

Effects of Clinician-Assisted Emotional Disclosure for Sexual Assault Survivors: A Pilot Study

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**Timothy Anderson,¹ Jennifer Fende Guajardo,¹
Rohini Luthra,² and Katie M. Edwards¹**

Abstract

This study assessed the effects of clinician-assisted emotional disclosure (CAED), an integration of emotion focused therapy (Greenberg, Rice, & Elliott, 1993) and emotional disclosure, in ameliorating distress experienced by survivors of sexual assault. A total of 670 female university students were screened for both histories of sexual victimization and clinically significant levels of global psychological distress. Twenty-eight females entered the treatment phase of the study and were randomly assigned to participate in either treatment or no-treatment control conditions. Participants completed a battery of instruments at each evaluation to assess interpersonal, global, and traumatic stress symptoms. At termination and 1-month follow-up, there were no significant differences between CAED and control group on any of the outcome variables. However, there were several differences between the CAED treatment and control groups at 3 month posttreatment.

¹Ohio University, Athens

²Mount Sinai Medical School, New York

Corresponding Author:

Timothy Anderson, Department of Psychology, Ohio University, Athens, OH 45701

Email: andersot@ohio.edu

Specifically, individuals in the CAED group reported significant reductions in interpersonal distress, namely, hostility and dependency and reductions in avoidance symptoms associated with posttraumatic stress disorder. These findings are useful for the development of emotion-focused therapies and, specifically, toward psychotherapy integration strategies that combine imaginal exposure with experiential techniques for emotional processing of previously avoided experience.

Keywords

sexual assault, posttraumatic stress, emotional disclosure, psychosocial treatment, therapy

The disturbingly high rates of sexual assaults are clearly documented. National data suggest that 15% to 25% of women will be the victim of an attempted or completed rape during their lifetime (Fisher, Cullen, & Turner, 2000; Tjaden & Thoennes, 2000). Research suggests college women are at greater risk for sexual victimization than women in the general population (Fisher et al., 2000). The mental health consequences of sexual assault are serious. Women who are victims of sexual violence have higher and more severe rates of posttraumatic stress disorder (PTSD) than survivors of accidents and natural disasters (Kessler, 2000; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). In addition to PTSD, there are many other insidious effects of sexual violence, which include psychological distress, physical distress, interpersonal problems, and increased risk for sexual revictimization (Ackard & Neumark-Sztainer, 2002; Lewis & Fremouw, 2001; Messman-Moore & Long, 2003; Ullman, 1996).

The vast majority of the research on treatment for sexual assault survivors has focused on cognitive behavioral therapies and strategies, including stress inoculation training (Foa, Rothbaum, Riggs, & Murdock, 1991; Kilpatrick, Resick, & Veronen, 1981), exposure therapy (Falsetti, 1997; Foa & Rothbaum, 1998), and cognitive processing therapy (Resick & Schnicke, 1993). Overall, exposure therapy has received the preponderance of empirical support for the treatment for PTSD (Nemeroff et al., 2006), though differential treatment claims remain less clear (e.g., Wampold, 2001).

Although various forms of imaginal exposure have been effective at various gradations, only emotional-experiential interventions for trauma have begun to receive attention. Interventions that are experience based, such as emotion-focused therapy (EFT; Greenberg et al., 1993), are designed to help clients both express and transform problematic emotional experiences

into more adaptive emotions. EFT-based treatments for trauma might help clients to reengage past and present experiences related to the trauma and, more importantly, to alter maladaptive emotional schemes that have emerged in relation to the traumatic event. Recently, a few researchers (Elliott & Davis, 1998; Paivio & Nieuwenhuis, 2001) have applied various aspects of EFT to the treatment of problems resulting from traumatic events (e.g., PTSD). Paivio and Nieuwenhuis (2001) developed and tested a 20-session-version EFT (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg et al., 1993) that was specifically tailored for adult survivors (AS) of childhood emotional, physical, and sexual abuse (EFT-AS). EFT-AS incorporates most aspects of EFT, but there is particular emphasis on emotional processing through the use of techniques such as gestalt chair work. Paivio and Nieuwenhuis (2001) reported that at termination, participants receiving treatment, relative to the wait-list control group, demonstrated significant reductions in global symptoms, interpersonal symptoms, target complaints, and self-blame when compared to a wait-list control group. The effects of the 20-session treatment were maintained at the 9-month follow-up. Although findings on the efficacy of EFT for sexual assault are encouraging, the applicability of EFT has not been assessed with regard to survivors of adult sexual victimization.

Clinician-assisted emotional disclosure (CAED; Anderson, Keefe, Lumley, Elliott, & Carson, 2001) is an adaptation of two of six EFT treatment modules (Greenberg et al., 1993) that focus on (a) the elaboration of sexual trauma narratives (systematic evocative unfolding) and (b) the emotional focusing and processing of these events. The structure of the treatment, however, is adapted from a four-session (usually within 1-2 weeks) experimental protocol used for emotional disclosure while narrating a stressful or traumatic life event (e.g., Pennebaker, 1997). This protocol has yielded consistent findings of immediate increases in negative affect (after completion of the sessions) but sustained physical health and psychological benefits for one to several months posttreatment in healthy samples, though the positive findings are not consistent for persons with physical or mental health problems (see Smyth, 1998, for a review).

As adapted in the present pilot study, the emotional disclosure task was exposure based because the treatment event to be narrated was specific to the sexual assault. This narrative base for the protocol is linked to EFT techniques via experiential strategies for working with narratives whereby the goal is to assimilate emotional experiences within more coherent narrative-emotional schemes (Angus, Lewin, Bouffard, & Rotondi-Trevisan, 2004; Honos-Webb, Harrick, Stiles, & Park, 2000). EFT strategies for narrative

development (e.g., Angus et al., 2004) and emotion-focused techniques in a supportive, client-directive treatment environment could be useful in addressing problematic emotional experiences that might arise in the face of exposure. A supportive, therapeutic environment may help clients to more fully experience problematic emotions related to the trauma(s), and there is some evidence that written disclosure in private (without therapeutic support) may not be effective when writing about sexual assault or child sexual abuse (Batten, Follette, Rasmussen Hall, & Palm, 2002; Brown & Heimberg, 2001).

The current study is a randomized controlled pilot study, designed to assess the effects of an EFT approach in ameliorating distress experienced by victims of adult sexual assault. We hypothesized that participation in CAED would lead to increased negative affect immediately after recounting these traumatic events. However, at 1 and 3 months after treatment, we predicted that the CAED group would evidence reductions in global, interpersonal, and traumatic stress symptoms relative to women in the control group.

Method

Participants

A total of 670 college women were screened for a history of sexual victimization and current levels of general psychological symptoms. Of these 670, 166 (25%) reported sexual coercion or rape victimization, and 112 (18%) met criteria for clinically significant psychological distress (see exact criteria below); 40% of sexually victimized women had clinically significant symptoms, whereas 13% of nonsexually assaulted women had equivalently high levels of distress. Overall, 65 women (11%) met both sexual assault and high psychological distress criteria for inclusion into the study. Forty-three participants met the criteria and were drawn for invitation into the study. Of those, 28 agreed to participate, 6 did not agree to participate, and 9 could not be reached. Two participants dropped out during the intervention phase (both stated scheduling difficulties as their reason for withdrawal). For treatment completers, 17 (65%) completed the 1-month follow-up, and 13 (50%) returned for the 3-month follow-up evaluation. The sample had a mean age of 19.3 years ($SD = 1.09$) and was mostly White (85.7%).

Measures

Sexual Experiences Survey (SES). The SES (Koss & Gidycz, 1985; Koss & Oros, 1982) is a self-report measure designed to identify various levels of sexual victimization using behavioral definitions. It has good psychometric

properties (Koss & Gidycz, 1985). The SES was used during the screening to select participants who reported unwanted vaginal, oral, or anal penetration through the use of coercion or force.

Positive and Negative Affect Scale (PANAS). The PANAS (Watson, Clark, & Tellegen, 1988) is a 20-item self-report measure that assesses positive affect (PA) and negative affect (NA). Items are rated on a 5-point scale ranging from *very slightly or not at all* to *very much*. Both the trait and state versions of the PANAS have high internal consistencies and factorial independence. For the trait version, $\alpha = .86$ for PA and $.84$ for NA, and for the state version, $\alpha = .89$ for PA and $.85$ for NA. Test-retest reliabilities are also acceptable for the trait version, ranging from $r = .60$ to $.63$, and somewhat lower for the state version, $r = .45$ to $.54$. The present study asked participants to take a state (present moment) version of the test and was administered after each session during the 10-day intervention period for both treatment and control groups. The PANAS served as a manipulation check for whether the CAED treatment was increasing NA immediately after sessions.

Inventory of Interpersonal Problems (IIP). The IIP (Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988) was designed to assess level of distress associated with interpersonal problems. The measure contains a 64-item self-report scale pertaining to interpersonal functioning. The items fall on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*). Alden, Wiggins, and Pincus (1990) reported Cronbach's α in the range of $.72$ to $.85$ for the IIP-C (client) Scales. Tracey, Rounds, and Gurtman (1996) found that the IIP-C retains the circumplex structure (goodness-of-fit indices ranging between $.91$ and $.96$) across levels of the general factor in five subsamples.

Outcome Questionnaire-45 (OQ). The OQ (Lambert et al., 1996) is a 45-item general symptom measure. This measure was designed to assess client progress in therapy by repeated administration during the course of treatment and at termination. Three aspects of the client's progress are measured: subjective discomfort, interpersonal relationships, and social role performance. Each item is scored on a 5-point scale ($0 = \text{never}$; $4 = \text{almost always}$). The OQ provides a total score as well as three subscale scores; for the purposes of this study, the total score was used. Lambert et al (1996) reported the internal consistency of the scale to be $r = .93$ and Lambert et al. reported test-retest reliability after a 3 week lapse to be $r = .84$.

Impact of Events Scale-Revised (IES-R). The IES-R (Horowitz, Wilner, & Alvarez, 1979) is a self-report measure designed to assess current subjective distress for any specific life event. The IES-R has 22 items that comprise 3 subscales: intrusions (8 items), avoidance (8 items), and hyperarousal (6 items). Scale scores were expressed as the item means. Content of the items parallel *Diagnostic and Statistical Manual of Mental*

Disorders (4th ed. [*DSM-IV*]; American Psychiatric Association, 1994) criterion for PTSD, each rated on a scale ranging from 0 (*not at all*) to 4 (*extremely*). In a recent review of the psychometric properties of the IES, Sundin and Horowitz (2002) provided mean alphas from 18 studies that were consistent and homogenous for each subscale: avoidance ($\alpha = .82$) and intrusions ($\alpha = .86$). The IES has good construct validity with other indicators of PTSD and the most commonly used measure in trauma research (Borkovec, Castonguay, & Newman, 1997).

Procedure

Participants were recruited through introductory-level psychology classes at a medium-sized Midwestern university and received course credit for their participation in the screening. To avoid selection bias, the sign-up message made no reference to sexual assault. Participants were screened in groups of 25 or less. At the screening session, participants completed informed consent and then filled out the SES, OQ, and a future contact form.

Participants who indicated having experienced a sexual assault that involved coerced or forced vaginal, oral, or anal penetration (affirmative responses on any of the 6-10 items on the SES) and who had a score of 59 or higher on the OQ were contacted and asked to participate in further stages of the study. Women agreeing to participate were randomly assigned to either the experimental ($n = 15$) or the control group ($n = 13$).

The experimental group participated in four half-hour sessions of CAED within a span of 10 days. The CAED protocol was conducted by advanced doctoral students in clinical psychology who had obtained at least 1 full year of direct clinical experience providing psychotherapy in outpatient settings. Each session was audiotaped and therapists were supervised by a licensed clinical psychologist who was knowledgeable in the CAED procedures.

Participants in both the treatment and control group reported for four sessions over a period of approximately 10 days. Those receiving CAED met with a therapist for 30-min sessions, whereas participants in the control group also reported to the lab but only completed questions about their mood (and without receiving any form of treatment).

CAED. This is an adaptation of EFT (Elliott et al., 2004; Greenberg et al., 1993), specifically, techniques from the first two treatment modules that include (a) systematic evocative unfolding of emotional narratives and (b) emotional focusing, for experientially tracking emotions at a moment-to-moment level. These EFT techniques and strategies are framed within four sessions

that occur within 10 days and ideally in 4 consecutive days (see Esterling, L'Abate, Murray, & Pennebaker, 1999, for a review).

Early in the first session, the participant is invited to identify and narrate a specific sexual assault event. The clinician assesses the specificity of the memory and encourages the participant to increase experiential specificity of the narrative at a moment-to-moment level. At these points, clinicians also are encouraged to discuss the fact that the narrating of the traumatic event is self-directed. While relating the trauma narrative, clinicians search for emotion markers that serve to direct further exploration and within-session emotional processing. Once the initial narrative and preliminary emotional processing is completed, the clinician assesses emotion markers and how emotions are integrated within the narrative. Some common issues that arise include (a) the person becomes overwhelmed by feelings (e.g., shock and numbness) and unable to relate them to specific experiences or within a narrative structure, or (b) the person focuses on details of the story at the expense of emotions. The nature of the emotional blockage should lead the clinician to two parallel tasks: (a) systematic evocative unfolding or (b) focusing.

Systematic evocative unfolding (or "unfolding") is used to encourage discovery and elaboration of the narrative and to process problematic emotional reactions. Elliott and colleagues (2004) noted that using unfolding to fill in gaps in the narrative is common when working with emotionally powerful and stressful events like trauma. Consistent with Greenberg et al. (1993), systematic evocative unfolding includes critical treatment activities of (a) identifying markers of emotional experience within the narrative, (b) reevoking the experience of the event as fully as the participant is comfortable doing, and (c) linking their internal reactions to their understanding of external memories of event. Angus and colleagues (2004) suggested that a participant's ability to link emotional experience from narration to external facts and meanings from the narrative are a basic component of change in experience-based treatments.

In emotional focusing, participants are encouraged to enter into an internal framework and attend to their moment-by-moment emotional experience, usually in isolation of the facts and context of the event. In our protocol, the narrating of the event transitions from focusing on external events and toward the participant's internal "felt sense" at a particular marker in the narratives. As with EFT (Greenberg et al., 1993), focusing involves the following subtasks: (a) identification of an emotion marker, (b) directing attention to the experience, and (c) elaboration of feelings, often to the point at which the patient experiences a feeling shift and emotional relief.

Systematic evocative unfolding and emotional focusing are treated as a balanced pair of activities. Systematic evocative unfolding is designed to expand the emotional awareness of the narrative context, whereas focusing is designed to expand the experiential awareness of emotions related to these story elements. Overall, the clinician balances these two tasks by shifting the focus between expanding the emotional narrative structure and elaborating the felt sense for any moment within the story.

Training. Therapists completed a 2 day workshop in which half of the time was spent on didactic instruction of CAED. The other half of the time was spent on role-plays using client sexual-assault scripts. Before the start of the study, each therapist was required to complete at least one supervised training case. Participants for the training cases were drawn from participants who had not met both inclusion criteria for the study. The practice purposes of the sessions were explained in advance and all participants were given information on psychological services available in the community.

Results

Manipulation check. Analysis of the PANAS at treatment Sessions 1 through 4 served as a manipulation check of sessions for the CAED group, relative to the no-treatment control group. Table 1 presents means and standard deviations on the PANAS. The CAED condition had higher NA scores than the control group for Sessions 1, 2, and 4, but not for Session 3. Hence, overall the CAED sessions appeared to achieve the expected increase in negative affect. PA scores were mostly not affected by the sessions, with the exception of Session 2 (where the CAED group had significantly greater PA than the control group).

Table 2 provides means and standard deviations for general, interpersonal, and traumatic stress symptoms for baseline, termination, 1-month follow-up, and 3-month follow-up periods. Change at termination and 1- and 3-month follow-up periods were evaluated with mixed model ANOVAs where time was a within-subjects variable and condition was a between-subjects variable. There were no significant differences in changes between CAED and control group on any of these outcome variables at termination or the 1-month follow-up.

However, there were several differences between the CAED treatment and control groups at the 3-month follow-up. With regard to interpersonal symptoms, there was a significant difference between CAED and control group in total IIP change from baseline to 3-month follow-up, $F(1, 9) = 5.71$, $p < .05$, $\eta^2 = .39$. Analysis of the IIP octant scales were examined to identify

Table 1. Means and Standard Deviations for Postsession PANAS

		Session											
		1				2				3			
		M	SD	t		M	SD	t		M	SD	t	
NA													
CAED		30.06	9.02	4.65**		24.53	8.49	2.11*		24.47	9.21	1.88	
Control		18.46	3.84			19.00	5.62			19.42	5.23		4.02**
PA													
CAED		22.31	7.42	1.50		25.18	8.55	2.15*		26.25	10.28	1.03	
Control		18.92	4.61			19.17	5.29			20.42	6.07		1.03

PANAS = Positive and Negative Affect Scale; PA = positive affect; NA = negative affect.

* $p < .05$. ** $p < .001$.

Table 2. Means and Standard Deviations for Symptom Measures Across Time

	Evaluation Period							
	Baseline		Termination (10 days)		1 Month Posttreatment		3 Months Posttreatment	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
OQ								
CAED	78.3	18.6	64.0	25.9	65.3	19.1	52.5	20.3
Control	81.4	17.8	73.8	27.5	61.6	22.4	68.1	12.2
IES Avoidance								
CAED	2.91	0.80	2.76	1.25	2.51	1.23	1.91	0.81
Control	2.88	0.63	2.89	1.00	2.63	0.78	3.09	0.82
IES Intrusions								
CAED	2.09	1.12	1.84	0.75	1.51	0.45	1.27	0.26
Control	2.45	0.95	2.42	0.15	2.03	0.58	2.25	0.78
IES Hyperarousal								
CAED	2.17	1.18	1.81	0.76	1.52	0.66	1.42	0.62
Control	2.36	2.19	2.19	1.09	1.94	0.57	1.71	0.71
IIP								
CAED	171.4	32.6	162.8	42.5	166.8	21.5	157.4	18.8
Control	171.1	39.8	172.5	39.8	152.2	21.5	181.5	26.2

OQ = Outcome Questionnaire; CAED = clinician-assisted emotional disclosure; IES = Impact of Events Scale; IIP = Inventory of Interpersonal Problems.

the circumplex location for these total interpersonal symptom changes. Two of these subscales were significantly decreased in the CAED group. Relative to the no-treatment control, participants in the CAED group displayed fewer problems with interpersonal dependency (JK), $F(1, 10) = 9.01, p < .05, \eta^2 = .50$, and interpersonal hostility (DE), $F(1, 10) = 7.17, p < .05, \eta^2 = .44$.

Also, at 3-month follow-up, there was a significant decrease on the IES Avoidance subscale for the CAED group relative to the no-treatment control group, $F(1, 10) = 5.20, p < .05, \eta^2 = .34$. Although there were decreases on the IES Hyperarousal and Intrusion subscales from pretreatment for the CAED group at the 3-month follow-up, these decreases were not significant.

As the only significant effects occurred with only half of the completed sample, separate analyses were performed to test whether there were baseline differences on all major variables between those who completed the 3-month follow-up versus those who did not. There were no significant differences. We also tested for whether those who remained in the study had significantly more change at 1-month follow-up over those who dropped out, and there were no significant effects.

Discussion

These findings provide preliminary evidence that emotion-focused approaches may be useful for reducing interpersonal distress and avoidance symptoms of PTSD for survivors of sexual trauma. However, this was a pilot study and a more powerful sample size with refined methods is needed. Thus, the significant changes in the present study were from a small and restricted sample and was delayed until after 3 months of this brief four-session treatment. Promising leads for treatment development, future research, and the limitations of this study will be discussed below.

Decreases in IES Avoidance were delayed, similar to changes reported in other treatments for this population (e.g., Resick, Jordan, Girelli, & Hutter, 1988; for reviews, see Foa & Meadows, 1997; Nemeroff et al., 2006). It is assuring that CAED led to decreased avoidance symptoms given that avoidance is closely related to the severity and maintenance of PTSD, more so than other trauma-related variables (Batten, Orsillo, & Walser, 2005; Plumb, Orsillo, & Luterek, 2004), and is believed to render women less able to perceive danger in their environment and are thus more likely to be sexually revictimized (Chu, 1992; Cloitre, Scarvalone., & Difede, 1997; Kluft 1990).

Women in the treatment group also reported relatively greater decreases in total IIP interpersonal problems and more specifically to problems with dependency and hostility at the 3-month follow-up. This is promising given that Rich, Gidycz, Warkentin, Loh, and Weiland (2005) found that the increases on the IIP predicted subsequent sexual victimization. As noted by Rich and colleagues (2005) and Grauerholz (2000), women's interpersonal patterns may shape relationships with romantic partners and significant others, who are the most likely to revictimize these women. Altering problematic interpersonal patterns could have the additional benefit of decreasing the likelihood of future sexual revictimization. For example, interpersonal problems with regulating warmth and submissiveness (IIP dependency) may interact with interpersonal complementarity of dominant styles when relating to potential victimizers. According to EFT, emotions serve as interpersonal messages (Greenberg & Safran, 1987) that may be adaptive and effective or maladaptive and ineffective (Greenberg & Paivio, 1997).

With regard to global distress, the lack of significant changes in OQ is problematic because the OQ was used to select the sample. It is possible that repeated administration of the negative self-characteristic items from OQ may have threatened the validity of later administrations of the measure (Jorm, Duncan-Jones, & Scott, 1989), though the OQ has been frequently used repeatedly in longitudinal research designs (Lambert, Gregersen, &

Burlingame, 2004). As a matter of hindsight, it might have been more fitting to select participants with a more specific distress measure like the IES as trauma symptoms are more relevant to the specific traumatic events that these women experienced. It should be noted, however, that the treatment group's OQ mean was below the clinical cutoff level at the 3-month follow-up, whereas the control group remained in the clinically impaired range.

The current study meets a number of "gold standards" for treatment research for traumatic stress (Foa & Meadows, 1997) while failing to meet others. The study used a randomized controlled design, reliable and valid measures, a manualized and replicable protocol, and unbiased assignment to treatment. Yet the study is limited by selection on global, rather than specific, target symptoms and the lack of a blind clinical evaluation. An additional limitation is that there was no baseline interview for a clinically diagnosable disorder. Perhaps, the greatest limitation is the small sample size and the fact that half of the sample did not return for the 3-month follow-up. Nonetheless, it is noted that similar small samples are somewhat more common in treatment of sexual assault and traumatic stress in general (Foa & Meadows, 1997). Furthermore, major variables did not differ by dropout status and neither did initial levels of change. Still, low return rates limit the statistical stability of groups, and, therefore, we view these findings as preliminary but encouraging of future research.

In terms of emotional processes at the session level, women in the CAED group reported significantly greater levels of NA following each of the sessions (except Session 3), relative to the control group. These immediate negative reactions are consistent with other studies of private disclosure (see Smyth, 1998, for a review), and it has been suggested that such immediate negative reactions are predictive of subsequent physical and psychological health improvements (Pennebaker, 1997). However, attempts to apply these findings to health populations have had mixed results that include some modest effects of improved coping and decreased stress (Smyth, 1998). Nevertheless, there is promising evidence that emotional disclosure, while temporarily increasing negative mood, ultimately decreases distress experienced among survivors of sexual violence.

Although there were no immediate gains at termination or the 1-month follow-ups, the significant findings at the 3-month follow-up are consistent with recent findings of delayed effects from the emotional disclosure treatment literature (Kelley, Lumley, & Leisen, 1997; Paivio & Nieuwenhuis, 2001). Kelley et al. (1997) used private emotional disclosure with rheumatoid arthritis patients and found no initial treatment improvements compared to a nonemotional disclosure control group, but they found lower levels of

affective disturbance and better physical functioning for the private emotional disclosure group at 3 months posttreatment. A common hypothesis in the literature is that disclosing emotions to the trauma may allow for the beginning of a meaning-making process, but that this more cognitive work with the trauma narrative may take additional weeks and months beyond the completion of treatment (Freyd, Klest, & Allard, 2005). With regards to the CAED protocol, it is possible that the four sessions over the short span of 10 days activated a process of further emotional and cognitive processing, the effects of which were evidenced at the 3-month follow-up.

Future Directions

The present study did not explore the emotional processes of those in the treatment group, and future study would benefit from including measures and strategies to examine emotion and narrative shifts within sessions. Significant shifts from one emotion to another (e.g., sadness into anger) is a primary goal of EFTs (Greenberg, 2002) and should be identifiable within sessions of successful therapeutic work. Furthermore, future research might also explore whether attending to emotional processes while processing a threatening event can lead to more sustainable treatment changes relative to exposure or EFT-based strategies alone. Future research should include larger and more diverse samples, longer follow-up periods, and additional outcome measures, including a measure of sexual revictimization.

Furthermore, future research clearly needs to incorporate qualitative reports of how women feel they benefited from the treatment, in addition to qualitative analyses that explore the evolution of women's emotion-focused narratives over the course of treatment. Orchowski, Uhlin, Probst, Edwards, and Anderson (in press) conducted in-depth qualitative analyses of two cases from the sample from the present study to explore the use of these emotion-focused strategies with survivors of sexual assault. Both cases involved intimate-partner sexual assault, and therapists encouraged expression of emotion around the event. In one case, however, the participant had difficulty identifying a clear problem statement, frequently used rape myths (Burt, 1980) to blame herself and justify her partner's assault, and showed relatively few emotion-shifts toward adaptive emotional expression. However, the therapist in the second case was more attentive to identifying the participant's self-benevolent "voice" and more actively participated in challenging the emergence of rape myths in the participant's emotional disclosure of the event. Those cases also illustrate that the goal of emotion-focused strategies used in the present study is not simply the quantity or intensity of the emotion

disclosed (as our use of the PANAS measure might suggest) but situating those emotions within the survivor's personal, interpersonal, and cultural network of meanings. Clearly, future research would benefit enormously by the creation of quantitative measures (and other research strategies) that could better capture such complexity than is currently possible.

In sum, the findings from the current study provide preliminary support of EFT in treating avoidance symptoms of PTSD and interpersonal problems. However, future research using rigorous methodological designs is needed to more closely examine the efficacy of this treatment. Unlike most treatments for PTSD to date, CAED combines both exposure and emotion-focused treatment components. Better understanding of these emotional processes (also known as activation and habituation) has been viewed from multiple perspectives to be at the heart of the change process (Foa & Kozak, 1986; Greenberg, 2002; Samoilov & Goldfried, 2000). Clearly, there is an overlap in how cognitive-behavioral, experiential, and dynamic approaches might effect change through emotional processing of trauma. We believe that experiential strategies for processing emotions in the face of emotionally charged material can contribute to the treatment of trauma and the development of psychotherapy integration.

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Bios

Timothy Anderson, PhD, is an associate professor of psychology at Ohio University. He is recipient of the Distinguished Early Career Award from the International Society for Psychotherapy Research in 2004. He earned his PhD at Miami University in 1993 and completed a postdoctoral fellowship at the Center for Psychotherapy Research at Vanderbilt University in 1996. His research focuses on treatment process and outcome research with special emphasis on the interpersonal skills of the

therapist, experiential and dynamic treatments, and the role of relational process variable in treatment.

Jennifer Fende Guajardo, MS, is a graduate student in the Psychology Department at Ohio University and is working to complete her PhD in clinical psychology. She is a registered substance abuse professional in Missouri and works as an outpatient therapist and as an administrator for the Substance Abuse Traffic Offender Program (SATOP) at Family Counseling Center of Missouri, Inc. She holds a master's degree from Ohio University and a bachelor of arts from Miami University. Her research interests include the therapeutic alliance, client expectations, client preparation for treatment, substance abuse, and therapy outcomes.

Rohini Luthra, PhD, is a clinical psychologist working at the Mount Sinai School of Medicine. She has a BS from Smith College and a PhD from Ohio University. Prior to completing her graduate degree, she completed a predoctoral internship at the Boston University School of Medicine and worked with adult psychiatric inpatients at the Lemuel Shattuck Hospital as well as HIV positive children at the Children's AIDS Project. She then completed a 2-year postdoctoral fellowship at Boston Medical Center, where she specialized in research and clinical work with traumatized children. She is currently a faculty instructor at the Mount Sinai School of Medicine and specializes in research on childhood posttraumatic stress disorder.

Katie M. Edwards, MS, is a graduate student in the clinical psychology doctoral program at Ohio University. Her professional interests include the causes, consequences, and prevention of intimate partner violence in addition to the ethical considerations of trauma research and therapy with women currently in abusive relationships.