

Tx: What's over the top? Feeling that you want to be important and special in your family?

CSA: Yeah I guess. It's too much. I'm asking for too much.

Tx: It's too much to ask...I've heard P say to you, "I want you to come in, I want you to be with me, I want you to be a part of this family, I want you to help me".

CSA: (sobbing) But I don't do it right, I don't do it right, I don't get it.

Tx: What don't you do right?

CSA: I don't do the things that she wants me to do right. I don't ... (still sobbing).

Tx: It sounds like it's really hard for you to even try to learn how to be important and to believe that P really does want you.

CSA: Yeah (some calming)

Tx: Can you tell P how hard it is for you to believe?

CSA: (long pause)

Tx: What would happen if you let yourself look at P right now? Just look at her and let her see you. Just a little bit. Keep breathing, it's okay. What does it feel like to let her see you just a little bit.

CSA: It's ...it's so hard.

Tx: Can you tell P how hard it is to let her see you? How hard it is for you to let her in.

CSA: I don't know. Just sometimes I don't feel like I have a life. I don't have a centre. I don't have a family. I try to have my own life. I want to be a part of their life but I don't know how to do it...I don't know (sobbing).

Tx: What happens inside when you think about letting yourself stop watching and taking the risk to join in the dance in your family?

CSA: (shaking head) I just don't feel like I measure up.

Tx: You're not good enough...

CSA: I can't do everything the way that they want me to.

Tx: I just can't do it the way that you want me to do it...

CSA: Yeah. I feel confused. I feel like I want to do it but I don't understand why things are so hard and why I just can't figure it out. Why is everything so much work?

Tx: Sometimes it just feels really hard.

CSA: I don't understand why I'm always the person who's just...seems to be a strain on the family. Everything seems to work well for them when I am not there. They have their own ways and when I come along I just wreak havoc (sobbing).

In this example the therapist attempted to direct the CSA survivor in to an enactment where she could express her fear of being unimportant and her need to be included, to her partner. On each attempt, the survivor turned away from her partner, started to sob and became more dysregulated with shameful affect. This was characteristic of early enactments directed from the CSA partner to the non-CSA partner. You will notice that in this transcript segment the non-CSA survivor did not participate at all. This was characteristic of early sessions with these couples where the majority of time in sessions was spent focused on the CSA survivor and coaching interactions as the therapist attempted to help the CSA survivor contain her overwhelming affect. In fact, within the context of this session, the CSA survivor partner was expressing her distress about her partner not wanting her to be a part of the family when, in fact, the non-CSA partner had repeatedly invited her to participate in the family. The reality that presented itself at a later point in therapy was that the CSA partner simply could not tolerate taking the risk to try to engage in a family.

In enactments directed from the non-CSA partner to the CSA survivor the CSA survivors responded similarly, in that they did not respond to their partner's actual statement or request, but instead began expounding upon their shamefulness and the fact that all of the couple's problems were a result of their woundedness. Again, therapists needed to stop the processing in the session and attend to helping the survivor to contain their affect, resulting in the disregard of the non-CSA partner's vulnerability and risk taking in turning to their partner, and the re-focusing of the session on to the CSA partner.

Over the course of therapy, four of the CSA partners (1,6,13, 14) who evidenced this pattern of dominant shameful affect slowly began to demonstrate higher levels of affect regulation. They became more able to put their own feelings on hold to listen to their

partners' needs. Similarly they began to voice lower levels of shameful, self-blaming statements. Additionally, they demonstrated an expanded range and decreased rigidity of affective expression, moving from primarily experiencing shame to experiencing a broad array of primary affective states which were more responsive to the actual content and context of the emotional experience in the moment. They began to be able to identify primary affect underlying the shame that was appropriate to the clinical and relational context. Further, these partners exhibited a greater differentiation of past from present in their emotional responding. As such, this global theme may be amenable to positive clinical change.

The quotations below illustrate statements that demonstrate an intermediate level of differentiation of affect and decreased shame, as the participant began to question the automatic assumption of shame and started to separate the past from the present.

I am not what this child tells me I am. I can listen to that voice and talk back to it.

I'm still feeling damaged but I am beginning to be able to talk about what's bothering me...my fears, and you just listen.

It's not all my fault that things are bad. I don't want to be blamed for P's drinking. I'm tired of being blamed.

The following is a transcript from session 17 with the same couple featured in the first transcript where the trauma survivor partner was able to more fully engage in the EFT therapy process, to make space for her partner and respond to the content and context of the therapy session and her partner in the present. They are discussing the same issue of non-CSA partner's desire to have the CSA partner be an active participant in parenting and family life. The CSA partner is able to talk about how triggering her step-son, is based on her experiences of being sexually abused by her teenaged siblings. Additionally, she continues to be challenged to believe that her partner is there for her.

Tx: What do you need for the dream that you have for the future to happen?

P: I feel like if I say that, I am asking for change. I would love for her to trust in us, in my son, to spend time with us and to enjoy being with us.

Tx: Can you tell her that?

P: I would love for you to just be with us, to love my son.

CSA: I know you want that from me. I find it so hard to be with him because it feels scary and out of control to be with a teenaged boy being with you or to think about playing. I don't know how to play. Playing was not even a possibility when I was growing up but...I want to be there for you and your son.

P: She has told me that I am only 60% there so I am...

Tx: How much of you is there?

P: As much as I have and as much as I can give.

Tx: Can you tell her that?

P: I'm here, I'm here for us, for you and for our family. I feel like I'm here as much as I can be...there's nothing on reserve. We're having problems so we aren't having as much sexual intimacy as you might want but...

CSA: Around the intimacy issue, you've said to me...

Tx: Let's just go back because P is saying, "I'm giving you everything I've got; all that I can give in terms of my love for you". Not the sexual issues but..."I love you as much as I am capable of loving you". What part of you heard that or couldn't hear that and needed to move somewhere else? Can you let it in, how does it feel?

CSA: (pause) Some part of me doesn't believe. The part that's been hurt. But I know that the rest of me could believe. The rest of me does believe that P is loving me with a deep love and that she does want to be together but I still have a hard time being around her son and that makes her feel like I don't love her. Part of her doesn't believe me because she would say, how can you love me that much but you can't be with my son? Another part of me feels that she does deserve me trying harder.

In this segment the CSA survivor was able to tolerate her partner's request to join with her in parenting and the intimation that she was not currently meeting that need. Further she was able to differentiate a statement of need from a statement of her worth, and identify emotions underlying her response to the triggering situation. She demonstrated an

ability to receive her partner, to make space for her partner and to understand her own responses to relational challenges. While she did attempt to change the focus of the unfolding discourse from the family to their sexual relationship, she did not become dysregulated in response to the therapist's attempts to keep the focus.

Over the course of therapy for five couples (5, 7, 9, 15, 16), this phenomenon did not occur. For Couple 7, as the therapy progressed the CSA survivor partner became re-engaged in the relationship and began to respond to her non-CSA traumatized partner's needs and fears. However, through the therapy process, the non-CSA traumatized partner began to evidence high levels of distress related to recounting his own traumatic experiences, and this level of distress derailed the re-engagement and expanded emotional experience that had begun to develop in the CSA survivor partner. She began to withdraw and became unable to respond to her partner's needs. The therapy process was terminated before this couple was able to move through this phase of the process. In Couple 16 this process also did not occur. Over the course of therapy with this couple it became more and more evident that the CSA survivor partner was struggling with a significant impairment in short-term memory and insight, possibly related to the impact of trauma on her cognitive capacity. This impeded the couple's progress through EFT over and above this theme and would also have required a longer therapy process to work through these challenges.

For Couples 9 and 15, the likely reason for the absence of this developmental phenomenon was related to increasing levels of emotionally abusive behaviour by the male partners both in and out of therapy sessions, which did not allow for enough safety in the relationship or in sessions for this to occur. These couples terminated their relationships.

Anger: *You will never prove to me that I can trust you; I must shut you out.*

Anger was the second dominant affect demonstrating affective constriction in one of the CSA partners and two non-CSA trauma partners who used anger as the principal response to any affectively triggering stimuli (CSA: 5; non-CSA trauma: 7, & 14). The global theme that emerged from these couples was related to blocking new relationship experiences with the belief that the partner could never prove themselves trustworthy or safe and, thus, the CSA survivor must shut out her partner to protect herself. For the non-CSA partner in Couple 14, a similar process as described above under the Shame theme where expanded affective responding and regulation developed and unfolded over the course of therapy occurred. For Couple 7 in the non-CSA trauma partner this process began and was derailed, likely for the reasons listed above related to the CSA partner's emotional withdrawal from the process. In Couple 5 this process did not occur and this couple terminated their relationship at the end of therapy. In fact, this CSA survivor was not able to even begin the process of delineating the past from the present in therapy and continued to see her partner as a danger to herself and her daughter. In these partners, anger was the dominant response to any request or statement of distress. These three partners were members of dual trauma couples and the process of increasing the range and modulation of affect over the course of therapy either happened in both partners (14), or neither partner (7 & 5). The following quotations illustrate some basic themes.

How long will it take for her to be thinking about the both of us?

I'm not stupid; I know what's going on.

That's a stupid question. I'm not going to ask her that. If you want to know the answer to that, you ask her.

I've got to take care of our daughter and you've got to take care of your sons. I've never needed anyone and I certainly don't need you. You are just like my father.

In all of these couples their traumatized partner experienced this anger as very triggering. In Couple 14 this anger could trigger dissociated regression to early traumatic experiences in the CSA survivor partner. The CSA survivor's child-like internal self state was extremely frightened by this anger. This issue will be discussed under the theme of Dissociation. This non-CSA partner did not acknowledge his anger. The anger had to be contained and this partner had to come to understand the impact of his anger on his partner before any processing could proceed.

Anger played a similar role to shame in early sessions. Enactments were blocked or derailed and the angry partner could not respond to the present content and context of the therapy. An example from a transcript from a session late in Stage One follows. This couple is talking about how the CSA partner's anger pushes the non-CSA trauma partner away. In this case the non-CSA trauma partner has been withdrawn in the relationship. He experienced severe emotional and physical abuse in childhood and had withdrawn to cope with his partner's frequently escalating anger and attacks. He has begun to reengage and the therapist is trying to help her tell him about how difficult it is to let go of her hypervigilance, and to support him in telling her about how he feels attacked and afraid of her anger in their relationship.

Tx: Even as you talk about it, the image I have is that you go into separate rooms.

CSA: I just don't trust his judgment. Until I see all the facts I'm not willing to believe anything.

Tx: So are you saying, "I wish I could trust you but I just can't do that right now". Is that what you are saying?

CSA: well...yes, not completely,

Tx: Can you just say that to him, "I wish I could trust you but I can't do that right now".

CSA: (flippantly, in an angry tone) I wish I could trust you but I can't completely do that right now.

Tx: I can't do that right now, hmm,

CSA: (voice softens slightly) I can't hold it, not completely,

Tx: It's so hard for you to trust that he will be there when he needs you.

CSA: Another perfect example was the...(rising tone)

Tx: (lowers voice, slows down) Just stay there, just stay with the trust part. "I can't really be certain that you will be there for me when I need you".

CSA: No, right. And I don't think...it's just your character...(attacking)

Tx: (lowers voice again, speaks slowly) I think we're talking about your experience here. It's that it's so hard for you to trust. I know there have been things in the marriage but there have been a whole lot of things that have shown you that he wants to be there for you. It seems that when things are hard it is especially difficult for you to trust him and you get triggered into the...I just can't trust...

CSA: Life is not the way he sees it. I look at reality and he looks at the dream. So, I've got to look at reality to make up for him.

Tx: What happens to you P when you hear that CSA can't trust you?

P: It's frustrating, you know, how can I get that trust? How can I get that faith from her that I am here with her looking at the details.

CSA: (attacking) Everyone has faults, mine are my moods you know, well I look at it that one of his faults is that he doesn't plan well enough. Like the Bell bill, you know, I don't know if it's a lack of trust...I'm just more careful and he just doesn't think about reality.

Tx: How does it feel P, to hear her say that.

P: I just let it go, there's no point, it's just going to drag me down...

CSA: (attacking) because it's reality.

Tx: What's happening, P?

CSA: I'm getting squashed, it's frustrating to get shoved in the corner over and over again. It's hard to be told over and over that I'm not good enough, that I'm a bad boy.

Tx: That you're bad?

CSA: Who said you were a bad boy? I never said that.

P: Well for wanting to have things that you think we shouldn't.

CSA: I never said that.

Tx: I think that's what he is feeling when you say..."remember that time, remember that time", he was being pushed into the corner. I can't fight it, it's too hard.

P: Well...I wish she would stop fighting against me.

Tx: Can you say that to her?

P: I don't know...I've been put in this place so many times where I am wrong, I don't know how to feel. I've gotten away from running away but I don't know how to do this over and over. I wish you would stop fighting against me.

CSA: That is not the situation. We agreed that it was a misunderstanding.

Tx: We don't have to go back, we can just stay here in this moment. You are telling P that he is wrong to feel the way he does, that his experience is wrong.

CSA: How did I do that?

Tx: You just said, "we agreed that no one was wrong". You just told him that he is wrong to feel that way.

CSA: (cuts her off) So how should I say it?

P: It doesn't matter what I say, it won't make any difference, I can't tell her that.

Tx: So you are afraid to tell her that, that it will make things worse, that her anger will just push you down even harder.

P: Yeah, the more I talk the worse it gets and it's just

Tx: Can you tell CSA how afraid you are of her anger? Just how much it impacts on you.

P: I just shut up and let it go. I'm afraid of your anger, I'm afraid if I speak up or become more active that I will just fuel the fire. I just let it go.

CSA: I'm frustrated but I'm not mad. We talked about something...

Tx: Stay here in the present. P says, "your anger is frightening me".

CSA: The frustration is about before.

Tx: Just stay here with what is happening right now when P says to you, “your anger is...”.

CSA: (cutting therapist off) This is going to sound really cold but, I mean sure, It's not fun to hear but...I'm not responsible for his feelings. I mean I'm just saying what's on my mind. I may as well just stop talking if he is going to feel that way.

Tx: It's like you are too angry to even hear. “I'm too angry to even hear you say how hard this is for you. I can't even listen”.

CSA: (long pause) I still don't think I'm angry. (laughs) Maybe I'm missing a piece of the puzzle here but I still don't think I'm angry. I don't know where to go. I don't know what to say or do.

Tx: What would you say you are feeling right now?

CSA: I'm frustrated, I don't know...I don't get it...

Tx: So can you say that to him? “I don't know what to say”.

CSA: I don't know how to respond. There you go...that's perfect...I don't know what to say, don't know what to do, don't know how to avoid it, how to let it go.

Tx: Do you feel stuck? “I don't know how else to do this to let you know what I need other than anger”.

CSA: I still don't agree with the anger part. I just say things directly, that's just me. It's just the way I am. I could beat around the bush and come up with all sorts of words that don't count for anything but...what's the point?

Tx: When P says he is pushed in to a corner and pushed down and down, is that what it was P?

P: hmm

Tx: It's like, “I just don't know how to do it”. Is that what you mean?

CSA: I know what he's saying. Okay. It's like he's a puppy. But, all I'm doing is saying what's on my mind. I'm not swearing or hitting him. I don't think I'm being emotionally abusive. I'm saying what it is that needs to be said and by doing that I'm putting somebody down, I'm putting him in the corner. I'm doing this, I'm doing that. Well then I may as well just stop talking and you go live your life and I'll live mine and you....Sometimes that would be the easiest way. Why do you go in the corner? Maybe it's your perspective that needs to change.

Similar to the process that occurred in the couples where shame was the dominant affective response to any stimuli, this CSA survivor was not able to respond to her partner's expression of fear and helplessness. The therapist made four attempts to assist the couple in an enactment, each time making the content of the enactment smaller and smaller, slicing it thinner and more focused on the present moment experience of the partner. Multiple attempts to refocus the survivor on the experience of her partner and to help her put her overwhelming angry response on hold, so that she could be present for him in the moment, failed. The therapist was attempting to show the non-CSA trauma partner that re-engagement would diminish the angry responses of his partner, but ultimately what he learned was that it continued to be emotionally unsafe to re-engage. This transcript is representative of the other couples where anger was the dominant affective response in one member of a dual trauma couple. As such, this global theme may be less amenable to clinical change than that of shame.

Hypervigilance to attachment figures: *I just can't feel safe.*

Hypervigilance is a central feature of posttraumatic responding, and is one of the symptoms that is very resistant to change through treatment. Hypervigilance to attachment figures, in particular the partner was present in all of the CSA survivor partners and in five of the non-CSA partners (1, 5, 7, 14, 18). This global theme was organized based on the following basic themes.

One predominant basic theme was that this hypervigilance to the attachment figure was associated with significant challenges in maintaining de-escalation and transitioning into Stage Two of the EFT model. Many of the trauma survivors reported in sessions that the calm was frightening and difficult for them. They reported that they were waiting for something to go wrong and would become so hypervigilant to their partner that they would

quickly re-escalate between sessions. Partners of CSA survivors reported that they were always on alert for their partner to become dysregulated. In the words of one partner “I never know what’s going to light the fuse”. Four of the couples (1, 7, 13, 14) resorted to attempting to maintain their de-escalation by not speaking to each other between sessions. Over the course of therapy they became more able to reassure and soothe each other. In the dual trauma survivor couples this process took longer than in the CSA only trauma couples. This will be further discussed under the heading EFT Model: Stages and Steps.

Hypervigilance was also illustrated by trauma survivors being highly attuned to any statement or behaviour by the therapist or their partner that might provoke feelings of self-blame, shame, risk of attachment loss or imply impending failure of their partner to be trustworthy. Quotations that illustrate this basic theme follow.

She feels like I am judging her even when I tell her I am not. She is hypersensitive to criticism and I just can’t say anything to her or make even a suggestion.

I have to think about everything I say. Anything could send her off.

She is always looking for something and there is always something not quite right.

I’ve got to take care of our daughter. You take care of your boys. No one defended me. I must defend me and my daughter. My Dad was loving and kind too so there is no reason why he won’t be the same. If he is like my father then maybe he’ll do what my Dad did.

Five of the CSA survivors (6, 7, 13, 14, 18) had not disclosed many aspects of the story of their abuse or their healing journey to their partner at the onset of therapy. Over the course of therapy these survivors were actively supported by the therapist in sharing their story, and their partners were coached in how to respond to these disclosures. Hypervigilance symptoms appeared to decrease following these disclosures and all but Couple 13 were amongst those who reported clinically significant improvements in relationship satisfaction.

Eight of the CSA survivor partners (1, 5, 6, 7, 13, 15, 16, 18) and two non-CSA trauma partners (5, 14) demonstrated the basic theme that became termed the “I Will Never”. This became known as “I Will Never” over the course of study to denote the often used phrase, “I will never trust him/her”. These trauma survivors extended their hypervigilance to their partners and were acutely attuned to any suggestion that their partner might not be trustworthy. In fact, these partners suggested that they would never trust their partners because they could never be sure that they were trustworthy. Even in the face of ongoing fidelity, support, reassurance and in some cases heroic efforts to prove their trustworthiness, these trauma survivors simply could not let go of their terror that their partner might prove untrustworthy. This topic is also covered under the heading Attachment Injuries.

This hypervigilance to any evidence of un-trustworthiness was highly distressing to both partners in the relationship and was also very challenging to confront in therapy. Some quotations below illustrate this basic theme.

I will never trust her...he’s got the winning ticket and she’s not going to be there for me. She will never love me the way she loves him. I’m not in.

Maybe I don’t have enough faith. A voice says, I’m not enough, he’s going to leave and find someone better. Maybe he did have an affair, maybe he really isn’t who he says he is. How can I know?

It’s too dangerous for me to let my wall down. It’s going to get slammed. I know he can’t be there for me. I want to but I can’t. He would have to be perfect for me to risk.

I’ve tried taking risks before and I’ve always regretted it. Everything is an example of why I shouldn’t trust him. I do want to try but I don’t think he really means it.

The experience of not being trusted and constantly watched was also distressing for partners. Quotations below illustrate this point.

It is demoralizing. I work so hard to get every little scrap of trust.

How can you even know that I won't be there if you aren't willing to take the risk?

I've always felt like a failure that I couldn't help her feel safer.

Over the course of therapy, therapists repeatedly coached the trauma survivors to take small risks in extending trust to their partners. This was a slow process but six of the couples were able to build tentative bridges of trust between them (6, 7, 13, 14, 16, 18). However, for some couples, this hurdle was not overcome in the therapy even in the later stages of EFT. A poignant transcript that illustrates this challenge in a dual trauma couple in the second last session of therapy where both partners were struggling with allowing themselves to take this risk follows.

Tx: You went home thinking, are we both willing to jump into this pool at the same time and take the risk? You're both saying that what I need is relying upon what the other person needs but what the other person needs relies upon me doing what I am afraid of doing...there was a stuck point there, a real catch 22. Has something shifted in you over the last week?

P: It's interesting because this process has been unfolding over many weeks. It's been building and this morning I felt ready and I said to her "I am going to recommit myself to you, to our relationship" and I said it twice and she said, "No...you can't do that, you're not ready".

CSA: Well it's true. I can't trust that she is really wanting to go there. I feel like it's a last ditch effort.

Tx: So, you say, "I am willing to take that risk because you are that important to me". (turning to CSA) And what happened inside you that caused you to say, "No, You can't do that"? The very thing that you long for, the very thing that you want so much from P as we strip away all the layers and get right to the bottom. The very thing you need is the very thing you say..."No". What happened in you when she said "okay...I do commit to you".

CSA: I don't believe it.

Tx: "I don't believe it". Okay, okay, "I didn't believe it". What happened inside? What voice spoke up and said, "don't believe, that's dangerous"?

CSA: I don't know. (sighs)

Tx: Do you know what it feels like to feel safe with another human being?

CSA: No...I mean.

Tx: Have you ever experienced feeling nurtured and trusting that that person will be there for you?

CSA: (muffled and crying) No.

Tx: So even after 8 years of P trying, trying, trying, it's still not in you, you can't hold it in your body. Can you look at P and see how sad she looks. P, what's coming up for you that after all this time...?

P: (crying) I've held you...I've been there for you...I feel so sad that she can't trust me after all of this time. I thought that there had been times when she was able to feel safe with me.

Three of the couples did not begin to shift this domain of hypervigilance over the course of therapy (1, 5, 15). Two of these terminated their relationship. The process of learning to trust and to be less hypervigilant to the threat of the partner failing them in some way, was really only begun in this therapy with all of the couples. Thus, this global theme may be quite resistant to clinical change over the course of treatment and require the development of specific intervention strategies.

Sexuality: *Sex is shameful and I need control.*

In all but one of the couples, issues with sexuality were highly salient. The only couple that did not have significant struggles in their sexual relationship was the one lesbian couple in the study. Regardless of the number of years the couple had been together, the age of the partners or the degree of trauma, all of these couples struggled with divergent levels of desire. Conflict arose over the frequency of sex and in negotiating a sexual relationship that was not a trauma trigger to the CSA survivor partner.

All of the nine survivors had strong sexual triggers and many of them continued to harbour negative and shameful thoughts about sexuality. The majority of these survivors voiced that they wanted emotional intimacy as a pre-condition to sexual intimacy, and that

they needed to have control over sexual activity. Further they felt that it was necessary that sexual touch be predictable and that their partners always respect their need to stop at any time during the sexual encounter. Some quotations that illustrate basic themes of sex being dangerous and triggering follow.

I know that he respects when I say no but I feel guilty for not wanting sex, for not feeling aroused. I just don't even want to talk about it. When it's happening I just want it to be over. I still feel like sex is dirty and painful and wrong.

Sex is not a sign of caring...it's only there because I exist...because I am a woman. I've never learned how to associate it with loving.

Anything sexual makes me bizurk. I will never be fixed. I am just leftovers from my family.

Another basic theme was that the majority of the couples had already imposed a sexual moratorium on their relationships prior to beginning therapy due to ongoing conflict and distress. Only two of the couples (6 & 15) had not ceased sexual activity by the beginning of therapy. These were the two youngest couples. Both of the survivors voiced the opinion that the only thing that they had to offer to their partner was sex even though they found it very triggering.

Over the course of therapy these struggles were normalized by the therapist and couples were supported in talking openly about their sexual relationship. Survivors were coached in identifying their trauma triggers around sexual contact and communicating these to their partners, while partners were supported in providing the physical safety and emotional intimacy that would allow their CSA survivor partners to feel that they were being respected. All but two of the partners (14 & 15) were very willing to accommodate to their CSA partner's needs for sexual control and to avoid certain activities or positions. These two non-CSA partners reported feeling resentful that they had to be so accommodating to their partners around sexual issues. For the partner in Couple 14 this

changed over the course of therapy as he became more aware of his own unmet needs and how they might be met with his partner. Couple 15 terminated their relationship.

In fact, the majority of non-CSA partners reported feeling much more comfortable in approaching their partners because they were less afraid of hurting or triggering them when they understood their partners' sexual trauma triggers.

The following is a segment of a session where a CSA partner is explaining her triggers to her partner who had been feeling afraid that she did not find him attractive any more because of her withdrawal from their sexual relationship and illustrating the basic theme of needing control over sexual triggers.

CSA: When we're lying in bed or in the hot tub I feel like... trapped. I know I'm not but I need to feel that I have a way out. I felt like I couldn't move when it happened and he was lying on top of me. I couldn't move so when we're in bed and you're falling asleep with your leg on top of me I get that feeling. I know that's where it's from. I was trapped.

P: Now I understand why you don't want to cuddle. It's really helpful for me to understand. To know what happened, it helps me.

CSA: I want to protect you from it. I could never imagine someone I love going through that.

Primarily therapists approached this issue through psychoeducation. This will be discussed in the section on psychoeducation. Four couples were given videos and books to read and six couples (1, 5, 6, 7, 13, 14) were given exercises to do outside of therapy, including gradually increasing from emotional intimacy, to gentle non-sexual touch over clothes up to full intercourse. One partner bought a little stuffed lion to show her partner when she was feeling triggered and other couples developed new ways of communicating about sex including safety signals. As CSA partners developed greater affect regulation strategies, had told their stories to their partners and learned how to turn to their partners for support, these issues became less conflictual and distressing. However, over the course of

therapy there was very little movement in CSA survivors' reported levels of sexual desire and the frequency of sexual activity.

Couples 9 and 15 ended their relationships prior to the beginning of Stage Two and did not address their identified sexual issues in therapy.

Observations of the Application of the EFT Model with CSA survivors

The treatment offered in this study was Emotionally Focused Therapy with an awareness of the needs of traumatized couples. This awareness led to therapist led modifications from the extant model which included psychoeducation on trauma, slower pacing, explicit support for survivors' affect regulation by therapists, and more support in risk taking in directed interventions which have been identified by Johnson (2002) as being important in working with these couples. Implementation checks verified adherence to the general normative model and the researcher and clinical supervisor assessed the degree to which therapists applied the additional elements of psychoeducation, affect regulation support and slower pacing of the theoretical model. Given the significant distress, both relational and intrapersonal, that faced these couples, it was inevitable that the EFT model would by necessity be applied in a way that was responsive to the unique clinical needs of these couples. As such all sessions were reviewed with the goal of observing the process of EFT as applied to these couples with the goal of being able to further articulate the developing model.

Stages and Steps

The duration of EFT therapy with non-trauma couples is approximately 15 sessions, but the model has been successfully condensed to 8 to 12 sessions for treatment outcome studies. As recommended, EFT optimally requires 30 to 35 sessions. This was condensed to 20 sessions for this study. Our couples attended an average of 19 sessions with a range

of 11 to 26. Due to the restrictions on the number of sessions, this mean is artificially lower than would be seen in an open ended therapy process, as all but two couples reported a desire for further treatment and indicated that they did not feel as though they were ready to terminate therapy. This finding supports one of the primary assertions of the theorized EFT process, that trauma survivors will require an elongated therapy process.

For seven couples (1, 6, 7, 13, 14, 16, 18) who maintained their relationships and reported positive outcomes, the average number of sessions required to reach a first episode of de-escalation was 6.4. For the three couples (5, 9, 15) who ended their relationships at the termination of their therapy the average number of sessions in this process was 11 with two of these couples never completing the tasks of Stage One.

The Stage One process with the negative outcome group couples was considerably longer than the positive outcome group. For these couples, de-escalation was hindered by a combination of numbness and dissociation in the withdrawn partner and hostility and attacking behaviour from the critical pursuing partner.

In Couple 5 the critical pursuer was the CSA survivor. In Couples 6 and 9 the critical pursuer was the non-CSA non-trauma partner. In fact, in both of these couples therapy was terminated following multiple attempts at de-escalation which resulted in increased attacking behaviour in the non-CSA non-trauma partner, which elevated to an emotionally abusive level, and which was noted by both CSA partners and therapists.

The positive outcome couples required an additional average of 14.5 sessions to maintain de-escalation and begin the process of re-engagement/softening of Stage Two. Only one of the negative outcome couples completed Stage Two. Couple 5 completed this stage in 15 sessions which did not differ from the other group. The primary apparent reasons for the elongated Stage Two process were the challenges with affect regulation that

were reviewed above, and the challenges in maintaining the de-escalation required to truly enter Stage Two.

Maintaining de-escalation requires that the couple be able to differentiate the past from the present and express their needs to each other in ways that draw their partner closer to them. Additionally, hypervigilance and “I Will Never” stances made it difficult to maintain the de-escalation between sessions, due to the tendency of the survivors to be triggered into distress in response to any perceived failure or betrayal of their partners. Essentially these couples struggled at the transition to Stage Two for many weeks, de-escalating and re-escalating between sessions.

Upon consolidating the De-escalation they then truly entered Stage Two and were faced with the tasks of the Re-engagement/Softening stage where couples are coached and supported in expressing vulnerability, and expressing needs which theoretically results in trusting their partner more, feeling that the other can be accessible, responsive and accepting of limitations. As discussed above under the themes related to affect regulation and hypervigilance, CSA survivor couples found these tasks uniquely challenging, and much more time was required to support them through the processes than in a non-trauma couple.

When reviewing softening attempts using the stages of the softening identified by Bradley and Furrow (2004), only Couples 6 and 14 had completed all of the steps in a full softening prior to the end of therapy. These were the two greatest change couples that were included in the process analysis. These two survivors demonstrated the least constricted affective range and regulation at the beginning of therapy.

Of the couples who entered Stage Three only Couple 6 could be rated as having completed the EFT process by therapist reports, and by the researcher based on the review

of all sessions. In spite of this, Couple 6 continues to receive services from their primary therapist on an ongoing basis and reported in their exit interview that they felt much closer and able to support each other but that this felt very fragile. This couple was only dealing with trauma in one of the partners, and was the only CSA survivor who had not experienced intrafamilial, early, severe and chronic CSA.

In general, couples had only begun to enter the final stages of therapy at the end of the therapy process. Couples indicated in their exit interviews that they felt as though this therapy was addressing their needs but that they did not feel finished therapy. Four couples requested follow up services. All of these couples were offered continuing services.

All of these findings are supportive of the optimal recommendation that EFT requires 30 to 35 sessions.

The Trauma is In the Cycle

A foundational principal in the process of EFT is the explication, expansion and alteration of rigid negative interactional cycles in distressed couples. In the CSA survivor couples, these cycles differed from those of non-trauma couples in that the childhood trauma was concretely and rigidly embedded in the cycle. In the dual trauma couples these cycles were even more rigidly fixed in past traumatic experiences and were being reciprocally reinforced. Withdrawn CSA survivors who evidenced higher levels of numbing, dissociation and hyperarousal appeared to be experienced by their pursuing partners as more unavailable, thus creating higher levels of pursuit.

Examples of these are described here.

Couple 1: Dual trauma couple. Pursue – Withdraw Cycle. The CSA partner experienced severe sexual abuse by siblings and father, the chaos of a mentally ill mother

and severe deprivation. The Non-CSA trauma partner experienced physical abuse in childhood and adulthood, and witnessed the death of her son.

The CSA survivor partner seeks out her non-CSA trauma partner to soothe her anxieties about belonging, being important and being cared for. As these reassurances are not readily available in the hustle and bustle of daily family life, CSA trauma partner escalates and becomes emotionally dysregulated. She yells and cries and feels abandoned and invisible. The non-CSA trauma partner experiences triggers back to the fear and terror of the domestic violence that she experienced and withdraws from her partner into her bedroom. She experiences her CSA partner as anything but invisible. The CSA survivor partner experiences this withdrawal as confirmation of her abandonment and becomes even further dysregulated and frantic, reacting behaviourally by banging on doors, yelling and crying, resulting in both partners reinforcing her sense of being too much, shameful and unfixable.

Couple 6: Single trauma couple. Pursue – Withdraw Cycle. The non-CSA non-trauma partner approaches CSA partner for affection. The CSA partner experiences pressure, shame and trauma triggers and withdraws emotionally becoming numb and disconnected. The non-CSA partner feels rejected, hurt and angry. The CSA partner feels afraid of non-CSA partner's anger and she withdraws even further. She becomes dissociated, disorganized and further withdrawn and is challenged to stay present enough to take care of their son and their home. The non-CSA partner tries to help by offering suggestions. The CSA partner experiences these suggestions as criticisms and confirmation of her brokenness. She then experiences deeper shame which triggers her traumatic memories of being helpless and dirty.

These are two examples of how the trauma experience became inserted into the couples' interaction cycles. Over the course of therapy for positive outcome couples, the therapist assisted the couples in identifying the trauma as an enemy, that the couple could fight together by helping them to see how the trauma had become embedded into the cycle and how the interactions were triggering old trauma-related emotions. Couples began to identify trauma triggers together and many began working as a team to conquer these challenges rather than seeing each other as the problem. By the end of the therapy these couples were able to identify and interrupt their cycle. However, this process was still fragile and all of the couples had periods of regression and required ongoing support. Many of the couples reported at their exit interviews that they were afraid that they would not be able to maintain this capacity beyond the therapy.

While this process was very helpful for couples, three of the therapists were not as concrete about this externalization process. The therapists for Couples 9, 16 and 18 did not focus on externalizing the trauma from the cycle as explicitly as the other therapists. Couple 9 terminated their relationship and Couples 16 and 18 did complete therapy with self-reported positive outcomes, but observations of process suggested that these two couples did not achieve the same level of resolution and change as evidenced by their continuing tentative interactions in sessions.

Attachment Injuries

Attachment injuries are often identified over the course of the first two steps of EFT, and result in difficulties in completing the tasks of Stage Two; Reengagement/Softening due to the unwillingness to take risks and expose vulnerabilities to a partner who has betrayed them and with whom one does not feel safe.

The definition of an attachment injury is when one partner does or says something to the other partner that damages the attachment bond and impacts on how the relationship is defined and experienced in the present. As emotions underlying the interactional cycle are exposed and processed, these incidents become activated and the resulting reminder of how dangerous the partner is obstructs the ongoing process of change (Johnson, 1996a).

Seven couples (1, 5, 6, 7, 13, 14, 16) reported events that appeared to be attachment injuries, but on closer examination it is argued that what was actually being seen was an extension of the hypervigilance, “I Will Never” phenomenon. Firstly, for an attachment injury to have occurred, there has to have been a time when the injured partner did feel safe in their relationship and trust their partner to create a context where basic assumptions about the security of their attachment could be shattered. This condition was not met in these couples, as all of these partners had experienced chronic hypervigilance and attachment insecurity throughout their relationships. There had never been a time of feeling safe. Secondly, the event has to have had an element of betrayal or injury, the level of which these cited injuries did not have. That does not mean that these events were not experienced as injuries in the relationship, simply that they did not meet the criteria identified by Makinen (2005).

Additionally, the quality and nature of these events were quite different from the traditional attachment injury. Examples of attachment injuries from a recent study examining their resolution included partners abandoning their partner at a salient time of need such as an illness or miscarriage, infidelity and receiving an exotic massage (Makinen, 2005). While an injury could be a more minor incident, they were generally tied affectively to a previous deep betrayal by a partner. In our couples the identified injuries were of qualitatively lower severity and could be directly linked back to the betrayal and trauma of

childhood experiences rather than events in their relationships. These clinical findings suggest that events of lower severity can trigger attachment injurious responses, especially in couples where one or both partner is dealing with Complex PTSD. Examples of identified injuries follow.

I know that she was trying to hide something or she wouldn't have kept looking at the answering machine as though there was a message on it that she didn't want me to hear. I really can't trust her.

I don't know, I think anybody would know that you shouldn't leave wet towels in the laundry basket. It's just another example of how he won't be there for me.

I brought home a book on trauma and he didn't want to read it. It just showed me how unimportant I am to him.

For these couples, these specific incidents were brought up recurrently throughout the therapy, were not tied to other injuries by the partner and were used as examples of why the traumatized partner should not trust their partner. The affective tone of these injuries matched that of the original traumas; betrayal and abandonment.

Psychoeducation

Psychoeducation is not a key component of the regular EFT process but has been theorized to play an important role in the process of EFT (Johnson, 2002). In support of this assertion, positive changes on the measures of relationship satisfaction and trauma symptoms were associated with the frequency and specificity of psychoeducational interventions in the therapy sessions. The two greatest change couples (6 & 14) received the highest quantity and specificity of psychoeducation of the couples. Both of these therapists had many more frequent and specific efforts to educate couples about the impact of trauma on survivors and relationships. In fact, for Couple 14, two full sessions were devoted to educating both partners about the impact of trauma on personality development and dissociation and the psychophysiology of trauma, as less direct efforts to externalize

the trauma had failed up to that point. Psychoeducation was also used frequently for four additional couples (1, 5, 7, 13). Psychoeducation was very rarely used with Couples 9, 16 and 18.

Psychoeducation covered many different areas in the therapy process. A predominant theme was didactic education about the nature and impact of trauma on relationships and individuals. Affect regulation, tension reduction behaviours, dissociation, trauma triggers and flashbacks, personality development and trauma, trauma and attachment, trauma and physiology and the impact of trauma on sexuality were common areas within the topic of the impact of trauma. The specific goal of this may have differed between therapists, but the apparent result in all cases was the externalization of the trauma as a force that the couple could work together to fight. There were other therapist behaviours that achieved this goal that will be discussed in the section on therapist behaviours.

Other areas of psychoeducation included understanding normative developmental processes for trauma survivors who were in conflict about how to parent after their trauma, how to ground oneself, basic communication skills, breathing and relaxation exercises and self-care.

These observational findings were highly supportive of the theoretical assertion that psychoeducation will play an important role in EFT and provided further validation for this process model.

Therapist Behaviours

The implementation check was performed to ensure that EFT was applied consistently and as per the model. This check also assessed key therapist behaviours and it was found that all therapists in the study utilized the therapist behaviours that are

characteristic of EFT. However, beyond these key EFT therapist behaviours, therapists needed to adapt strategies to deal with the specific challenges of these traumatized couples as per the theorized EFT process.

Affect Regulation and Containment

The theoretical process of EFT highlights the importance of coaching and supporting trauma survivors in regulating their affect in sessions. In support of this assertion, affect regulation was a particular challenge for the CSA survivors. Some of the non-CSA trauma survivors and therapists were required to focus significant energy on supporting the CSA survivor to regulate their affect. In traditional EFT, therapists use evocative responding, affective attunement, empathic reflection and heightening to expand upon affect in sessions and access underlying emotional experiences for reprocessing. Therapist behaviours designed to heighten affect were used sparingly in early sessions due to the challenges with affect regulation that readily became apparent.

Contrary to traditional EFT where there is an equal division of time between partners in the session, the majority of early sessions in EFT was spent focused on the CSA survivor partners. Therapists stayed very close to their traumatized clients and provided significant containment for their affective experience.

In this study the approach to accessing affect for processing in sessions would more aptly be described as affective sculpting. As a sculptor with a piece of clay these therapists would heighten the affect in the most minimal way, monitor the client response to affective activation, then follow with soothing empathy and containment if there were signs of dysregulation. The therapist would then continue this heightening and containment process throughout a segment of the session such that the survivor would have a short experience of safe affective engagement rather than flipping between being numb or overwhelmed.

These periods were very short in early sessions and expanded in duration and range of affective experiencing over the course of therapy.

These findings provided support for the theoretical EFT assertion that support and facilitation of affect regulation in survivors will be an important factor for therapists working with traumatized couples.

Coaching/Scripting Interactions

The EFT model also suggests that traumatized couples will require a higher level of direction in interactional tasks and help facilitating new emotional responses than non-traumatized couples.

Therapists were observed to provide very explicit coaching of partners through key interventions and affectively charged moments in the therapy. In particular, during attempted enactments, the therapists stayed very close to trauma survivor partners, subtly scripting their responses, and helping contain them when they were unable to hear their partner's vulnerability or when they became dysregulated through the process. While it is common in EFT to shape enactments and restructure interactions through semi-scripted prompting, in these couples the segments were shorter and more directive. A therapist would prompt the survivor with a specific short utterance such as "can you tell him that you are afraid", or "can you turn to him and tell him how hard it is to trust?" These short utterances focused on the affective experience in the moment followed by holding and coaching the survivor to allow their partner to respond. In many instances therapists would vocally hold the survivor through the response of their partner to their stated feeling or need, using short utterances, instructing them to take a breath, listen to their partner, stay present while using a very soft, slow vocal tone.

A more normative example in EFT of restructuring an interaction in a non-trauma couple to create an enactment would be,

So can you tell him, Marsha, if I can try and summarize what you just said, “I need to know that I’m special to you and that you think that I can do it, that I can fly on my own. And that even if I crash, I need to know that everyone will survive and I’ll still be special to you, even if I quite school”, Is that it? (Johnson, 1996a) p. 194.

This example is far more elaborative, lengthy and less clearly directive.

These observational findings were supportive of the assertion that therapists working with CSA couples using EFT will need to provide a higher level of direction in interactional tasks and help in facilitating new emotional responses than with non-traumatized couples.

Imagery

Imagery is a common method of expanding awareness in sessions in EFT and therapists in this study used imagery to further externalize the trauma and bring the couple together in a mutual battle against the “dragon”. Therapists frequently used the images of fighting a dragon or having a shadow standing behind the partner of the trauma survivor such that they could not respond to their partner in the present. Therapists for seven couples (1, 5, 6, 7, 13, 14, 15) utilized imagery extensively. Therapists expanded upon imagery brought into sessions by survivors creating a unique image that fit the experience of the survivor. Male partners embraced the image of riding in on their white horse or slaying the dragon to help and protect their loved one while CSA partners reported that the externalization of their trauma in this way helped them feel less shame and self-blame about their relationship distress. One CSA survivor went out and bought a stuffed lion since she couldn’t find a dragon and she used this to show her partner when the dragon was

in the room. He reported that this helped him respond to her distress without feeling rejected.

In the segment of transcript that follows the therapist uses the image of the dragon with a couple early in the therapy process

Tx: I just wanted to clarify something about your reaction in the mornings. It's not unusual that somebody who's experienced a trauma, a sense of being violated or having their boundaries broken in terms of their personal space, like the assault you have experienced, to have that kind of surface in different times and places and ways. And sometimes it can be experienced like feeling out of control if you don't know what's happening, like you're being touched and you're not quite awake. This is like something that other trauma survivors have also reported.

CSA: Oh, okay.

Tx: It's not unusual that that is occurring and that is important for you to understand. It's not about you. It's like there's a dragon in your bedroom. This dragon is in your bedroom and he's coming after you but only you can see him and that is terrifying and dangerous but your partner doesn't see it, he only sees how you are reacting to that dragon. When he touches you in the morning, you don't experience being cuddled by him you experience the dragon shaking you around a bit.

CSA: I feel like if I can't roll over and I can't move I'm going to go crazy and I panic.

Tx: If you can talk to him about the dragon he can realize that it's not about him and he can help you fight that dragon. He won't take it personally and he can come to your aid.

P: Yeah, sometimes I don't really understand what's going on and it confuses me and I don't get it.

Tx: You can stand beside her with your sword and slay that dragon...it's not about you, it's about the dragon. You can reassure her that it is okay, that you can create the safety that she needs.

P: okay

Tx: If you can feel like he is standing beside you and you are facing the dragon together then that dragon is going to go and hide because together you are a formidable opponent. If you guys agree that there is a dragon lurking around then together you can manage and control it and be strong. And then the dragon can't be in charge of your lives anymore. Does that make sense?

CSA: That does make sense.

The use of imagery here was evocative and served the multiple purposes of educating the couple about the lasting impact of trauma, externalizing the trauma, empowering the partner to support the survivor and normalizing the survivor's experience. This was characteristic of other therapists' use of imagery in those couples where imagery was utilized as an intervention throughout the study.

Coaching Attachment Related Behaviours

The theoretical process of EFT with trauma survivors indicates that therapists will assist couples in creating corrective emotional experiences, where working models of attachment can be revised, through explicit facilitation of risk taking around expressing attachment needs and coaching interactions to facilitate the development of new emotional responses.

Therapists in this study made frequent attempts to relate attachment distress in the couple to unmet attachment needs or overt betrayal by attachment figures in childhood. In particular, issues of affect regulation, hypervigilance and difficulty trusting were reframed in the context of failures of previous attachment figures to provide the emotional stability, security and containment required to overcome the impact of severe interpersonal trauma. Therapists reframed the seemingly unmetable needs of these survivors within an attachment framework and drew their attention to the disconfirming evidence of interactions with their current partner. For six couples (1, 5, 6, 7, 13, 14) challenges with taking risks, trusting and seeking comfort were explicitly placed in an attachment framework within sessions. An example of a transcript where underlying attachment needs were identified and placed in the context of the past traumas with gentle refocusing on the present attachment reality follows.

Tx: It sounds like there is a real struggle going on between the part of you that thinks you shouldn't ask for anything from anyone or try to connect with others with the other part of you that has that deep feeling of fear and longing.

CSA: Yes, I am terrified.

Tx: What is the fear in words?

CSA: That she won't truly ever connect with me. That she will never be enough or as much as I need her. I just think that...she can't really be there for me.

Tx: There's a deep fear that is there from your past reality that no one will be there for you. That you're not going to get what you need and that was real, it was realized. When P pushes you away when she feels you are being critical and clingy it just kind of makes it worse.

CSA: I've just been feeling that she doesn't make an effort...it's like she gave up a long time ago. There isn't the connectedness, I'm just waiting for her. I feel like she won't give me what I need.

Tx: It sounds as though you are afraid that nobody will be able to fill your need. What's that like for you P to hear that CSA fears that there can never be enough love and connection to help her feel safe?

P: Well...in some ways it is true, I do feel as though there will never be enough of me to fill her needs.

Tx: "There will never be enough of me to meet her needs". What is the feeling that comes up in you when you say, "I feel there won't ever be enough of me"?

P: Well, I guess I'm reminded of my mother who was in incest survivor and how she needed me and smothered me. There was never enough of me.

The therapist in this transcript helped the CSA survivor differentiate her real history of being wounded from her present experience of being afraid that her partner could not meet her needs. Additionally, she supported the non-CSA trauma partner in following the affective trigger of her partner's apparently unmeetable need back to her own attachment experiences. This was similar to the approach with other couples where the process of differentiating past attachment betrayals from the present context was incorporated into the ongoing discovery and uncovering process of therapy.

Summary of Findings

Ten couples participated in this study examining the application of EFT for Couples to couples where one partner had experienced the trauma of CSA. Preliminary analyses suggested that the measures used to assess the outcome variables were reliable. Positive findings in partial support of the outcome hypotheses demonstrated that half of the couples reported clinically significant improvements in mean relationship satisfaction, half of the CSA survivors reported clinically significant improvements in trauma symptoms on the TSI and all of the CSA survivors reported clinically significant improvements on the CAPS diagnostic interview.

Analysis of the process of change in best sessions revealed that the two couples with the greatest amount of change in their relationship satisfaction demonstrated higher levels of experiencing and more affiliative interactions than the two couples who reported deterioration in relationship satisfaction. However, these two groups may have been qualitatively different at the beginning of therapy, thus making direct comparisons between couples challenging.

Thematic analyses revealed that trauma in both CSA trauma survivor partners and some non-CSA trauma survivors had an impact on the application of EFT to these couples. In particular, challenges with affect regulation including flooding, numbing and dissociation and constricted range of affect slowed down the process of EFT and required specific efforts on the part of the therapist to contain, shape and work with affective experiencing in sessions. Over the course of therapy many of the trauma survivors developed increased capacity to affectively self-regulate, to experience a broader range of affect and to tolerate the affective experiences of their partners. Hypervigilance to attachment figures also created a unique set of challenges for therapists and partners who

struggled to coach the trauma survivor to take the risk to trust their partner and to use their partner as a resource for managing their trauma symptoms and daily distress. Telling the story of their trauma and healing journey to their partners seemed to decrease levels of hypervigilance, yet coaching and structuring of interactions geared to support the survivor in taking risks and getting past the idea that “I Will Never” trust did not succeed in substantially diminishing the sense of fear and struggle in taking these risks.

All but one couple struggled with reclaiming their sexual relationship from the sexual abuse trauma. Seven couples imposed sexual moratoria, and all of the positive outcome couples learned to talk about trauma triggers, how to externalize the trauma, gradually moved from non-sexual touch to beginning a new sexual relationship over the course of therapy. They were provided with educational resources such as books and exercises to assist them in renewing their sexual relationships. However, the majority of couples did not resolve their sexual issues over the course of this therapy.

Implementation checks ensured that the treatment offered in this study was EFT for Couples and that therapists were utilizing the key behaviours and interventions of the model. Observations of the process of EFT with these couples suggested that the length of EFT with these couples was elongated with the majority of couples reporting that they did not feel that they had completed therapy at the end of the study and after an average of 19 sessions. This was in keeping with the proposed process of EFT with trauma survivor couples. The major hurdle experienced by these couples relative to the implementation of the EFT model was in the transition from Stage One to Stage Two. CSA survivor couples demonstrated particular challenges in maintaining de-escalation and were found to re-escalate between sessions over the course of many weeks. It was suggested that this finding may have been related to challenges with affect regulation, hypervigilance to their

partners and the “I Will Never” phenomenon. Only one of the couples was rated to have completed EFT at the end of the study.

The quality of the negative interaction cycle in these couples was compounded by the rigid and concretely embedded trauma histories of the partners. In dual trauma couples, this phenomenon was especially challenging clinically. In particular the past trauma was inserted into the interaction cycle such that distressing relational experiences and neutral relational stimuli could be distorted through activation of dominant trauma-laden affect.

Seven couples reported experiences that appeared to be attachment injuries. Upon closer investigation it became clear that these couples had never had a safe base of trust and security and thus the betrayal and injury of these qualitatively less severe events was triggering trauma related affective responding. Over the course of therapy these supposed injuries were repeatedly brought up and appeared to serve the purpose of reinforcing the relational hypervigilance and the “I Will Never” phenomenon.

Psychoeducation is not an intervention of normative EFT but is theorized to play a key role in EFT for traumatized couples (Johnson, 2002). This assertion was supported in these couples as couples who received more explicit and specific psychoeducation reported better outcomes in relationship satisfaction. Psychoeducation included the after effects of trauma on affect regulation and personality development, how to identify trauma triggers, how to manage flashbacks, and the impact of trauma on sexuality and the process of healing the couple’s sexual relationship. Thus the importance of this intervention was supported.

Therapists utilized the standard behaviours identified in the EFT manual and also made some accommodations for traumatized couples through the supervisory process and in relation to the theoretically hypothesized process of EFT for trauma survivors.

Alterations in the process of heightening affect were demonstrated with the goal of containing and regulating the affect of the trauma survivors. In particular therapists used more of an affective sculpting rather than heightening to access and expand upon underlying emotional experiences for reprocessing. Therapists spent more time in sessions with the trauma survivors and they closely coached and scripted most interactions in the early sessions of therapy.

The use of imagery to expand and illustrate emotional experience is common in EFT. In this study the majority of therapists utilized images such as the dragon of trauma to help the couple externalize the trauma and coach the couple to work together to fight the impact of the trauma on their relationship. Therapists were also very specific and targeted in their attempts to reframe relationship distress in attachment terms, and to make the connections between current attachment based fears and past attachment traumas.

How Results Support the Formulation of EFT for Traumatized Couples

- An extended number of sessions; 30-35 is recommended for EFT with traumatized couples. These couples received 20 sessions. Results indicated that a longer treatment time would have been better.
- Relapses from de-escalation can be expected in traumatized couples and slowing the pace of the first stage of EFT may moderate this phenomenon.
- Emotional risks taken in sessions need to be small and actively supported, coached and facilitated by therapists.

- Affect needs to be sculpted and contained especially in early sessions to manage hyperarousal and emotional dysregulation. Survivors also need to be actively supported in staying present in sessions and finding new ways to manage emotional distress rather than using dissociation and numbing.
- Dual trauma in couples requires even slower pacing and greater attention to trauma symptoms and affect containment.
- Trauma appears to create greater sensitivity to hurts and injuries in the relationship thus attachment injury resolution will need to be incorporated into the therapy for injuries of qualitatively lower severity and nature than in non-traumatized couples.
- Trauma will likely be rigidly embedded in the negative interaction cycles in traumatized couples, and interventions helping the couples see this connection will be especially important in the resolution of distress.
- Externalization of the trauma through therapist interventions such as psychoeducation, imagery and explicit articulation of connections between past trauma and current distress are associated with positive outcomes.

Table 7

Summary of Characteristics Associated with Mean Relationship Satisfaction Change

Couple	Years Together	Age Average	Complex PTSD	Dual Trauma	Therapy in Years	TSI CSA	Expanded Affect	Regulated Affect	Numbing	Dissociation	Hypervigilance I Will Never	Telling Story	Psychoed
6	7	28	-	-	>1	↓	↑	↑	↓	↓	-	+	+
7	38	59	+	+	>10	↓	-	N/A	↓	↓	-	+	+
14	2	45	-	+	>10	-	↑	↑	↓	↓	N/A	+	+
16	28	53	+	-	<1	-	-	-	↓	N/A	-	-	-
18	30	49	+	-	>10	-	-	-	↓	N/A	-	+	-
Significant Positive Change													
1	8	43	+	+	>1	-	↑	↑	↓	↑	+	-	+
13	29	51	+	+	>10	↓	↑	↑	N/A	N/A	-	-	+
Not Significant Positive Change													
Not Significant Negative Change													
5	5	37	+	+	<1	↓	-	-	N/A	↑	+	-	+
15	2	23	+	-	-	-	-	-	↓	N/A	+	-	+
Significant Negative Change													
9	7	33	+	-	>1	↓	-	-	↓	↓	N/A	-	-

+ = Presence of factor, - = Absence of factor, ↑ = increase, ↓ = decrease (on outcome variables denotes clinically significant)

Table 8

Summary of Characteristics Associated with CSA Survivor TSI Trauma Symptom Change

Couple Together	Years Average	Age	Complex Dual Trauma	Therapy in Years	DAS	Expanded Affect	Regulated Affect	Numbing	Dissociation	Hypervigilance I Will Never	Telling Story	Psychoed
5	5	37	+	<1	-	-	-	N/A	↓	+	-	+
6	7	28	-	>1	↑	+	+	↓	↓	-	+	+
7	38	59	+	>10	-	-	N/A	↓	↓	-	+	+
9	7	33	+	>1	-	-	-	↓	↓	N/A	-	-
13	29	51	+	>10	↑	+	+	N/A	N/A	-	-	+
Significant Positive Change												
Not Significant Positive Change												
1	8	43	+	>1	-	+	+	↓	↓	+	-	+
14	2	45	-	>10	↑	+	+	↓	↓	N/A	+	+
15	2	23	+	-	-	-	-	↓	N/A	+	-	+
16	28	53	+	<1	↑	-	-	↓	N/A	-	-	-
18	30	49	+	>10	↑	-	-	↓	N/A	-	+	-

+ = Presence of factor, - = Absence of factor, ↑ = increase, ↓ = decrease (on outcome variables denotes clinically significant)

Discussion

The purpose of this study was to explore the use of EFT with CSA survivors and their partners. In assessing outcomes the concept of the reliable change index was utilized to determine whether the treatment did have an impact on couples over the course of the therapy. Qualitative coding strategies were utilized to relate the process of change in couples to the identified outcomes. A case study replication methodology was utilized to examine the use of EFT with these couples thematically.

Outcome

Characteristics of Participants Relevant to Interpretation of Outcomes

These female CSA survivor participants represented a highly distressed sample with the majority having experienced chronic, severe and early intrafamilial sexual abuse. Eight out of the ten of whom appeared to meet the putative criteria for Complex PTSD. In-keeping with the characteristics of our sample, Bennet, Hughes and Luke (2000) associated intrafamilial abuse with more frequent, longer-lasting abuse resulting in more severe psychopathology. These survivors would not have the benefits of the potential moderating impact of a cohesive, supportive family environment given that the presence of intrafamilial abuse is highly associated with other familial risk factors such as parental stress, conflict and lack of warmth which are also associated with later psychological distress (Merrill, Thomsen, Sinclair, Gold, & Milner, 2001). For nine of our ten survivors, their trauma occurred in the context of an attachment relationship that should have been a safe base for the development of future interpersonal relationships of trust, safety and intimacy but was instead a source of fear, betrayal and psychological trauma.

These couples were highly relationally distressed with half of the sample evidencing trauma in both partners. The average relationship satisfaction in couples at pre-treatment was bordering on the range for divorced couples.

Relationship Satisfaction

Half of the couples in this study reported clinically significant increases in mean relationship satisfaction over the course of the therapy. The mean change in relationship satisfaction in the overall sample of CSA survivors over the course of therapy exceeded the cut-off for clinical significance. Three couples reported deterioration in mean relationship satisfaction over the course of therapy. These couples terminated their relationships after therapy. The prediction that CSA survivor couples would report clinically significant improvement in relationship satisfaction over the course of therapy was partially supported.

Given the high rate of dual trauma couples, the prevalence of Complex PTSD symptomatology in these couples, the limited number of sessions and the extremely low mean DAS scores in CSA survivors at pre-treatment (77.9), a 50 % rate of clinically significant improvement in relationship satisfaction may indicate levels of improvement that contravene clinical expectations and warrants further exploration of this model.

The researchers used the norms for relationship satisfaction for a non-clinical outpatient population which, given the consistent finding of lower levels of relationship satisfaction in CSA survivors, may have been an overly stringent standard against which to compare these couples. A previous study with a population facing the trauma of parenting a chronically ill child found that an appropriate cut off point to determine satisfaction for these couples was 110 versus 114 for non-traumatized couples (Gordon Walker, Johnson, Manion, & Cloutier, 1992), suggesting that distress cut-offs for trauma couples may be

lower than those in non-traumatized couples. At outcome, only three of our couples met the cut-off for relationship satisfaction based on Spanier's community norms (1976).

Putting these findings in the context of the couple therapy literature will also offer greater perspective. In a review of studies examining the efficacy, effectiveness and clinical significance of empirically supported couple therapies for couples who did not report trauma related symptoms, Behavioural Marital Therapy demonstrated clinically significant improvement in 56% of couples, and Cognitive Behavioural Marital Therapy demonstrated clinically significant improvement in 70% of non-traumatized couples at post-treatment in a similar number of sessions to the number offered in this study (Baucom et al. 1998). Therefore a 50% clinically significant improvement in relationship satisfaction in this particular highly distressed sample may represent a clinically relevant level of improvement of relationship satisfaction in these couples over the course of therapy. However, these results are not in-line with the highly significant observed outcomes for EFT in previous studies with non-trauma couples of 70- 75% of couples meeting criteria for recovery which was defined as no longer being relationally distressed and it will therefore be important to integrate a non-traumatized control group into future studies to examine the differences in process and outcome between these two groups (Johnson, Hunsley, Greenberg, & Schindler, 1999).

Another important factor to consider in examining these findings is that the majority of the couples in the study did not feel that they were ready to terminate therapy at the end of the study. In their exit interviews many of these couples indicated that they were only just beginning to regularly try to find new solutions to old problems and generalize their experiences in session to the relationship outside of therapy. In fact, only one of the greatest change couples was actually rated by the researcher as having completed all of the

stages and steps of EFT. Based on these findings may reflect more of an intermediate level of change than an optimal post-therapy rating. This provides further support for the recommendation of offering between 30 and 35 sessions of therapy for traumatized couples.

Two of the CSA survivors in the study terminated relationships with partners who were growing increasingly emotionally abusive. The male partner in both of these couples showed low levels of commitment and willingness to participate in the therapy process and both couples attended fewer sessions than the mean due to their decision to terminate. Both of the CSA survivors in these couples credited the EFT therapy with helping them wake from their defensive numbness, become aware of the abuse in their relationships and to feel both entitled and empowered to make a positive change for themselves through leaving their relationships. However, the non-CSA partners in these couples may have felt that the therapy was overly focused on their partner and thus potentiated defensive responses escalating into emotionally abusive behaviours. Alternately, they may have experienced the emotional dysregulation of their partners in the EFT process to be particularly challenging resulting in an increase in observed emotionally controlling behaviours. However, these partners did not express concerns about the treatment process in exit interviews. It is not the goal of EFT to facilitate the termination of relationships and it is therefore important in future expanded empirical studies to track characteristics of couples who terminate their relationships due to elevated distress versus those who evidence resolution of relationship distress to determine if there are any particular couple or partner characteristics associated with negative outcomes that might represent contraindications for EFT for trauma survivors. Given the high prevalence of trauma survivors experiencing

revictimization in relationships these observational results may provide important data with which to understand the clinical process of working with these couples.

Trauma Symptoms

Five CSA trauma survivors reported clinically significant decreases in trauma symptoms on the TSI and all of the CSA survivors reported clinically significant improvements on the CAPS diagnostic interview at the end of therapy. Given the chronicity of trauma symptoms, these findings are clinically significant and represent a contravention to what would might be expected in a 20 session therapy process. This is true especially given the apparent level Complex PTSD in the majority of the CSA participants.

The CSA partners in Couples 5 and 9 reported clinically significant decreases in trauma symptoms on the TSI. While the CSA partners in couples 5, 9, and 15 reported clinically significant decreases in trauma symptoms on the CAPS. These couples terminated their relationships at the end of the therapy process. This raises the question of whether decreases in trauma symptoms are related specifically to the hypothesized improvements in relationship functioning or are, in fact, more causally associated with decreased stress overall, i.e. ending a distressing relationship or having less distress in the relationship. Future empirical study will enable the statistical assessment of this question.

Improvements in trauma symptomatology on the CAPS were more pronounced than on the TSI. This may be due to greater sensitivity to clinical change in Complex PTSD and distressed partners on the CAPS due to a higher number of questions related to interpersonal functioning on the CAPS.

The CAPS is the most extensively investigated interview for PTSD symptoms and has been assessed for validity across different traumatized populations including CSA

survivors (Weathers, Keane, & Davidson, 2001). In a review of the first ten years of research utilizing the CAPS interview, Weathers et al. (2001) identified 29 treatment outcome studies utilizing CBT, exposure based group therapies and Eye Movement Desensitization Reprogramming (EMDR) which provided evidence for the sensitivity of the CAPS interview to clinical change. Improvement rates identified on the CAPS ranged from 20-90% over the course of treatment. Unfortunately, none of the reviewed studies were based upon experiential or systemic therapies and thus comparisons to our findings are challenging. However, our identified reductions in symptoms are in line with those identified in other cited treatment outcome studies.

It is important however that the CAPS results be considered carefully and in the context of the administration of the measure given that CSA survivor participants were not blind to the purpose of this interview. Survivors were aware at the onset of the treatment that they were required to meet certain criteria to be included in the study. Additionally, survivors were told the purpose of the study in the intake session and thus may have been aware that improvements in trauma symptoms were one of the measured outcomes. As a result of this it is important to consider this finding in light of potentially significant demand characteristics in the assessment situation both pre and post-therapy.

Attachment

One CSA survivor partner demonstrated a clinically significant decrease in attachment related anxiety on a self-report measure of attachment from pre to post-treatment. Two CSA survivors displayed a clinically significant decrease in attachment related avoidance over the course of therapy.

The findings of this study on the self-reported ratings of attachment anxiety and avoidance as measured by the ECR-R do not then provide substantial support to the

prediction of the enhancement of attachment security through EFT in this population.

Given that the process of change in EFT rests upon the theoretical assertion that the therapy unveils, challenges and then reworks attachment responses in relationships, it is important to understand why there seemed to be very little change in the dimensional scores of attachment anxiety and avoidance. A recent study examining the resolution of attachment injuries in couples using EFT, found statistically significant changes in ratings of attachment anxiety but not avoidance (Makinen, 2005). This researcher argued that the clinical characteristics of the particular population studied and the stability of attachment over time could be possible explanations for these limited findings. An earlier study directly assessing the impact of EFT on attachment found some gains in attachment at post-treatment as measured by two self-report measures based on Bartholomew's dimensional model of attachment, but these gains were not maintained at the 4 month follow-up (Sims, 2000).

There are three possible explanations for this failure to find a significant impact of EFT therapy on self-reported attachment. The first is simply that attachment is a stable construct that is resistant to therapeutic change, and that while EFT may, in fact, be challenging attachment based assumptions in relationships and that key attachment behaviours do seem to change in change events such as softenings (Johnson, 1988), these are not having a lasting effect on the general self-reported attachment ratings of participants. The second possible explanation is that EFT does not have an impact on attachment and that the interventions in EFT that are hypothesized to impact upon the attachment schema of partners are having an effect on some other construct of intrapsychic or interpersonal functioning. Another possible explanation, is that EFT is, having an impact on attachment that cannot be measured using a self-report measure of attachment

cognitions. It may take some time and substantial repetition of new behaviours and relational experiences to shift a budding procedural, implicit learning of attachment security into a longer-term change in explicit cognitive schemata of attachment.

Given that this is an important theoretical issue that has the potential to call into question the theoretical underpinnings of EFT, it will be important to test this assumption utilizing newer methodology for measuring attachment, based on behaviour rather than cognitive self-reports. Crowell, Treboux, Gao, and Fyffe (2002) have developed a new methodology for studying adult attachment in romantic relationships using behavioural observation. This is an approach with promise that bears consideration in future studies.

Process

Analysis of the process of change in best sessions revealed that the two couples with the greatest amount of change in their relationship satisfaction demonstrated higher levels of experiencing and more affiliative interactions than the two couples who reported the greatest deterioration in relationship satisfaction. At pre-treatment, the greatest change couples exhibited higher levels of affirming and understanding, belittling and blaming and ignoring and neglecting. These negative change couples exhibited more sulking and appeasing. Interestingly, the pre-treatment greatest change couples exhibited higher levels of hostile and autonomous interactions which, one would assume, reflected higher levels of distress or negativity in these couples, and put them at a disadvantage relative to the other couples who were not exhibiting these behaviors at the same level. This finding may be considered in light of the observation that improvements in relationship satisfaction and trauma symptoms over the course of therapy were associated with the development of an expanded range of affective expression. Thus it may suggest that even though these couples were exhibiting higher levels of negative interactions, they were exhibiting a

greater range of behaviours and a higher level of differentiation in responding, and were beginning with advanced capacity relative to other couples in the study to benefit from EFT. In a larger scale study it will be important to compare greatest change, greatest deterioration and couples with a median amount of change. Additionally, the analyses utilized to measure differences on process measures in this study were purely observational and a larger scale study utilizing quantitative analyses is recommended before any stronger process of change statements can be made.

Thematic Analysis

Affect Regulation

Thematic analyses revealed that traumatic sequelae in both CSA trauma survivor partners and some non-CSA trauma survivors had an impact on the application of EFT to these couples. Affect regulation was the most significant area of challenge for CSA survivors in EFT. Shame, anger, hypervigilance and an inability to trust and take risks were significant challenges for the therapists and couples. Given the challenges that survivors evidenced in managing affect and the difficulties that were faced in helping survivors regulate their affect throughout the process of EFT in this study it will be important to assess whether a model such as EFT that utilizes interventions designed to heighten affect is the most appropriate therapy for CSA survivors. This is a question that can only be answered in a larger scale study.

The conceptual framework for understanding the possible impact of CSA on the application of EFT was based on the literature and clinical evidence regarding treatment of Posttraumatic Stress Disorder. While the participants in our study did meet the diagnostic criteria for Posttraumatic Stress Disorder, systematic review of the clinical evidence suggests that the severity and diversity of trauma sequelae in these participants would more

aptly be understood within the putative diagnostic framework of Complex Posttraumatic Stress Disorder (Herman, 1992) or Disorders of Extreme Stress (DESNOS) (van der Kolk, 1996). Additionally, half of our couples were dual trauma couples.

In clinical settings, these individuals are characterized as having pervasive difficulties with self-regulation, experiencing even minor stressors as overwhelming, having a loss of ability to focus on relevant stimuli and an inability to inhibit themselves when aroused (van der Kolk, Perry, & Herman, 1991).

This conceptualization provides a greater degree of understanding for the pervasive deficits that many of the CSA participants in the study had in the specified domains. The only three CSA participants who would not have met these criteria based on the review of the therapy, were from Couples 6, 14 and 18 who were the three couples who demonstrated the highest level of change on relationship satisfaction. The CSA partner in Couple 6 did not demonstrate the same degree of challenge with affect regulation and self-capacities. Her abuse was a single episode sexual assault during adolescence and her PTSD symptoms were acute rather than chronic as in the other survivors in the study. The CSA survivors in Couple 14 and 18 had had many years of individual therapy and were highly adept at articulating the impact of trauma on their responses in their relationships and processing emotional material in sessions. In fact, the clinical challenges in working with Couple 14 were related to the distress and trauma of the non-CSA partner.

Research findings of treatment outcome studies with individuals meeting the criteria for Complex PTSD/DESNOS offer further clarification for some of these findings. In particular, Ford and Kidd (1998) found that it was meeting the criteria for DESNOS rather than having experienced early developmental trauma that distinguished treatment outcomes in a multimodal milieu therapy. In particular, they found that the DESNOS participants

responded poorly to therapy due to problems with self regulation or showed negligible response to treatment and that those with high levels of anger had the worst outcomes.

This research may offer some clarification for the minimal change in two couples and for the deterioration in Couple 5 where the CSA survivor was continuously flooded with angry affect and did not shift in her inability to regulate her affect over the course of 26 sessions of therapy. Additionally, in Couple 1, where both partners had experienced severe trauma, a finding of no change can may understood in relation to the significant impairments in affective and interpersonal functioning that both members of this couple displayed, and which are explained by this framework. In sum, given the high prevalence of suspected Complex PTSD in our participants (80%), finding clinically and statistically significant improvements in relationship satisfaction and trauma symptoms may contravene expected outcomes for couple therapy with these clients.

If this conceptual understanding of these clients is extended back to the existing research on the process of change in EFT greater understanding of the challenges to full engagement in the therapy can be found. In particular, Greenberg et al.'s (1985) initial exploration of the role of affect in the context of therapeutic change indicated that many clinical problems are caused by a disconnection between the synthesis of emotion and cognition, and that affect regulation, differentiation and integration must by necessity develop for therapeutic change to occur. Thus, CSA survivors who meet the putative criteria for Complex PTSD, will face significant challenges in fully engaging in EFT and in benefiting from the treatment unless they are carefully supported in the development of new skills and affect regulation capacities.

Given the high levels of suspected Complex PTSD and dual trauma evident in this sample, the findings of clinically significant change in over half of the sample are tentatively promising and suggest that further study is warranted.

The Model

The findings of this study provide initial exploration and clarification of the theoretical process of EFT with trauma survivors. In particular the application of the EFT model with these couples was elongated, quantity and specificity of psychoeducation had an impact on outcome and therapist interventions including higher levels of support for affect regulation and directing interactions so that affective regulation capacities were respected and risks were small and calculated were associated with positive outcomes in couples.

The majority of couples reported that they did not feel that they had completed therapy at the end of the study after an average of 19 sessions. The major hurdle experienced by these couples relative to the implementation of the EFT model was in the transition from Stage One to Stage Two. CSA survivor couples demonstrated particular challenges in maintaining de-escalation and were found to re-escalate between sessions over the course of many weeks.

Once again, if these findings are put in the context of the developing trauma literature, they can be clarified and further articulation of the EFT process for CSA survivors can be made. As discussed, CSA survivors who meet criteria for DESNOS and PTSD exhibit alterations in memory and learning that may have impacted upon the ability of couples to maintain de-escalation and to resolve the hypervigilance “I Will Never” issue in 20 sessions. To fully understand these issues it is important to incorporate what is known about both the biology and psychology of trauma.

Using neuroimaging technology Rauch, van der Kolk, Fisler, and Alper, (1996) and van der Kolk and Fisler (1995) found that PTSD participants demonstrated significant impairments in working memory and in selective attention. In particular what they found was that these participants selectively attended to fear inducing or threat provoking material. So in fact, “I Will Never” may simply represent the fact that these survivors can completely miss the 100 positive attachment enhancing behaviours of their partners and selectively attend to the one day when their partner forgot to call home from work to say that they would be late for dinner. This selective attention would then reconfirm their unwillingness to take risks in the relationship thus supporting the assertion that the EFT with trauma survivors will require more sessions, more coaching and more facilitation of interactions that disconfirm trauma laden beliefs.

Additionally, ongoing trauma research has found validation for the clinical evidence of significant challenges in maintaining new learning in the context of emotionally disruptive stimuli. In particular, brain areas involved in verbal processing and verbal memory become deactivated in PTSD participants when they are exposed to emotionally arousing experimental conditions (Rauch & Shin, 1997). Further, Shin et al. (1997) identified alterations in neurological functioning in PTSD participants that resulted in a constant activation of biological stress responses. Yehuda (2003) identified that low cortisol levels in chronic PTSD participants were a part of a larger biological stress response that never properly terminated and which can result in an inability to regulate affect. This chronic stress response may be associated with the inability to leave the past in the past, as traumatic emotions and memories are constantly activated (Yehuda, 2003).

Therefore, the CSA survivors in this study re-escalating frequently between sessions, finding it challenging to retain the new relational learning and interpreting

relational experiences and interactions through the lens of the past may, in part, have been a clinical manifestation of these phenomena. New learning in the relationship was disrupted as soon as a trauma trigger was activated or a selectively attended threat to attachment safety occurred. These findings further clarify why such explicit interventions around externalizing the trauma and providing psychoeducational explanations for trauma related distress were so helpful to these couples.

Characteristics Associated with Outcomes

Due to the thematic nature of the case by case qualitative methodology used in this study it was difficult to make specific statements about characteristics associated with outcome. In particular since the goal was to identify common factors, identifying different variables associated with outcome was a challenge. However, there were some expressions of the identified themes that varied between couples and were associated with outcome. These assertions are based upon a comparison of observed change on outcome measures and qualitative analyses of the identified themes over the course of therapy.

Demographics. There was only one demographic characteristic that was associated with outcome. Having been in individual therapy in CSA survivors was positively associated with outcome. Four of the five CSA survivors who were members of couples that reported clinically significant change in mean relationship satisfaction had participated in individual therapy for at least one year prior to starting the study. These survivors appeared to have greater capacity to differentiate past from present, identify trauma triggers and articulate their emotional responses than other CSA survivors in the study.

Trauma Related. Dual trauma couples evidenced more challenges in completing the stages and steps of EFT than single trauma couples. These couples experienced more significant challenges in learning new ways to respond to each other. Trauma survivors

who evidenced more severe deficits in affect regulation required more sessions and more support to engage in the EFT therapy process. The higher levels of constriction of affect and the presence of trauma related dominant affect stalled the process. Outcomes for couples where shame was the dominant affective expression were better than for those who evidenced anger. The higher the level of expanded affect the more stable and positive the treatment gains in later stages of therapy. Additionally, anger in a dual trauma couple was more associated with negative outcomes than shame.

Further, the more hypervigilant the trauma survivor appeared to be, the more sessions it took and the more re-escalations occurred prior to the completion of the transition from De-escalation to Re-engagement.

Telling the Story. Five of the six CSA survivor partners who over the course of therapy disclosed previously unknown details about their abuse and their healing journey to their partners were members of the five couples who reported clinically significant improvements in mean relationship satisfaction.

However, the higher the level of “I Will Never” in the traumatized partner the lower the likelihood of reaching Step 9 and maintaining the decreases in distress from the De-escalation stage. The one couple where both traumatized partners displayed high levels “I Will Never” terminated their relationship.

Therapist Related. The higher the observed levels of explicit externalization through the use of psychoeducation and imagery of the trauma from all domains of the couple distress including identifying and externalizing the entrenchment of the trauma into the couple’s negative interaction cycle, the more easily the couple moved through the process of EFT. This factor was also associated with positive outcomes. Specific affect regulation strategies such as affective sculpting rather than heightening were associated

with lower levels of flooding and distress in sessions. Providing very specific and frequent psychoeducation was associated with more positive outcomes.

Clinical Implications

The findings from this study provide important initial exploration of the process of EFT with trauma survivors and their partners. Additionally, the rich qualitative data obtained through the thematic analysis allows for further articulation of EFT with trauma survivors to provide more explicit clinical recommendations for therapists working with CSA survivors and their partners.

EFT for couples is a therapy which utilizes an attachment framework and key interventions involve heightening of affect and articulation of underlying attachment fears and needs to reconstruct interaction patterns and build secure attachment in the couple. This is a therapy that is predicated upon the capacity of the participants to process affective material verbally and to tolerate affective arousal. The hypothesized model of EFT for trauma survivors (Johnson, 2002) proposes accommodations for the limitations of CSA survivors in these capacities which have been supported by the findings of this study, and provides a response to the question of whether given the significant detriments in these capacities in CSA survivors. Based on our findings, utilizing appropriate assessment methods and the explicit use of the recommended EFT modifications to the model may allow EFT to be a helpful intervention for CSA survivors and their partners in terms of improving relationship satisfaction and trauma symptoms. Further empirical study is required before any stronger statements can be made.

CSA survivors struggled to regulate their affect throughout the process of EFT and, in particular, in the early stages of the process. This called into question the appropriateness of utilizing an affectively activating therapeutic process with these couples.

However, emotion researchers and trauma focused clinicians and researchers discussing individual therapy for trauma survivors are of the consensus that while didactic learning is an important first level of intervention for trauma survivors, the only way to shift chronic trauma-based affective disturbances and relational schemas is through the accessing, activating, expressing and resolving of these schemas in the context of a new and restorative therapeutic relationship. EFT for trauma survivors and their partners provides the addition of intervening directly at the level of the primary attachment relationship for the survivor and creating the direct context for the development of a new emotional experience of the partner. While this may be more challenging with trauma survivors, it has the potential to be profoundly and deeply restorative (Briere, 1997; Paivio & Nieuwenhuis, 2001; van der Kolk, 1996).

The original theoretical extension of EFT to trauma survivors was mapped upon the three phase model of trauma therapy and argued that EFT would provide an important adjunct to individual therapy (McCann et al., 1990). It was suggested that the three stages of trauma therapy in this model were mirrored by the EFT model. In particular it was suggested that the first stage, Stabilization paralleled the De-escalation stage of EFT. However, the findings from this study suggest that for Complex PTSD participants, the De-escalation stage of EFT was not stabilizing per se and in fact, for some participants, it can be highly challenging and triggering. Additionally, CSA survivors who had had more individual therapy reported more positive outcomes. As suggested in the initial formulation of EFT it is most aptly incorporated into trauma treatment following preliminary recovery and work where reestablishing interpersonal connections and accumulating restitutive emotional experiences are the focus of the therapeutic work (Herman, 1992 & van der Kolk, 1996).

Assessment

The findings of this study have explored the process of EFT with CSA survivors and their partners and have provided rich clinical data to allow for greater articulation of the model.

Based on our finding that one of the most significant challenges for CSA survivors and their partners in EFT couple therapy is regulating and containing affect in sessions, it is recommended that a thorough couple assessment be carried out prior to beginning EFT .

In determining the appropriate treatment paradigm for any given couple, assessment of simple and complex trauma symptoms is recommended. Using the Structured Interview for Disorders of Extreme Stress (SIDES) (Pelcovitz et al., 1997) and the Diagnostic Assessment for Posttraumatic Symptomatology (DAPS) (Briere, 2001) which is a well validated self-reported measure of trauma symptoms that yields diagnostic information about PTSD, referred CSA clients and their partners would initially be assessed for PTSD versus DEPNOS/Complex PTSD.

With a diagnosis of simple PTSD, it is probably appropriate for couples to begin EFT immediately. With a diagnosis of Complex PTSD it will be important to further evaluate affect regulation and self-capacities. The Inventory of Altered Self Capacities (IASC, Briere & Runtz, 2002) is a 63 item measure that has been shown to be reliable and valid in both community and clinical samples. This measure assesses three areas of self capacities, including the ability to form and maintain relationships, the ability to develop and maintain a stable sense of self and the ability to tolerate and control strong affect and would be the recommended approach to assessing a trauma survivor's capacity to tolerate EFT. If this measure does not yield a clinically significant score in the domains of self and affect regulation, then a couple would be considered appropriate to begin EFT with careful

accommodations for the extent of the trauma symptomatology in the survivor. Of course, assessment is an ongoing process, and these recommendations relate only to the initial stages of therapy. Many of the participants in our study did not disclose the extent of their trauma history, dissociative symptoms and psychological distress until a level of safety had been established in the therapy. Assessment for increasing levels of distress or diminished capacity to tolerate an affectively stimulating therapy should be ongoing.

For CSA and other trauma survivors who evidence clinically significant impairments in self capacities and affect regulation, a referral to an individual therapist who specializes in working with clients with complex trauma symptoms is appropriate. Referring to a therapist who has a systemic perspective and will include the partner in the therapy process periodically would be ideal. This survivor and their partner may be in a clinical position to be re-referred for couple therapy at a later date.

Therapeutic Process of EFT with Trauma Survivors

A pre-condition for the application of EFT to trauma survivors and their partners is the expertise of therapists in both EFT therapy and in working with CSA survivors. These therapists must by necessity have a broad base of knowledge about the impact of trauma and have the capacity to contain significant traumatic affect in sessions. The therapists in this study were all screened for these skills prior to beginning this study

The findings of this study provide some support to the model of EFT for trauma survivors and allows for the articulation of specific recommendations beyond the original theoretical conceptualization (Johnson, 2002).

1) As the therapist begins guiding the couple through the process of EFT it is recommended that they move slowly using affective sculpting and working to maintain what Briere (1997) calls the Therapeutic Window. Using explicit strategies of titration of

affective heightening will ensure that each survivor's capacity to tolerate affective arousal is respected. As such trauma survivors are supported in being emotionally engaged in processing rather than shooting over the mark and being dysregulated or under the mark and being numbed or dissociated. Gradual scaffolding of survivors in developing greater levels of affective differentiation and regulation is also recommended. Restructuring of interactions should be done in a developmental fashion with gradual increases in the level of affective challenge. Numbing and dissociation will be monitored by therapists moment by moment, and survivors supported in developing safety and skills at staying present in therapy.

2) Directed interactions in therapy need to be highly scripted and structured with risks being minimal and partners being carefully supported.

3) Specific externalization of the trauma in the relationship including the use of imagery, psychoeducation and explicit interpretations of the negative interaction cycle are pivotal to the therapeutic process. Specific non-affectively stimulating didactic educational processes may circumvent some of the challenges that survivors face in incorporating new learning within an affectively charged environment.

4) The process of EFT will need to be lengthened. This is required to avoid the repetitive re-escalation, de-escalation cycle that was identified in couples in this study and to address the complex needs of these couples such as high levels of mistrust and hypervigilance. It is suggested that, in particular, a longer Stage One process will allow for more explicit preparation for de-escalation and for the couple to be feeling more safe and contained within the context of the therapy thus minimizing the degree of relapse from de-escalation. Given the challenges that trauma couples may face with maintaining new

learning, it is recommended that extensive repetition of experiential relearning with explicit training on how to identify and diffuse re-escalation or relapse be undertaken.

5) Facilitation of disclosure of details about the survivor's traumatic experiences and healing process is also an important element in the process of EFT. In our study partners stated that they knew that their partner was abused, but that they did not know anything about what actually happened to them. Additionally, they stated that they felt closer and more able to support their traumatized partner when they understood what had happened to them. The findings from this study suggest that it is useful for therapists to help survivors let their partner in on their story, and understand that letting go of the secret can be an important element in the healing process for both the individual and the couple and can facilitate progress through stages of the model where open dialogue is essential.

6) Extrapolating the past from the present will continue to be a pivotal task throughout therapy and couples need to be supported in looking at the puzzle pieces of their life and putting the pieces back carefully noticing where the trauma stops and the present begins. If one or both partners moves in to shame or self blame, processing will need to be put on hold until containment can be reestablished. The goal of this process is to assist the couple to be able to separate out their trauma, articulate their needs and feelings without flooding and make space to listen to their partner's needs without dissociating or numbing or being overwhelmed with shame and self-blame.

7) Our findings suggest that facilitating the expression of unmet attachment needs is more complex with trauma couples and that both partners will require support and containment in this process. For trauma survivors this can involve identifying needs that have been disowned through escalating relational distress, but can also include needs that were never met in the context of a neglectful or abusive childhood or betrayals and injuries

from childhood attachment relationships, and the blocking of allowing the self to need or express any need due to threats of abuse. Our findings suggest that this process can induce shame, self-blame and trigger trauma based responding.

8) The termination stage with trauma couples needs to be more gradual than with non-trauma couples given the risks for relapse, re-escalation and challenges maintaining new relational learning.

Through EFT, trauma survivors can be supported in looking at themselves head-on, normalizing their responses to trauma, their fears and their needs and helping them use their partner as a mirror for the present context of their lives in a safe attachment relationship. In many ways this relational context creates an antidote to the shame of unmet needs. A therapist who intervenes in flooding with trauma based shame by directing the survivor to see how their partner is loving them in the present can provide a powerful bridge from the trauma into the new healing possibilities of their relationship. Supporting the trauma survivor in taking the risk to ask for what they need can be deeply transformative.

Additionally, survivors can be supported in responding to their partner's feelings and needs. Based on our findings they will need to be supported in understanding that their partners can express their needs without them being annihilated by shame and that they do have the capacity to respond to their partners in the present.

Limitations of the Study

Although the observations in this study yielded important data regarding the theorized EFT process with trauma survivors and their partners it has some limitations that need to be considered.

Methodology. In an effort to paint as vibrant a picture as possible of the application of EFT to CSA survivors in this first study, an exploratory qualitative approach was taken

to analyses. As such, statements regarding the efficacy of EFT with CSA survivors beyond this study must be very tentatively made. The generalizability of these findings is limited. However, before empirical study can be carried out on the theorized EFT model for trauma survivors descriptive exploration was required yielding more specific recommendations for the therapeutic application of EFT with survivors and their partners.

The lack of quantitative analyses meant that important factors could not be controlled for statistically. For example, the presence, absence and length of previous psychological treatment is an important potential confounding factor that was only assessed observationally.

Measures. Utilizing community norms for the DAS measure may have created an artificially stringent standard against which to measure change in relationship satisfaction over the course of the study. Additionally, in future a measure of the therapeutic alliance would be a beneficial addition. Psychotherapy research consistently finds that the quality of the therapeutic alliance is associated with outcome and in exit interviews, our couples all reported that they felt very positively oriented towards their therapists. This may have been an important variable that was not assessed. As discussed above, the measure of attachment may not be assessing the domain or experience of attachment change that may occur with EFT. Recommendations for assessing this issue were discussed.

Given the prevalence of reported trauma in our non-CSA partner participants, it was a limitation of this study that we did not measure trauma symptomatology through the CAPS in both partners at both pre and post treatment. Additionally, trauma experiences were not assessed utilizing a quantitative measure of traumatic experiences to insure that all traumas were accounted for in our understanding of the impact of CSA on the treatment. Potentially, unreported, non-CSA traumas may have also played a role in the long term

interpersonal distress of the survivor or her partner. It will be important for future studies to consider these measurement issues during the development phase of the study.

Sample. It was the goal of the researcher to examine the use of EFT with simple PTSD CSA survivors in single trauma couples. However there was a high prevalence of dual trauma couples and the majority of the participants in this study would have met the putative diagnostic criteria for Complex PTSD. This may have complicated the ability of the researcher to identify themes specifically related to CSA trauma and for couples to achieve positive outcomes in the limited number of sessions available.

It is possible that recruitment played a role in obtaining such a highly distressed sample. In particular, the majority of participants were referred by community therapists who were familiar with the principal investigator, the supervisor, or both. This may have led to a preponderance of highly clinically distressed couples. Additionally, it is possible that there was an association between the fact that the therapy was free and the levels of distress in these couples such that those survivors who are less distressed might be more occupationally functional and therefore in a better position to voluntarily seek fee for service therapy.

The size of the sample also limited the ability of this research to generalize findings beyond these observations and to identify statistically significant effects of therapy on the majority of the outcome variables. However, exploratory qualitative study requires extensive and in-depth analyses. Additionally, working with a highly distressed population over 20 sessions of therapy with volunteer expert therapists necessitates a small sample size. The absence of a control group further limits the generalizability of these findings.

Length of Treatment. Couples in this study were offered up to 20 sessions of therapy with the average number of sessions being 19. However, all but one of the couples

reported at the exit interviews that they did not feel as though they were ready for therapy to end. We did not have the opportunity to assess levels of change over a longer-term therapy that may have more adequately addressed the levels of distress that this sample was experiencing.

In previous EFT research with non-trauma couples, the process of therapy has been successfully condensed from the 15-20 sessions that would occur in a clinical setting to 8-12 sessions to expedite the research process. It is apparent from this study that this abbreviation of sessions is not an effective research strategy with trauma couples and that they will not tolerate an acceleration of the therapy process due to the challenges with affect regulation and pacing.

Follow Up. The absence of a built-in follow-up is a limitation of this study especially given the number of couples who indicated that they would like to continue with couple therapy. It is highly likely that these participants had not completed the full process of EFT and that our results represent an intermediate level of change. All participants did express openness to being contacted in the future for follow-up and this may be investigated at a future date.

Future Directions

The results of this study provided an initial exploratory illustration of the use of EFT with CSA survivors and their partners. Both process and outcome observations provided some initial support for the theoretical process of EFT with trauma survivors and their partners and provided rich data upon which to base the development of specific therapeutic recommendations for working with traumatized couples.

While we are further ahead in understanding many of the themes related to trauma and the application of the EFT to these couples, the multidimensional nature of this data

has created many questions about process and efficacy of EFT with trauma survivor couples that will only be answered through future research. Future directions in the study of EFT and trauma need to be focused around understanding the clinical factors that are correlated with positive outcomes and treatment efficacy.

The next step in this particular field of inquiry is to use the results of this study to further articulate and refine the EFT model with trauma survivors and their partners. Future research involving larger samples where quantitative assessment of treatment efficacy can occur and explicit assessment of affect regulation, relational hypervigilance and behavioural assessment of attachment is performed at regular intervals will allow for more specific statements to be generated regarding the process and efficacy of EFT. Ideally, this study would examine the use of EFT with participants dealing with both simple and complex PTSD presentations in survivors of diverse forms of trauma.

Following this it is recommended that controlled clinical outcome studies utilizing the clarified EFT model be carried out to provide a higher degree of validation of the process and efficacy of EFT. Given the challenges that the survivors in this study faced with regulating affect, learning new relational ways of being and maintaining their gains in therapy, it would be appropriate to perform these controlled comparative outcome studies examining the efficacy and process of a less affectively oriented and more didactic approach to working with trauma survivors in couple therapy. Given the levels of empirical validation and some preliminary theoretical extension of theory to trauma survivors, Behavioural Marital Therapy would provide an appropriate comparison to EFT.

In conclusion, this study painted a broad and colourful picture of the experience of CSA survivors and their partners in EFT couple therapy, explored the use of the EFT model with this population and provided important observational data upon which to base specific

recommendations for the continued development of EFT. Our findings clarified the impact of trauma on the implementation of EFT with CSA survivors and highlighted the importance of providing focused and explicit interventions to survivors that accommodate to their unique challenges. In spite of challenges with regulating and differentiating affect, especially shame and anger, improvements in relationship satisfaction and trauma symptoms suggest that the EFT model may be a promising intervention for trauma couples. Perhaps the most salient result however is the tentative provision of support for the theoretical and clinical assertion that incorporating couple therapy into the healing process of trauma survivors in relationships may be powerful and timely. This inclusion can provide an opportunity for healing on a deeper relational level that can occur in individual therapy while incorporating the survivor's primary attachment figure into the healing journey from which they have historically been alienated.

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APPENDIX A

Media Advertisement
Standardized Telephone Screening Procedure
Information and Consent Form

Does NOT meet the criteria

If the caller does not meet inclusion criteria, thank them for their interest in the study. Ask caller if he/she would like to be referred elsewhere for treatment.

Has the caller been referred elsewhere for treatment? _____

If yes, please specify:

Catholic Family Services	_____
Centre for Psychological Services	_____
Family Service Centre of Ottawa	_____
Jewish Family Services	_____
Ottawa Couples & Family Institute	_____
Catholic Family Services	_____
Royal Ottawa Hospital	_____

Does meet the criteria

If the couple meet all the inclusion criteria, obtain the names of the potential participants and their phone numbers. Offer the caller to list of resources.

Names: _____ Tel.: (H) _____
 _____ (W) _____
 _____ (H) _____
 _____ (W) _____

Address: _____

Set up an appointment for completion of questionnaires and advise couple that this may take up to 1 ½ hours.

Date _____ Time _____
 Place: Centre for Psychological Services (give appropriate directions).

Therapeutic Approach Used in This Study

The particular approach of couples counseling that you will be offered is called Emotionally Focused Couples Therapy. This form of therapy has been established to be successful in helping distressed couples improve their relationships.

Benefits

No benefits are guaranteed to you for taking part in this study. As a result of the therapy, you may experience less distress and more intimacy in the relationship and you may also begin to resolve conflicts with more satisfaction, but no guarantees are made.

Risks

The risks of the study include experiencing uncomfortable feelings when discussing relationship problems during the therapy process. You may find that therapy does not adequately resolve your presenting issues.

Confidentiality

Confidentiality of all tape recordings and written responses will be respected according to the ethical guidelines of the College of Psychologists of Ontario. Your names will be known only to the people who are directly involved in the research. These include the principal investigator, the clinical supervisor, and your therapist. Anonymity will be assured through the pooling of all data so that the published results will be presented in group format and no individual or couple will be identified.

If researchers wish to keep certain recordings for training purposes, you will be asked to sign a consent form to this effect. All other recordings will be completely erased after the end of the study. Written responses to questionnaires as well as progress notes written by the counselors will be kept in a confidential file at the University of Ottawa.

In some situations, the investigator must break the confidentiality agreement. These exceptions are in cases of a court order, of imminent danger to yourself or to others, of disclosures of child abuse, or of disclosures of abuse by a health care professional. In terms of child abuse, we are required by law to inform the appropriate authorities if we become aware that any child under the age of 16 is at risk of being abused. So, while this does not relate to any disclosures of your own childhood abuse experiences it would be necessary for us to report to authorities if you disclosed to us that your abuser was still in regular, unsupervised contact with young children.

APPENDIX B
Process Measures