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EMOTIONALLY FOCUSED THERAPY FOR COUPLES AND CHILDHOOD SEXUAL ABUSE SURVIVORS

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This study explored Emotionally Focused Therapy (EFT) for couples with childhood sexual abuse survivors (CSA) and their partners. Half of the couples in this study reported clinically significant increases in mean relationship satisfaction and clinically significant decreases in trauma symptoms, and 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 were identified to play a role in the challenges that survivors experienced in fully engaging in the EFT process. 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.

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 to create and maintain these healing bonds.

The trauma literature has 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. Therapists have also missed 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. In this vein, this study explored the use of Emotionally Focused Therapy (EFT) for couples dealing with childhood sexual abuse (CSA). In particular, the goals were to examine the ways in which EFT would aid couples in alleviating their relationship distress and help survivors deal with the aftereffects of their traumatic experience. This study is the first systematic, if exploratory, evaluation of any clinical couples' therapy for CSA survivors and their partners.

PSYCHOLOGIC SEQUELAE OF CSA

In a meta-analytic review, Neuman, Houskamp, Pollock, and Briere (1996) found a significant association between CSA and anxiety, anger, depression, revictimization, self-mutilation, sexual problems, substance abuse, suicidality, impairment of self-concept, interpersonal

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problems, obsessions and compulsions, dissociation, posttraumatic stress responses, and somatization. More recently, Paolucci, Genuis, and Violato (2001) conducted a meta-analysis and found significant associations between CSA and the following outcomes: posttraumatic stress disorder (PTSD), depression, suicide, sexual promiscuity, the victim-perpetrator cycle, and academic performance.

In a longitudinal study, Kendler et al. (2000) confirmed the findings of other cross-sectional studies that CSA twins had a significantly higher likelihood of developing lifetime psychopathology. Nelson et al. (2002) found that twins with a CSA history evidenced significantly increased levels of depression, suicide attempts, conduct disorders, substance dependence, rape, and divorce. Authors have also suggested that CSA acts as a general stress factor that amplifies the impact of later stressful life events (Horwitz, Widom, McLaughlin, & Raskin White, 2001).

Spataro and Mullen (2004) assessed the impact of CSA on survivors over 20 years. Survivors evidenced a three times greater risk of developing anxiety disorders and acute stress disorder than controls, and were diagnosed with five times higher rates of personality disorders than controls.

However, even in light of significant interpersonal violation, CSA survivors display a remarkable longing for relationships with others and for stable attachment relationships (Allen, Huntoon, Fultz, & Stein, 2001). Research suggests that interpersonal relationships are potential moderators and mediators of the relationship between CSA and long-term distress (Runtz & Schallow, 1997; Whiffen, Judd, & Aube, 1999). However, the clinical literature has documented long-term and significant impairments in interpersonal functioning in CSA survivors (Nelson & Wampler, 2000). Polusny and Follette (1995) argue that, for CSA survivors, attempts to avoid negative thoughts, feelings, and memories result in coping mechanisms such as dissociation, substance abuse, casual sexual behaviors, and avoidance of interpersonal relationships. While these mechanisms work in relieving pain in the short term, there are negative long-term consequences, such as feelings of isolation, dissatisfaction with relationships, and sexual dysfunction. CSA survivors report problems with emotional communication, intimacy, power, control, and sexual difficulties in intimate relationships (Pistorello & Follette, 1998).

Three exhaustive reviews of this literature have been published within the last 6 years (Davis & Petretic-Jackson, 2000; DiLillo, 2001; Rumstein-McKean & Hunsley, 2001). All found that CSA survivors report more current relationship problems than nonsurvivors, 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.

Partners of CSA survivors identify isolation, pain, anger, frustration, dissatisfaction, and communication problems as major concerns (Reid, Wampler, & Taylor, 1996). Partners also 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. CSA can then have a significant effect on survivors' ability to engage in healthy, supportive intimate relationships and on their partners (Feinauer, Callahan, & Hilton, 1996).

While the majority of treatment modalities for CSA have focused on the individual, an alternative and effective therapy for CSA survivors might 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. It is thus 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 offers a theoretical conceptualization of the relationship between CSA and later interpersonal dysfunction that has received some empirical support (Alexander, 1992). Research has 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 (Simpson & Rholes, 1998). Securely attached couples were characterized by higher levels of trust and commitment, and higher dyadic satisfaction (Simpson, 1990).

Many CSA survivors show a fearful/avoidant style of attachment, reporting negative views of themselves and others. This style is characterized by high levels of avoidance of closeness and sharing and high anxiety about their partner and their relationships (Simpson & Rholes, 1998). As such, a couple therapy for CSA survivors should be based on an awareness of attachment-related processes in couple distress and in the couple therapy process.

Couples Therapies and CSA Survivors

Currently, the literature that discusses couples therapy for CSA survivors and their partners is primarily based on theoretical discussions or case-study descriptions. Compton and Follette (2002) have attempted to articulate the application of Behavioral Marital Therapy (BMT) to couples where one partner is a CSA survivor. They emphasize training around issues such as dissociation, affect regulation and learning to minimize tension-reducing behaviors such as substance abuse or self-harm, and the development of communication skills, psychoeducation, and behavioral exchange skills. Buttenheim and Levendosky (1994) and Maltas (1996) offer a conceptualization of a treatment of a CSA survivor from an object relationships and a psychoanalytic perspective. These authors contend that early trauma is reenacted in adult intimate relationships. These reenactments are unconscious and therefore interpreted as viable present experiences. This work suggests interpretations and education be geared toward assisting the couple in moving out of old reenactment patterns where the past is understood and kept separate from the present.

The rationale for couple therapy differs between these interventions. For the behaviorist, couple therapy allows the partner to be educated about the effects of trauma, to better understand the survivor, and to build the ratio of positive to negative interactions and reorient their relationship. More 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 to refocus them in the present.

EMOTIONALLY FOCUSED THERAPY

Emotionally focused therapy is a form of couple therapy that 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 couple interventions (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998). (See Johnson, 1996, for a complete description of the EFT process of change.)

Emotionally focused therapy has been found to be effective with diverse populations, including depressed women (Dessaulles, 1991; Johnson, 1998) and families experiencing chronic stress or coping with a chronically ill child (Gordon Walker, Johnson, Manion, & Cloutier, 1996). EFT has also been systematically applied to distressed couples dealing with different forms of traumatic stress (Johnson, 2002). Case studies have been published in the literature on the use of EFT with couples in which one partner has symptoms of PTSD (Johnson & Williams-Keeler, 1998).

Emotionally focused therapy emphasizes the role of affect in therapeutic change. Powerful attachment emotions are observed as organizing the rigid interactional cycles, such as blame/defend or pursue/withdraw, in dysfunctional interactions. Key emotions are restructured in the safety of the therapy sessions. New emotions then can be used to move partners into new

positions with their partner. Expressing primary underlying feelings of fear, for example, instead of reactive anger, changes the signals to, and evokes new responses from, a partner.

It can be argued that EFT is particularly suited to couples facing trauma as it deals directly with affect regulation and assists couples in obtaining social support, which, when blocked, is linked to challenges in recovering from trauma. Johnson (2002) suggests that a more secure bond with a partner creates a safe haven that helps the CSA survivor regulate her grief, anger, and fear in a positive self- and relationship-enhancing way. This safer relationship with a partner helps the survivor deal with emotionally loaded re-experiencing symptoms such as nightmares, intrusive thoughts, and flashbacks in a constructive way. Turning to one's partner for comfort then begins to replace other negative affect regulation strategies such as self-injury 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 expectations and fears concerning others can be revised. The therapist tracks and clarifies how each partner processes key relationship events and the attributions that occur in these events. The acceptance and reassurance of the partner in key change events are also hypothesized to increase the CSA survivor's sense of self-worth. The facilitation of new cycles and behaviors confirms positive perceptions of the spouse and allows for the continued reprocessing and integration of traumatic experience. This powerful process uses the partner as an ally in the healing.

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 impede many CSA survivors in developing healthy relationships. Consistently, survivors report higher levels of relationship distress and divorce and lower levels of intimacy and communication in their relationships. Additionally, as 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 like 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 within the family. Therefore, it was the goal of this study to explore the use of EFT with CSA survivors and their partners.

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 is based is 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. Specific themes that arose in the treatment of couple distress in EFT for CSA survivors were identified through a thematic analysis.

Thematic analysis is a qualitative methodology that 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 was modified to be applicable to the audiotaped sessions of couple therapy. Step one is to develop a coding framework which is guided by the theoretical approach and research questions. Step two identifies basic lower-order themes that can be derived from the clinical material. In step three, the data are organized into global themes which researchers can begin to build into theories and models of change.

Particular measures were implemented to minimize the threats to internal validity that can accompany qualitative methodology (Kazdin, 1981). The same case-study protocol was used in a series of cases, each of which was designed to provide data on outcome and themes associated with EFT in survivors. Specific hypotheses were developed to guide the investigation; data were gathered at specifically identified intervals in a systematic fashion; 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 audiotaped, 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). Implementation checks were carried out.

Quantitative measures were also administered and analyzed using the concept of the reliable change index. 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 cutoff is set based on an a priori determination (Jacobson & Truax, 1991). Clinically significant change was defined as an improvement or deterioration of one standard deviation (*SD*), or a change that led to movement out of the clinical range on a measure. 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

Quantitative outcome measures. It was predicted that there would be the following posttreatment effects: (1) survivors and their partners in EFT would display a clinically significant increase in levels of relationship satisfaction from pretest to posttest as measured by the Dyadic Adjustment Scale (DAS; Spanier, 1976), (2) survivors would display a clinically significant decrease in traumatic symptomatology from pretest to posttest as measured by the Trauma Symptom Inventory (TSI; Briere, Elliott, Harris, & Cotman, 1995) and the Clinician Administered PTSD Scale (CAPS). Hypothesis 1 was considered supported if the CSA survivor and partner's DAS scores increased beyond one *SD* (16 points) or if couples' DAS scores increased to above the cutoff for distressed relationships (98; Spanier, 1976). Hypothesis 2 was considered to be supported if a clinically significant decrease of traumatic symptomatology was reported in CSA survivor's pre- and postscores on the TSI or the CAPS. Clinically significant decreases on the TSI were defined as decreases of >1 *SD* (10 points) in T scores. Clinically significant decreases on the CAPS were defined as decreases of >1 *SD* (17) or movement into the nonclinical range (<65).

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. A total of seven therapists were involved in this research who were trained in EFT by the originator of EFT. Therapists ranged from master's-level clinicians to doctoral-level psychologists. The therapists received weekly supervision and all of the therapists offered their services on a voluntary basis.

Participants

Ten couples were recruited through local media and community agencies. Couples had been living together for at least 1 year; one partner reported an experience of child sexual abuse defined as unwanted sexual touch before the age of 18 by a person more than 2 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 and the average couple score on the DAS had to be in the mild to severely distressed range (i.e., scores between 70 and 97).

Descriptive Characteristics

Ten couples completed an average of 19 sessions and completed the pre- and posttreatment questionnaire packages. The number of therapy sessions ranged from 11 to 26.

Demographic Characteristics

All of the CSA survivors were female. The average age of the CSA survivor partners was 40.50. The average age of the non-CSA partners was 43.00. Couples had been together for an average of 14.90 years. The average number of children per couple was 1.5. 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.

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 had each received over 10 years of therapy in total. Three CSA survivors had undergone between 1 and 2 years of individual therapy and two CSA survivors 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 had not received any prior individual treatment.

Quantitative 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.

The Dyadic Adjustment Scale. The DAS (Spanier, 1976) 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). 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.

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 (TSI; Briere et al., 1995) is a self-report measure of trauma symptomatology while the CAPS (Blake et al., 1990) is a structured clinical interview designed to yield a diagnosis of PTSD. Reliability and validity of the TSI have been assessed by a number of researchers, including the author (Briere, 1995; Runtz & Roche, 1999). Reliability ranges from alpha .82 to .91 on the clinical scales which include validity scales. 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 domains. 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. 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.

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 process and outcomes of CSA survivors and their partners in EFT.

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 engage fully in the EFT process. Through the process of supervision and consultation with the therapists, tentative basic themes were identified. Following the end of therapy for couple one, the principle researcher reviewed all audiotapes for these tentative basic themes and identified further themes through the systematic review. A coding sheet was developed. These themes were validated through the review of randomized audiotapes by two couple therapy researchers, unattached to this study. 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 emerged following this second couple. At the end of therapy for each couple, the researcher reviewed all audiotapes for these themes using the developed coding sheet. 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. Basic themes were then grouped into larger global theme categories.

RESULTS

Psychometric Properties of the Measures

Preliminary analyses were conducted to test the assumptions regarding the reliability of the self-report measures. The sample consisted of all 20 participants and reliability was calculated on pre- and posttreatment scores for the DAS and the TSI. 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.

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*.

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 difficult life events that they defined as traumas. This population then was severely traumatized and half of the couples were experiencing the effects of dual trauma in their couple relationships.

OUTCOMES OF QUANTITATIVE MEASURES

In partial support of the prediction, half of the couples reported clinically significant improvements in mean relationship satisfaction on the DAS from pre- to posttreatment (pretreatment mean = 78; posttreatment mean = 94). Two of these five couples were dual-trauma couples. The overall mean improvement in relationship satisfaction for CSA survivors was one *SD*, a clinically significant change for the overall sample of survivors. 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 1 year prior to starting the study.

All 10 couples completed the treatment protocol and at least the minimum required number of therapy sessions. However, three couples terminated their relationships over the course of the study. One of these was a dual-trauma couple. Over the course of therapy in two of these couples, the non-CSA male partners became increasingly emotionally abusive. The male partner in these couples responded to the process of identifying underlying emotions and attachment needs with emotionally abusive behavior toward their partners and, in some instances, toward the therapists. In the remaining couple, the CSA survivor partner developed a high level of anger and verbal aggression toward 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 behaviors of these partners were not evident or reported at the time of intake, and would have been considered a contraindication for EFT.

Clinical change in TSI trauma symptoms was determined by comparing partners' change scores over the course of therapy with the normative *SD* of 10. Half of the CSA survivors reported clinically significant improvement from pre- to posttreatment. Three of these were from dual-trauma couples. The mean overall TSI scores for the CSA survivors was 66 at pretreatment and 58 at posttreatment. This represented an improvement of 8 points for the total sample, 2 points lower than our a priori determined cutoff for clinical significance.

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 *SD* of 17. Increases or decreases of >1 *SD* or no longer meeting the cutoff for a diagnosis of PTSD (>65) were predetermined to indicate clinically significant change. All CSA survivors reported clinically significant improvement from pre- to posttreatment. Nine of the survivors' CAPS ratings decreased by more than 17 points and eight of the CSA survivors no longer met criteria for PTSD on the CAPS at the end of the study, encompassing all of the CSA survivors between the two definitions of change. The mean CAPS score for CSA survivors at pretreatment was 83, decreasing to 46 at posttreatment, representing a mean improvement >2 *SD*s of change in trauma symptoms.

THEMATIC ANALYSIS

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

(1) Emotional Flooding: *Feelings are dangerous and overwhelming*.

Nine of the CSA survivors and four of the non-CSA traumatized partners evidenced significant emotional flooding in sessions, which had an impact on their ability to participate actively 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. These survivors were particularly challenged to regulate their affect when their partner was directed to reach out to them and ask them to help in meeting a relational goal or an attachment need.

> 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.

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

On the opposite side of emotional flooding was the emergent global theme of emotional numbing as a result of fearing emotional overwhelm and loss of control. Emotional numbing and overcontrol were characteristics of many trauma survivors' responses to emotionally challenging situations in the therapy. Many of the survivors 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 evidenced substantial numbing of affect in therapy sessions. The only CSA survivor who evidenced severe hyperarousal who did not also evidence numbing was the CSA survivor who exhibited her dominant affect as anger rather than shame.

> 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.

By the halfway mark in the therapy, survivors began to take risks in sharing their fears related to becoming emotionally overwhelmed or coping with this hyperarousal through numbing. Therapists guided their partners to respond in soothing and supportive ways and to learn how and when to check in and support their partner in managing their affective experience. Partners reported feeling more capable of helping their CSA survivor partners than before the therapy. Emotional dysregulation appeared to be amenable to clinical change over the course of therapy.

(3) Dissociation: *I just can't stay here.*

In six couples, the CSA survivor partners evidenced clinically relevant dissociative symptoms in the therapy as identified by their primary therapists and the principle investigator through the audiotape review. The global theme emerged from the basic themes of the CSA survivor's unwillingness or 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 couple's negative interaction cycle.

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

Over the course of therapy, survivors evidenced lower levels of reported dissociation outside of sessions and observed dissociation within sessions. Therapists slowed down the process to assist the survivor in staying present in the same way as the affective hyperarousal was managed, 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 guided to help their partners when they dissociated. These observations suggest that dissociation may also be amenable to clinical change over the course of couple treatment.

(4) Constricted Range of Affect and Affect Dysregulation.

In sessions, the expression of needs and relational distress by the non-CSA partner was observed to trigger affect dysregulation in survivor partners. In particular, it was apparent in both the CSA trauma survivors and the non-CSA traumatized survivor partners that they had one particular affective state that was dominant, unregulated and tied to their trauma. For the majority of the CSA survivors and non-CSA traumatized survivor partners, this affective constriction was associated with shame. 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 complicated 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. Survivors had been shamed by their abusers and taught that they were damaged. Any need or desire was then 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.

Shame: I am damaged and unlovable.

Trauma survivors expressed feeling that their woundedness rendered them culpable for relationship distress, damaged, and unlovable. These partners evidenced the tendency to become immediately flooded with shame in response to any emotional trigger.

> 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 messed up and can't have a normal relationship. Why can't I get it right?

This shame was pervasive and went beyond an affective experience into a way of defining the self.

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

This experience of shame was accentuated by non-CSA partners who tended to make blaming statements.

> 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 were that sessions were often stilted and slow and frequent pauses in the process were required to allow for restabilization, for 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.

Over the course of therapy, this pattern of shameful self-blaming slowly began to fade and demonstrate an expanded range and decreased rigidity of affective expression, becoming more responsive to the actual content and context of the present emotional experience.

(5) 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 survivors and half of the non-CSA partners. This global theme was organized based on the following basic themes: hypervigilance to the attachment figure, telling the story, and "I Will Never."

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 survivors reported in sessions that the calm of de-escalation was frightening 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 also 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." In the dual-trauma survivor couples this process took longer than in the CSA-only trauma couples.

Half of the survivors 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 guided in how to respond to these disclosures. Hypervigilance symptoms appeared to decrease following these disclosures.

The basic theme of "I Will Never" arose over the course of the study out of the often used phrase, "I will never trust him/her." 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. The experience of not being trusted and constantly watched was also distressing for partners.

> 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.

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

Over the course of therapy, therapists repeatedly guided 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. However, for some couples, this hurdle was not overcome in the therapy even in the later stages of EFT. This process of learning 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.

(6) Sexuality: *Sex is shameful and I need control.*

In all but one of the couples, issues with sexuality were highly problematic regardless of the number of years the couple had been together, the age of the partners, or the degree of trauma. Conflict arose over the frequency of sex and in negotiating a sexual relationship that was not a trauma trigger to the CSA survivor partner.

The survivors had strong sexual triggers and many of them continued to harbor negative and shameful thoughts about sexuality. The majority of these survivors voiced that they wanted emotional intimacy as a precondition to sexual intimacy, and that they needed to have control over sexual activity. The majority of the couples had already imposed a sexual moratorium on their relationships prior to beginning therapy due to ongoing conflict and distress.

Over the course of therapy, these struggles were normalized by the therapist and couples were supported by psychoeducation and encouragement 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 were very willing to accommodate their CSA partner's needs for sexual control and to avoid certain activities or positions. 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.

DISCUSSION

The purpose of this study was to explore the use of EFT with CSA survivors and their partners. The concept of the reliable change index was utilized in assessing outcomes. A case-study replication methodology was utilized to examine themes arising during therapy.

Relevant Characteristics of Participants

Participants represented a highly distressed sample, with the majority having experienced chronic, severe, and early intrafamilial sexual abuse; complex trauma. 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 psychologic distress (Merrill, Thomsen, Sinclair, Gold, & Milner, 2001). These couples were also highly relationally distressed, with half of the sample evidencing trauma in both partners. The average relationship satisfaction in couples at pretreatment was bordering on the range for divorced couples.

Outcomes: Relationship Satisfaction

In this study, half of the couples reported clinically significant increases in mean relationship satisfaction. The mean change in relationship satisfaction in the overall sample of survivors exceeded the cutoff 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 then 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 low DAS scores in survivors at pretreatment, this rate of improvement in relationship satisfaction is encouraging and warrants further exploration of this model of intervention.

The researchers also used the norms for relationship satisfaction for a nonclinical outpatient population which, given the consistent finding of lower levels of relationship satisfaction in CSA survivors, may also have been an overly stringent standard against which to compare these couples. Distress cutoffs for trauma couples may be lower than those in nontraumatized couples (Gordon Walker, Johnson, Manion, & Cloutier, 1992). Three couples met the cutoff for relationship satisfaction based on Spanier's (1976) community norms. These results are lower than observed outcomes for EFT with nontrauma couples (Johnson, Hunsley, Greenberg, & Schindler, 1999).

While all couples did complete the therapy protocol, the majority of the couples also reported in their exit interviews that they did not feel as though they were ready to terminate therapy at the end of the study. They indicated that they were only just beginning to generalize their in-session experiences to the relationship outside of therapy. These couples were provided with additional therapy sessions and further follow-up with these couples may occur at a later date. However, these findings may then reflect more of an intermediate level of change than an optimal posttherapy rating.

Outcomes: 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 contravene expectations for a 20-session therapy process. This is true especially given the apparent level of complex trauma symptoms in the majority of the CSA participants. The three CSA partners who terminated their relationships also reported clinically significant decreases in trauma symptoms. 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). Our identified reductions in symptoms are in line with those identified in other cited treatment outcome studies. However, the CAPS results must be considered carefully given that CSA survivor participants were not blind to the purpose of this interview. 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 posttherapy.

Thematic Analysis

Thematic analyses revealed that traumatic sequelae in both CSA trauma survivors and some non-CSA traumatized partners 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 processes affect but also, at times, utilizes interventions designed to heighten affect is the most appropriate therapy for CSA survivors. This is a question that can be explored in terms of further refining the practice of EFT for this population and can also be examined in a larger-scale study.

While the participants in our study met the diagnostic criteria for PTSD, systematic review of the clinical evidence suggests that the severity and diversity of trauma sequelae in these participants are aptly understood within the theorized framework of Complex PTSD (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 particularly pervasive difficulties with self-regulation, experiencing even minor stressors as overwhelming, having a loss of ability to focus on relevant stimuli, and having an inability to inhibit themselves when aroused (van der Kolk, Perry, & Herman, 1991). The three survivors who would not have met the criteria for Complex PTSD, based on the review of the therapy, demonstrated the highest level of change on relationship satisfaction.

Outcome studies with individuals meeting the criteria for Complex PTSD/DESNOS further clarify these findings. Ford and Kidd (1998) found that it was meeting the criteria for DESNOS, rather than having experienced early developmental trauma, that predicted 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 and that those with high levels of anger had the worst outcomes. This research offers some clarification of the minimal change in two couples and for the deterioration in one couple where the survivor was continuously flooded with angry affect. 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 would seem to exceed expected outcomes for couple therapy with these clients.

Findings by Rauch, van der Kolk, Fisler, and Alpert (1996) and van der Kolk and Fisler (1995) that PTSD participants demonstrate significant impairments in working memory and in selective attention may be important in understanding relational hypervigilance in these

couples. They found that these participants selectively attended to fear-inducing or threat-provoking material. So in fact the "I Will Never" theme may simply represent the fact that these survivors can completely miss the 100 positive attachment-enhancing behaviors 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 then reconfirms their unwillingness to take risks in the relationship, thus supporting the assertion that the EFT with such trauma survivors will require more sessions and more facilitation of interactions that disconfirm trauma-laden beliefs.

Ongoing trauma research stresses the clinical evidence for difficulties found in maintaining new learning in the context of emotionally disruptive stimuli. Brain areas involved in verbal processing and verbal memory become deactivated in PTSD survivors when they are exposed to emotionally arousing experimental conditions (Rauch & Shin, 1997). Further, Shin et al. (1997) identified alterations in neurologic functioning in PTSD participants that resulted in a constant activation of biologic stress responses. Yehuda (2003) identified that low cortisol levels in chronic PTSD participants were a part of a larger biologic 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. New learning in the relationship can then be disrupted as soon as a trauma trigger is activated or a selectively attended threat to attachment safety occurred. This suggests that EFT therapists might focus particularly on the processing of this inability to consider positive possibilities leading to shifts in trust. 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.

Clinical Implications

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

The hypothesized model of EFT for trauma survivors (Johnson, 2002) proposes accommodations for the sensitivities of CSA survivors in these areas that have been generally supported by the findings of this study. The explicit use of such modifications as these involve moving to contain emotion when necessary, slicing risks thin, and progressing more slowly in emotionally laden areas.

Childhood sexual abuse survivors struggled to regulate their affect throughout the process of EFT and, in particular, in the early stages of the process. Should, then, an affectively activating therapeutic process such as EFT be used with these couples? Clinicians and researchers seem to agree 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 expectations is through accessing, activating, and expressing these expectations in the context of a new and restorative relationship. EFT intervenes directly at the level of the primary attachment relationship for the survivor and creates 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).

In terms of assessment, the findings suggest that a thorough couple assessment be carried out prior to beginning EFT. Assessment of simple and complex trauma symptoms is particularly 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 DESNOS/Complex PTSD. With a diagnosis of simple PTSD, it is probably appropriate for couples to begin EFT immediately. With complex trauma symptomatology, it will be important to further evaluate affect regulation and self-capacities. For survivors who evidence clinically significant impairments in self-capacities and affect regulation, a referral to individual therapy may be more appropriate. The survivor and his or her partner may then be re-referred for couple therapy at a later date.

In terms of the therapeutic process of EFT with CSA trauma survivors, these findings support the following clinical refinements to EFT. The therapist must move slowly, containing and processing emotions, and take care to use explicit strategies 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. Interactions must also be structured with very gradual increases in the level of affective challenge, and numbing and dissociation must be monitored by therapists moment by moment. Specific externalization of the trauma in the relationship, including the use of imagery, psychoeducation, and explicit interpretations of the negative interaction cycle, is pivotal. Specific psychoeducation may circumvent some of the challenges that survivors face in incorporating new learning within an affectively charged environment. The process of EFT does need to be lengthened to 30–35 sessions as suggested (Johnson, 2002) to avoid repetitive re-escalation and de-escalation cycles and to address the complex needs of these couples such as high levels of mistrust and hypervigilance. Therapists can help survivors let their partner in on their story, and suggest that letting go of the secret can be an important element in the healing process for both the individual and the couple. Shame or self-blame needs to be validated, worked with, and/or contained. Couples will then be better able to separate out their trauma, articulate their needs and feelings without flooding, and make space to listen to their partner's needs. Attachment needs, never acknowledged in families of origin, must be normalized and validated.

A therapist who intervenes in flooding with trauma-based shame by directing the survivor to see how his or her partner is loving him or her in the present can provide a powerful bridge from the trauma into the new healing possibilities of the present relationship. Supporting the trauma survivors in taking the risk to ask for what they need can be deeply transformative and an antidote to shame.

Limitations of the Study

In this first study of CSA survivor couples in EFT, 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 tentative as the generalizability of these findings is limited. The lack of quantitative analyses means that important factors could not controlled for statistically. For example, the presence, absence, and length of previous psychologic treatment are important potential confounding factors that were only assessed observationally.

In terms of 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 this study. In the future, a measure of the therapeutic alliance would also be a beneficial addition even though these couples all reported in exit interviews that they felt very positively oriented toward their therapists. 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 posttreatment. The high prevalence of dual-trauma couples and the presence of Complex PTSD 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.

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. The absence of a control group further limits the generalizability of these findings. In previous EFT research with nontrauma 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.

Future Directions

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. Future research involving larger samples where quantitative assessment of treatment efficacy can occur and explicit assessment of affect regulation and relational hypervigilance 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.

CONCLUSION

Despite challenges with regulating and differentiating affect, especially shame, observed improvements in relationship satisfaction and trauma symptoms suggest that the EFT model may be a promising intervention for CSA 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 than can occur in individual therapy while incorporating the survivor's primary attachment figure into the healing journey from which he or she has historically been alienated.

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