TOWARD A PSYCHOTHERAPY INTEGRATION APPROACH FOR

COMPLEX POST TRAUMATIC STRESS DISORDER:

A CRITICAL LITERATURE REVIEW

by

Jacob Russell Confer

APPROVED:

Keith Edwards, PhD, PhD — Date 4-4-13

Cherry G. Steinmeier, PsyD — Date 4-4-13

APPROVED:

Clark D. Campbell, PhD, ABPP, Dean

4/4/13

Date

TOWARD A PSYCHOTHERAPY INTEGRATION APPROACH FOR COMPLEX POST TRAUMATIC STRESS DISORDER: A CRITICAL LITERATURE REVIEW

A Doctoral Research Paper

Presented to

the Faculty of the Rosemead School of Psychology

Biola University

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Psychology

---

by

Jacob Russell Confer

August, 2013

ABSTRACT

TOWARD A PSYCHOTHERAPY INTEGRATION APPROACH FOR
COMPLEX POST TRAUMATIC STRESS DISORDER:
A CRITICAL LITERATURE REVIEW

by

Jacob Russell Confer

The symptoms, assessment, and treatments of Post Traumatic Stress Disorder (PTSD) have been empirically investigated to the extent that there is a breadth of valid and reliable instruments investigating this psychopathological syndrome. There, too, exists a substantial evidence base for various treatment models demonstrating effectiveness in treating PTSD. There are, however, no instruments designed to investigate the phenomena associated with Complex PTSD, and it has yet to find its place in the *Diagnostic and Statistical Manual for Mental Disorders*. There are also few outcome studies demonstrating effectiveness of various treatment approaches for Complex PTSD. Consequently, the current paper is an exhaustive literature review of outcome studies from various theoretical treatment orientations that have demonstrated effectiveness in the treatment of Complex PTSD. The paper closes with a review of various psychotherapy integration approaches and how those may be applied to the current research reviewed.

TABLE OF CONTENTS

PAGE

PAGE

PAGE

PAGE

LIST OF TABLES

ACKNOWLEDGEMENTS

"Don't let us forget that the causes of human actions are usually immeasurably more complex and varied than our subsequent explanations of them."

− Fyodor Dostoevsky, *The Idiot*

This doctoral paper marks an integration of several years of formal academic training, clinical experience guided by intensive supervision and consultation, and personal and spiritual growth. This project is not merely an intellectual exercise wherein I review, critique, and synthesize research into some variant of clinical applicability. Nor is this paper simply a project to check off the list of requirements to attain my doctoral degree in clinical psychology. Embedded in this research project is significant meaning at both a personal and professional level of abstraction.

I vividly remember my first clinical encounter with an individual suffering from Complex PTSD. She was tortured by emotional pain and exhibited an inability to hold onto any semblance of reality. I was faced with a significant clinical challenge that I felt ill prepared to handle. I sought out supervision, consultation, emotional support, and scientific literature to serve as a life preserver for an inexperienced clinician attempting to tread water in an unruly sea. It was after empathically attuning to this individual's psychological anguish that I decided to dedicate my research project to a review of the scientific literature on Complex PTSD, and in so doing, discovering the most effective ways to mend the developmental wounds impinged on these hurting individuals. Therefore, I would like to offer gratitude to all my clients who have entrusted me to enter

their world and walk along side them toward a path of self-discovery, healing, and growth.

I would also like to take the opportunity to thank all of my professors at Rosemead School of Psychology, and a few in particular:

Dr. Keith Edwards, thank you for serving as the first committee member of this paper and for guiding me along the way. I also want to express gratitude for all that you taught me in your psychotherapy laboratory courses; your candor, gentle spirit, and openness impacted me in innumerable ways.

Dr. Cherry Steinmeier, thank you for serving as a committee member and for being an encouraging and supportive academic advisor. When taking Spiritual Disciplines with you, I was spiritually moved and my relationship with God was forever influenced.

Dr. Jenny Pak, you were the first person to teach me the art and importance of fostering empathic resonance with my clients, and you always encouraged me to think deeply about the human condition. Thank you for pushing me to the edges of my experience – a place language could not capture.

Dr. Nancy Duvall, thank you for allowing me to be a teaching assistant for Psychodynamic Therapy and for engaging me in intellectually stimulating conversations about field phenomenon, quantum physics, and the concept of the self.

Special thanks to my primary clinical supervisors, Dr. Yoon Lee, Dr. Meridith Phanco, Dr. Allen Kilian, and Dr. Nancy Bottorff. You each provided me the space to find myself in the midst of the muddled relational matrixes, that we all as clinicians find

ourselves lost in. To my didactic training psychotherapist, Dr. J. Michael Russell, thank you for the continual support, empathy, and encouragement to pursue my dreams.

To my friends and colleagues, thank you for playful banter, emotional and relational connectedness, and academic inquisition. A special thanks to the Psychoanalytic Think Tank including Kendra, Tasha, and Gina. We traversed the country speaking at international conferences, sought out consultation from psychoanalysts in the community and across the nation, and communed peacefully in our collective homes allowing space for organic conversations to unfold. I would also like to thank Megan for spiritual guidance and enduring friendship. Elizabeth, you provided the emotional and intellectual support necessary for the completion of this project. I owe you much credit for allowing me to talk through my theoretical formulations, and offering me yours. Special thanks to all of my friends outside academia: Devon, Ray, Adam, Greg, Tommy, and Brandon you all served as a source of laughter, male companionship, and space from the complexities of human suffering.

I take pleasure in this opportunity to also thank my family. To Mom and Dad, it is through the quality of my relationship with both of you that I developed a capacity for human connection, empathy, and self-reflection, all serving as fundamental characteristics of my chosen profession. Mom you served as a spiritual light and an emotional safe haven, and Dad your strength and steadfastness, led by example, augmented my understanding of self-sacrifice and unconditional love. To my sister, Hannah, and my brother, Benjamin, I want to express gratitude for being a constant source of good-natured competition, joy, and play. I am forever grateful to have siblings

as caring and loving as the both of you. Thank you to my now departed Grandma Jean who encouraged me to aspire to achieve my goal of becoming a clinical psychologist, and my Grandma Thelma who offered emotional and financial support to get me through times of need.

Finally, I express my most profound appreciation to my God the Father. Through your firm hand, the love and sacrifice of your Son, and the guidanceof the Holy Spirit, you granted me the gift of life, the physical, emotional and intellectual capacity, and the spiritual discernment and conviction, to pursue a career most intimately connected to the peak of your creation, humankind.

TOWARD A PSYCHOTHERAPY INTEGRATION APPROACH FOR COMPLEX POST TRAUMATIC STRESS DISORDER: A CRITICAL LITERATURE REVIEW

Introduction

The primary goal of the current paper is to discover the important elements of effective treatments that might serve as a basis for an integrated treatment approach to treating Complex Post Traumatic Stress Disorder (Complex PTSD). Specifically, the paper will offer a concise, research-based guide to understanding and treating Complex PTSD in an effort to inform and better prepare psychotherapists treating adult survivors of childhood physical, sexual, and/or emotional abuse. It is essential for psychotherapists to have a working knowledge of Complex PTSD itself, its associated sequelae, and research-based psychotherapeutic approaches to treat trauma survivors with the utmost clinical care and professionalism.

The following sections in the current paper will: (a) define Complex PTSD, its etiology, and its associated sequelae; (b) address methodological limitations of the studies reviewed in the current paper; (c) review outcome studies from a variety of theoretical orientations that are proposed to be efficacious and effective in treating Complex PTSD; (d) examine clinician and client perceptions on best and most effective practices in treating Complex PTSD; (e) summarize various psychotherapy integration approaches

and how those may be applied to the current research reviewed; and (f) offer suggestions for working toward a psychotherapy integration approach to treating Complex PTSD.

Etiology of Complex PTSD

Historically, the concept of Complex PTSD as a psychiatric construct has only gained moderate consensus among mental health professionals. The term "Complex PTSD" was first introduced by Herman (1992a, 1992b) in order to account for traumatic stress disorders that did not meet diagnostic criteria for PTSD as defined in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*; American Psychiatric Association [APA], 1980, 1994, 2000, to be released 2013; *DSM-III*, 1980). For instance, Herman (1992a) stated, "The current diagnostic formulation of PTSD derives primarily from observations of survivors of relatively circumscribed traumatic events. This formulation fails to capture the protean sequelae of prolonged, repeated trauma" (p. 377).

Previously proposed diagnostic constructs such as Post-Traumatic Character Disorder (Horowitz, 1986), Complicated PTSD (Brown & Fromm, 1986), Disorders of Extreme Stress Not Otherwise Specified (DESNOS; Pelcovitz et al., 1997), Developmental Trauma Disorder (van der Kolk, 2005), Type II Trauma (Terr, 1991), Self Trauma (Briere, 2002), and Posttraumatic Personality Disorder (Classen, Pain, Field, & Woods, 2006) encapsulate most phenomena typically associated with Complex PTSD. Despite the variety of proposed labels for this construct, Complex PTSD will be used in the current review, as this diagnostic label was proposed for inclusion in the *DSM-V* (to be released 2013; Resick et al., 2012).

Definitions of Complex PTSD

As a consequence of several labels proposed for this diagnostic construct, there are just as many definitions associated with the syndrome. For instance, van der Kolk, McFarlane, and Weisaeth (1996) define complex posttraumatic outcomes as stemming from severe, prolonged, and repeated traumas that are frequently interpersonal in nature. Briere and Scott (2006) go on to extend such severe and prolonged traumas as including "child abuse, torture, captivity as a prisoner of war or concentration camp internee, and chronic spouse abuse" (p. 31). To complicate the matter even more, Briere and Scott (2006) stated, "It has yet to be determined, in fact, whether complex PTSD is (1) a discrete syndrome, (2) the associated features of PTSD, or (3) as we generally believe, a wide range of outcomes that vary from person to person" (p. 32).

Paivio and Pascual-Leone (2010) define complex trauma as, "repeated exposure to threat of violence, including social and political violence through war or torture, domestic violence (as victim or witness), and childhood abuse" (p. 15). Furthermore, Davies and Frawley (1994) stated that, "Complex PTSD reflects the profound psychological and physiological disruptions commonly found among survivors of prolonged trauma, including adult survivors of childhood sexual abuse" (p. 27). As such, while there are several individual definitions of Complex PTSD, there is a sizeable amount of overlap and general consensus among the experts in the field.

Because the literature and outcome studies reviewed in the current paper are primarily with adult survivors of childhood physical and sexual abuse, the following definition of Complex PTSD will be used in the current paper:

> Traumatic stressors that (1) are repetitive or prolonged; (2) involve direct harm and/or neglect and abandonment by caregivers or ostensibly responsible adults; (3) occur at developmentally vulnerable times in the victim's life, such as early childhood; and (4) have great potential to compromise severely a child's development. (Courtois & Ford, 2009, p. 13)

Developmental Detriments of Complex PTSD

When prolonged traumatic experiences occur during developmentally vulnerable times in a victim's life, the psychological ramifications are vast. Given a "good enough" environment (Winnicott, 1960) and the subsequent development of a secure attachment, children who are not victims of trauma continually develop innate capacities for self-regulation, interpersonal regulation, and adaptive functioning (Karen, 1994; Siegel, 1999; Wallin, 2007). When trauma positions itself during stages of development that are intended for the fostering of these capacities, all areas of the person's psychological functioning are adversely compromised. For instance, Davies and Frawley (1994) made note that "repeated childhood sexual trauma affects every aspect of an individual's functioning: cognitive, affective, self-experiential, relational, and behavioral" (p. 27). This contention is consistent among several other authors and experts in the trauma literature (Briere & Scott 2006; Cloitre et al., 2009; Courtois & Ford, 2009; Paivio & Pascal-Leone, 2010; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola 2005).

Clinical Presentation of Complex PTSD

In further support, Herman (1992a) stated that survivors of prolonged victimization typically present to therapy with a greater number and variety of symptoms

than those not suffering from early trauma. Herman (1992a) added that survivors' levels of distress are typically higher than individuals' whom have not been abused, and that symptoms are typically present in multiple domains, including somatic, cognitive, affective, behavioral, and relational. Herman (1992a, 1992b) allocated seven categories as descriptors for the associated symptoms of Complex PTSD: (a) alterations in the regulation of affective impulses; (b) alterations in attention and concentration; (c) alterations in self perception; (d) alterations in perception of the perpetrator; (e) alterations in relationship to others; (f) somatization and/or medical problems; and (g) alterations in systems of meaning.

Other researchers have extended the scope by scientifically investigating the symptomology among adult survivors of abuse. In a survey exploring the symptoms observed and intervention strategies utilized by expert clinicians treating Complex PTSD, eleven symptom domains were discovered (Cloitre et al., 2011). These included: (a) reexperiencing; (b) avoidance/emotional constriction; (c) hyperarousal; (d) affect dysregulation; (e) behavioral dysregulation; (f) relational difficulties; (g) attentional disturbance; (h) state-like dissociation; (i) dissociative disturbances in self-concept; (j) disturbances in systems of meaning; and (k) chronic pain, numbing, and paralysis in body parts (Cloirtre et al., 2011).

In hopes of condensing the multiplicity of symptom presentations among the survivor population, the following sections will place symptoms into six discrete categories, including: (a) Cognitive; (b) Affective; (c) Interpersonal; (d) Intrapersonal; (e) Somatic; and (f) Behavioral Symptomology. Each category will be explicated in detail so

as to offer an in depth understanding of what symptoms are typically associated with, and observed among, individuals suffering from Complex PTSD.

Cognitive Symptomology

Survivors of early childhood trauma often present with a variety of cognitive disturbances. Davies and Frawley (1994) noted that psychological trauma negatively impacts one's ability to encode and process cognitive information via cognitive functions, such as assimilation and accommodation. For instance, Davies and Frawley (1994) stated that the overwhelming nature of the traumatic experience inhibits the ability of the child to "cognitively contain and process the enormity of the relational betrayal and physical impingement with which she [or he] is faced" (p. 28). Subsequent to such traumatic events, the survivor may begin to experience intrusive and unwanted thoughts that are disturbing and difficult to manage. In order to cope with ideational intrusions, survivors will often utilize "thought suppression" wherein they cognitively block or suppress the emotionally overwhelming thoughts and memories associated with the trauma (Briere & Scott, 2006). This defensive coping strategy, although possibly adaptive in the moment, becomes a cyclical pattern resulting in the loss of adaptive cognitive processing and functioning.

Survivors also exhibit alterations in attention and consciousness (Herman, 1992b). With respect to attention, survivors often exhibit difficulty concentrating, following directions, and completing tasks (Cloitre et al., 2011). Alterations in consciousness may lead to amnesias, dissociative episodes, and depersonalization (Courtois, 2006). Additionally, there are alterations in systems of meaning (Herman, 1992b). For example,

survivors may feel permanently damaged, ineffective, ashamed, and despairing (Cloitre et al., 2011). In citing other researchers and authors, Davies and Frawley (1994) made note of several other cognitive disturbances among the survivor population. These included: nonflexible cognitive schemata (Fish-Murray, Koby, & van der Kolk, 1987), intrusive thoughts and flashbacks (Herman, 1992b), dichotomous thinking (Fine, 1990), false attribution of blame and responsibility for past and present events (Young, 1988), and a sense of foreshortened future (Terr, 1991). Briere and Scott (2006) also included the following as trauma-related cognitive disturbances: low self-esteem, helplessness, hopelessness, excessive or inappropriate guilt, shame, inaccurate perception of danger in the environment, and idealization and/or inaccurate rationalization of the perpetrator's behavior.

Affective Symptomology

Survivors of early childhood trauma also present with a variety of affective disturbances. Most traumatized individuals seeking treatment present with a variety of depressive and anxiety related disorders; however, these disorders often do not capture the entirety of the clinical presentation. For instance, Herman (1992a) stated, "While major depression is frequently diagnosed in survivors of prolonged abuse, the connection with the trauma is frequently lost. Patients are incompletely treated when the traumatic origins of the intractable depression are not recognized" (p. 382).

In addition to a predisposition to chronic depression and anxiety, survivors display a variety of other affective-related problems. For instance, victims typically exhibit affect regulation/self soothing difficulties, which contribute to emotional

reactivity and explosive anger (Cloitre et al., 2011). Briere and Scott (2006) noted a variety of signs indicating problems with affect regulation. These signs included: (a) mood swings; (b) short but concentrated depressive episodes that resolve rapidly; (c) a tendency to act out, self-mutilate, become aggressive, make suicide attempts and gestures; and (d) dissociative responses to strong emotional experiences. Conversely, survivors also have a propensity toward emotional numbing wherein they demonstrate reduced emotional reactivity to trauma triggers (Briere & Scott, 2006). To sum this propensity toward a dialectic state altering between emotional reactivity and numbing, Davies and Frawley (1994) stated, "the inability to modulate arousal often leads to inappropriate motoric discharge of unbearable anxiety when the individual is hyperaroused and to similarly inappropriate emotional psychomotor constriction in the state of psychic numbing" (p. 30).

Interpersonal Symptomology

Trauma survivors also display a variety of interpersonal difficulties. Often it becomes an arduous task to develop and maintain intimacy with others. Their relational difficulties often consist of conflictual and/or chaotic relationships and preoccupation with or avoidance of relationships (Cloitre et al., 2011). One contributor to difficulties forming and maintaining intimacy with others may be that survivors have become mistrusting of others as a result of the internalization of the perpetrator/victim relationship. For instance, Courtois (2006) noted that victims have learned to perceive others as "venal and self serving, out to get what they can by whatever means including using/abusing others" (p. 88). Furthermore, Davies and Frawley (1994) stated that these

"interpersonal deficits are linked to the survivor's identity diffusion and tendency to react to others based on expectations forged during the trauma" (p. 33). Davies and Frawley (1994) eloquently described the interpersonal dilemma experienced by trauma survivors:

> Although they may have painstakingly constructed a public persona that is superficially friendly, vibrant, and efficacious, this identity is experienced as inauthentic and extraordinarily fragile. Just below the surface of this often impressively functioning veneer, the trauma survivor is trapped in an inner world of fragmentation, dissociation, terror, and rage. Often frightened that others will discover the hidden truths about them, trauma survivors, including patients with histories of sexual abuse, remain essentially disconnected from others. (p. 33)

Briere and Scott (2006) noted a variety of relational difficulties that survivors typically demonstrate. These included: (a) alertness to interpersonal danger; (b) abandonment issues; and (c) a need for self-protection through interpersonal control. Addressing alertness to danger, Briere and Scott (2006) stated that when trauma survivors present to treatment, they often "display signs of hyperalertness to potential aggression, boundary violation, unfair criticism, or other potential dangers" (p. 49). With regard to sensitivity to abandonment, they typically exhibit "a preoccupation with themes of needing people or relationships, fears of expectations of abandonment or loss in relationships, or historical renditions that seem excessively characterized by being left out or rejected" (p. 49). Survivors also demonstrate a need for interpersonal control to protect themselves from further victimization. Examples of controlling behavior include a drive toward autonomy, a tendency to overanalyze and control one's interpersonal engagements, and a negative response to perceived control, manipulation and/or influence by others (Briere & Scott, 2006).

Intrapersonal Symptomology

Dissociation has been mentioned in both the cognitive and affective symptomology sections, illustrating that dissociative mechanisms are often employed to deal with intrusive ideation and overwhelming affective experiences. Davies and Frawley (1994) make note that dissociation most notably impacts the organization of the self. They quote: "Unlike repression, which is a horizontal division into conscious and unconscious mental contents, dissociation involves a vertical splitting of the ego that results in two or more self states that are more or less organized and independently functioning" (p. 31). While these traumatized self-states are often split off from consciousness, Davies and Frawley (1994) noted that these self-states often surface and "make their presence felt via the emergence of recurrent intrusive images, violent or symbolic enactments, inexplicable somatic sensations, recurrent nightmares, anxiety reactions, and psychosomatic conditions" (p. 31). Herman (1992a) and Cloitre et al. (2011) stated that while fragmentation of the self (i.e., split off self-states) is frequently common among survivors, it can reach extreme forms, such as in the case of dissociative identity disorder. It is no surprise that those suffering from borderline personality disorder and dissociative identity disorder, both disorders of identity formation, often have abuse histories (Herman, 1992a).

Not only does early trauma inhibit the survivor's ability to form and maintain an integrated sense of self, it also impacts one's self-concept. Herman (1992a) noted that survivors of childhood abuse often develop a "malignant sense of self as contaminated, guilty, and evil" (p. 386). Courtois (2006) stated that survivors also have ongoing feelings

of intense shame, take responsibility for the abuse, and "incorporate lessons of abuse into their sense of self and self-worth" (p. 88). Survivors often lack a sense of agency, view themselves as ineffective, exhibit poor self-regard, and present with low self-esteem.

Somatic Symptomology

As a result of an inability to assimilate the trauma into an organized self, and the failure to regulate and integrate the affective and cognitive disturbances associated with the trauma, psychosomatic symptoms are often prevalent among the survivor population. Herman (1992a) observed that repetitive trauma often leads to insomnia, startle reactions and agitation, tension headaches, gastrointestinal problems, somatization disorders, and abdominal, back, and pelvic pain. Other forms of somatic distress often associated with childhood trauma include chronic pain and paralysis and/or numbing of body parts (Cloitre et al., 2011). Briere and Scott (2006) add that not only do survivors of trauma display somatization, psychogenic pain, anesthesia, and paralysis, but they also exhibit signs of sexual dysfunction and/or pain, as well as more severe conversion reactions like blindness and deafness.

Behavioral Symptomology

The culmination of cognitive, affective, interpersonal, intrapersonal, and somatic disturbances often creates behavioral uproars in which survivors engage in irregular, chaotic, and dangerous activities to cope with the psychological pain. Briere and Scott (2006) made note of five tension reducing behaviors that trauma survivors often engage in: (a) self-mutilation; (b) bingeing and purging; (c) excessive or inappropriate sexual behavior; (d) compulsive stealing; and (e) impulsive aggression. Concordant with such

observations, Cloitre et al. (2011) observed behavioral dysregulation, including: self-harm, aggression toward others, and risk taking. Moreover, survivors regularly have patterns of substance abuse and dependence. Davies and Frawley (1994) go beyond merely observing specific behavioral patterns among survivor populations; they capture the subtle dynamic nuances leading to dysregulated behavioral patterns. They stated:

> In addition to compulsive repetition of trauma, the neurobiologically mediated shifts from hyperarousal to psychic numbing result in seemingly unpredictable changes in behavior. When hyperaroused, a normally placid, even withdrawn, patient may become openly aggressive, verbally assaulting the therapist and others or motorically discharging affect (e.g., by throwing things or stamping feet). The same patient, when psychically numb, may become rigid, withdrawn, and virtually unresponsive to attempts to make contact. Finally, a patient whose use of dissociation results in severe fragmentation of the ego may exhibit very different behaviors when another self-state emerges. For instance, a usually conservatively dressed, well coiffed patient who usually sits poised on the couch may suddenly muss her hair and curl into a ball when in a more primitively organized state. (p. 34)

Summary of Complex PTSD Clinical Presentation

In summary, it is evident that survivors of early childhood trauma develop a vast array of disturbances in their self-organization and personality functioning. Of note, trauma survivors do not always exhibit such dramatic symptoms as previously described. They will often demonstrate a greater degree of pathology associated with one particular cluster (e.g., affective verus cognitive). Some survivors may present as withdrawn and terrified while others may present as reactive, angry, and hypersensitive to abandonment. Others may have a diagnosable dissociative identity disorder while others may only exhibit normal degrees of fragmentation within the self. The symptoms are non-linear, dynamic, and always on a continuum of severity. There also is not a specific set of

criterion to substantiate a diagnosis of Complex PTSD. Rather, these are merely symptoms typically associated with the syndrome.

Research on Complex PTSD

As has been illustrated, Complex PTSD as a construct has been defined in vastly different ways (e.g., prisoner of war, concentration camp detainee, victim of child abuse or chronic spousal abuse). Therefore, the research is not consistent when offering effective and efficacious treatments for "Complex PTSD." The current paper focuses on research surrounding one of the proposed definitions of Complex PTSD, the prolonged effects of childhood physical and/or sexual abuse. There is limited research on treatment with adult survivors of childhood physical or sexual abuse. The current paper aims to begin filling this gap by evaluating and consolidating the field's current knowledge about effective treatment of Complex PTSD, as well as to begin a discussion on the importance of integrated and individualized treatment for individuals suffering from Complex PTSD. In order to do this, the following sections will outline methodological and statistical considerations for studies in the treatment of Complex PTSD and will review important studies in this area with regard to specific treatment orientations. After reviewing the available literature on the topic, the current paper briefly summarizes and, as far as is possible, compares the most relevant research from different treatment orientations for Complex PTSD.

Methodological and Statistical Considerations

The outcome studies presented in the current paper generally demonstrated appropriate methodological and statistical approaches. For the sake of efficiency, five areas of methodological and statistical considerations that are particularly relevant to the reviewed studies are discussed in this section of the paper, rather than addressing potentially redundant concerns during the review of each individual study. These five areas are also intended to orient the reader to the types of research designs and data analyses used in the research reviewed. As explicated by Kazdin (2003), research methodology significantly impacts and/or limits what conclusions can be drawn from a given study, theory, or experience, including conclusions about relations between variables and cause-and-effect relationships. Accordingly, a brief methodological critique is indicated in order to identify limitations to the validity and generalizability of the research outcomes reported in the following studies.

This review is not intended to be unreasonably critical nor excessive in critique, but rather intends to recognize the realistic difficulties faced by researchers conducting clinical outcome research studies. Significant individual differences, variations in how a given clinical syndrome may manifest, high rates of co-morbidity with other diagnoses, potential difficulties with recruitment for clinical research, and, in some cases, substantial attrition rates are but a few limitations impacting these studies. Nevertheless, methodological and statistical analyses have important implications for a robust understanding of these research studies and deserve due consideration. Methodological and statistical issues that are particularly salient in the current literature review include

the following: (a) the lack of operational definitions for Complex PTSD; (b) the difference between efficacy and effectiveness studies; (c) treating therapists used in the studies; (d) research designs used in the studies; and (e) the way in which outcomes were measured and analyzed.

Lack of Operational Definitions

Operational definitions are definitions of concepts based on the methods or procedures used to measure the phenomena. Consensus regarding operational definitions is necessary to assure sufficient similarity in identified constructs for comparison across studies. Although the following studies all investigated the efficacy and effectiveness of various approaches for the treatment of adult survivors of either physical or sexual abuse, a form of Complex PTSD, comparisons of outcomes across these studies are limited, to some degree, by the current lack of a clear, operational definition for Complex PTSD. Because PTSD has been studied thoroughly over the decades, there is relative consensus among clinicians and researchers as to what characterizes this psychological disorder, as evidenced by the symptom criteria listed in the *DSM-IV-TR* (2000). There are also several psychometric instruments developed to assess PTSD that have demonstrated adequate reliability (i.e., consistency within scale items or across measures), validity (i.e., the extent to which the instrument actually measures what it is designed to measure), sensitivity (i.e., the percent of cases of the syndrome that are correctly identified by the instrument), and specificity (i.e., the percent of cases in which the syndrome is absent that are correctly identified as lacking the syndrome by the instrument). This is not the case, however, for Complex PTSD, in that there are currently no instruments that specifically

assess Complex PTSD as a discrete clinical syndrome. While there is one instrument that measures Disorders of Extreme Stress Not Otherwise Specified (DESNOS), which is The Structured Interview for Disorders of Extremes Stress (SIDES; Pelcovitz et al., 1997), this is not the same clinical syndrome as Complex PTSD. As such, the SIDES cannot be used to assess and diagnose Complex PTSD.

To address this limitation, researchers generally use a variety of psychometric instruments that target the symptoms typically associated with Complex PTSD (e.g., affective and cognitive disturbances, relational problems, and disruptions in identity formation). For example, the studies in the current review that utilized a control group ran statistical analyses to investigate differences between treatment and control groups with regard to both demographic data and clinical symptoms often associated with Complex PTSD. Moreover, several of the studies presented in this review used the same psychometric instruments targeted at investigating various symptoms associated with Complex PTSD and all selected measures demonstrated sound psychometric properties (e.g., well-established reliability and validity). This, however, does not resolve the problem of construct validity in the presented literature. While these approaches allow for an examination of treatment effectiveness in reducing particular symptoms, it does not entail the use of a consistent assessment of Complex PTSD across studies. Thus, significant variance remains in the psychometric instruments utilized and specific symptoms measured across studies. For these reasons, it is unclear as to whether or not two different outcome studies proposing effectiveness in treating Complex PTSD are, in fact, both treating the same clinical syndrome.

The limitations of such research approaches were further explicated by Resick et al. (2012) stating, "The strategy of using multiple measures of largely nonoverlapping symptoms that were not designed to measure CPTSD [Complex PTSD] is problematic for the diagnoses and measurement of CPTSD symptoms" (p. 244). In a commentary about the proposal of Complex PTSD being included in the *DSM-V* (to be released 2013), Resick et al. (2012) reviewed outcome studies investigating the treatment of symptoms that arise from repeated trauma. They stated:

> None of these studies, however, used CPTSD as an inclusion criterion, nor did they explicitly assess CPTSD. Further, although several of these studies used measures that presumably capture some of the symptoms of CPTSD, without employing cut points to distinguish between individuals with and without CPTSD the percentage of their samples who met criteria for CPTSD could not be computed. Therefore, these studies did not provide clear evidence of treatments that are effective specifically for individuals with CPTSD. (p. 247)

This quote concisely elucidates the paramount dilemma of the current research. It also captures the difficulties presented to the researchers and clinicians who are responsible for including and/or excluding specific psychological disorders in the *DSM-V* (to be released 2013). Of credit to the research presented in this review, with the exception of one study, the researchers did not claim to treat Complex PTSD, but rather adult survivors of childhood physical and sexual abuse. Nonetheless, the researchers were not investigating a discrete syndrome, rather a conglomeration of symptoms that were assumed to have resulted from childhood trauma. Notably, some of the studies did use PTSD as an inclusion criterion for the study, which enabled the researcher to demonstrate the effectiveness of a given treatment for treating PTSD, if not more specifically for treating Complex PTSD.

Efficacy Versus Effectiveness Studies

A second important group of methodological issues regards the relative strengths and limitations entailed in efficacy and effectiveness studies. Efficacy studies entail greater experimental control through the use of various research methods, including use of control groups and random assignment of participants to conditions. Kazdin (2003) described efficacy as referring to "research that is directed more toward the controlled conditions of the laboratory" (p. 140). The majority of the studies presented in the current review are efficacy studies utilizing a wait list control group and, in some cases, an additional group typically called a nonspecific-treatment or attention-placebo control group. These efficacy studies also generally utilized random assignment to allocate individuals to treatment groups, thus evidencing use of true experimental design. The benefit of these highly controlled studies is that they often exhibit strong internal validity. However, efficacy studies often have several threats to external validity (i.e., the extent to which the results of the study can be generalized to a broader population) due to the limitations of experimental methodology and may lose the ability to make inferences about "real life" treatment. For example, efficacy studies often exclude individuals who present with co-morbid diagnoses. While this procedure serves to increase statistical control and reduce the effects of co-morbid diagnoses on treatment outcomes, it can limit the generalizability of findings to general clinical populations in which individuals often present to psychotherapy with one or more co-morbid diagnoses.

In contrast, effectiveness studies entail "intervention research that is in applied settings and under the conditions in which treatment is actually administered" (Kazdin,

2003, p. 140). These studies often do not utilize a control group and may instead employ quasi-experimental methods by which participants are not randomly assigned to treatment conditions. While such approaches may have greater ability to generalize to broad clinical populations due to research conditions that better approximate common clinical settings, these studies often have methodological limitations that contribute to threats of internal validity (i.e., the extent to which changes in the dependent variable can be causally attributed to variations in the independent variable). The lack of random assignment is frequently a problem in effectiveness studies due to these studies utilizing a quasi-experimental design in which individuals are treated on a first come, first served basis. In the case of the current review, six of the nine studies used random assignment. In the absence of random assignment, it can be more difficult to rule out alternate explanations for treatment outcomes due to potential differences between treatment groups prior to treatment, potential confounding variables, or selection biases, all of which pose threats to internal validity. However, it is important to note that while random assignment is preferred, the lack of random assignment in well-designed quasi-experimental studies does not cause such significant problems that inferences and conclusions are weak (Kazdin, 2003). Furthermore, random assignment is often difficult to attain in clinical research.

Treating Therapists in the Studies and Related Concerns

An additional consideration in evaluating the findings of the reviewed studies results from graduate students serving as therapists in a large proportion of the outcome studies. The use of graduate students may impact therapeutic gains made by participants

and generalizability of findings in either a positive or negative direction. For instance, graduate students serving as therapists in outcome studies often receive more intensive supervision and training than a typical therapist, which may contribute to greater competence, better adherence to treatment orientation, and/or increased effectiveness of treatment. On the other hand, graduate students are less experienced than most practicing clinicians, which may have adversely impacted therapeutic changes. If, however, the use of graduate students limited clinical outcomes and statistical significance was noted with graduate student therapists, it is presumably true that the findings can be applied to more experienced clinicians, thus, contributing to greater generalizability. Despite these potential alterations in outcome as a consequence of graduate student therapist involvement, data from outcome studies using the Outcome Questionnaire 45.2 indicated that graduate students often demonstrate equal effectiveness in comparison to experienced clinicians, suggesting that the use of graduate student therapists does not significantly alter clinical outcomes (Okiishi et al., 2006).

Research Designs

There are three types of research designs used in the complex trauma research reviewed in this paper, each of which entails various advantages and disadvantages. First is the Pretest – Posttest, single-group design, which utilizes a single group of participants assessed on an outcome measure(s) both before and after receiving treatment. This is one of the weakest designs used to examine treatment outcomes, primarily because of the lack of a comparison group. Without a comparison group, researchers cannot confidently attribute causal efficacy to the intervention due to the existence of numerous plausible

alternate explanations for observed clinical change (significant or otherwise). While this design allows for measurement of change, statistical significance testing of that change, and may be appropriate when the use of a no-treatment control group is unethical or no alternate treatment is available, it is limited by a number of threats to internal validity (e.g., effects of history, maturation, and testing effects) that cannot be fully assessed in the absence of a second group. Additionally, researchers using this design to establish treatment effectiveness are making the possibly contestable assumption that the participants would not have experienced significant change without the treatment intervention.

The second design commonly utilized is the Pretest – Postest, comparison-group design without random assignment to groups. The inclusion of a second group against which the treatment group can be compared makes for a stronger design than that seen in the Pretest – Posttest, single-group design. While the inclusion of a comparison group is the strength of this design, the absence of random assignment continues to be a considerable limitation as attributing causal efficacy to treatment interventions is still problematic. There may be a number of alternative explanations for differences in change from pretest to posttest.

The third design utilized in the reviewed studies is the Pretest – Posttest, randomized clinical trial (RCT). This design is referred to as the gold standard for research designs when the purpose is testing treatment efficacy. The random assignment of participants to treatment conditions allows for attributing causal efficacy to the treatment factors that differ between the two groups. In several of the research studies

reviewed in this paper, the interventions received by the treatment group included several components that were not included in the treatment received by the comparison group. In these cases, a significant difference between the treatment and comparison groups can be attributed to the treatment package received by the treatment group that consists of multiple treatment components. However, the results do not allow for an attribution of clinical efficacy to any specific component.

Many of the studies reviewed in this paper include follow-up testing after the treatment has ended. The purpose of this testing is to determine the stability of change, if any, experienced by the treated participants. Follow-up testing is also designed to identify possible relapse affects. The length of time and the number of follow-up testing sessions used varies across studies.

Measurement of Outcomes and Statistical Analyses

All the studies reviewed in this paper used multiple measures of participant functioning. The measures included participant self-report questionnaires, clinician ratings, and/or third-party observer ratings, usually based on audio- or video-recordings. Researchers used multiple measures in order to describe the breadth of changes participants experienced. The challenge of using multiple measures, however, is that significant differences may be found on some outcome measures and not others. In these situations, researchers are left with the challenge of identifying possible explanations for the inconsistent results. The best outcome is when the treated group shows significant change on all the measures obtained relative to both the pre-test assessment and to the change experienced by comparison groups.

The statistical analysis of Pretest – Postest comparison group designs is further complicated by the fact that treatment outcomes can be analyzed in several different ways. The use of multiple measures introduces the additional complexity of multivariate statistics, although not all studies reported in this review that used multiple measures used multivariate statistics. There are two basic research questions the statistical analyses are designed to answer. The first is, "Did the treatment group experience significant change from the pretest to the posttest?" This research question requires use of a within-groups statistic, the most basic being the paired samples t-test. The multivariate version of this within-groups statistic is a one-way repeated-measures, Multivariate Analysis of Variance (MANOVA). The MANOVA, if significant, is then followed by univariate test, such as a paired samples t-test.

The second basic question that statistical analyses seek to answer is, "Did the treatment group experience significantly more change than the comparison group?" In a study including a pretest and a posttest along with a single comparison group, this question can be answered statistically using three different approaches:

1. Using change scores calculated for each participant (posttest – pretest), the mean change score of the treatment group is compared to the mean change score of the comparison group(s) using a between-groups statistical analysis, such as an independent samples t-test or one-way Analysis of Variance (ANOVA).
2. Using the pretest and posttest scores as well as any additional scores (e.g., follow-up measures or mid-treatment assessments) to serve as separate observations for each participant so that a repeated-measures design can be used for statistical

analysis. The repeated-measures factor is Time (e.g., pretest, posttest, follow-up) while the between-groups factor is Group (e.g., treatment group, comparison group). A significant treatment effect is indicated by a significant Time x Group interaction, which demonstrates that the groups are changing at different rates. Follow-up between-groups analyses are utilized to further examine the interaction. Ideally, these tests find that the treatment group is improving at a faster rate or to a greater extent than the comparison group.

3. Using the pretest as a covariate, the average posttest score of the treated group can be compared to the average posttest score of the comparison using an Analysis of Covariance (ANCOVA). Although this design is rarely used, it can be utilized to help statistically control for pretest differences between the treatment and comparison groups when between-group pretest differences cannot be controlled through other methods (e.g., random assignment). Many of the studies included in this paper utilized one of these three approaches as necessary in order to ensure the strength and validity of their conclusions, unless multivariate statistics were required.

The aforementioned analyses are all univariate statistics. There are multivariate counterparts to each of the three alternative statistical approaches identified above. When the studies reviewed in the current paper include follow-up testing, the statistical procedures become more complicated. The simplest design is when there is only one post-test assessment. Some of the reviewed studies use two follow-up assessments. While there is a number of commonly used statistical comparisons that can be utilized in such

designs, the primary focus in this review will be on comparisons involving change from the posttest to the follow-up testing. Focus on this component of change answers two questions:

1. Within the treatment group, "Do treated participants maintain treatment gains after a given amount of time has elapsed since the end of treatment (e.g, three months, six months, or one year posttreatment)?"
2. Between the treatment group and the comparison group, "Is the change or lack of change experienced by the treatment group from posttest to follow-up significantly different from that experienced by the comparison group?"

The statistical analyses examining changes from posttest to the follow-up are largely the same as those used for examining change from pretest to posttest. It should also be noted that the repeated-measures design identified above as the second option for assessing pretest to posttest change can be utilized to simultaneously assess both research questions regarding change from pretest to posttest and research questions regarding change from posttest to follow-up while controlling for familywise error rate (i.e., likelihood of a Type I error across several statistical analyses conducted in a given experiment or study), but does require some additional follow-up analyses. Some researchers also include an analysis of change from pretest to follow-up to determine if research participants are functioning better at follow-up assessment than they were at the pretest, which is essentially assessing for relapse.

In addition to the aforementioned statistical analyses, the reviewed studies also assessed and reported effect sizes. This is in response to recent research trends and

recommendations by the American Psychological Association that researchers report effect size statistics to supplement the traditional tests of statistical significance. Effect size statistics, such as Cohen's *d* and eta-squared (η^2) serve multiple statistical functions in the given studies. Namely, they serve as quantitative measures of the magnitude of a given difference (either between groups or between pretest and posttest assessments), allow for comparisons across studies utilizing various sample sizes, are less impacted by sample size variation than are tests of statistical significance, and generally provide a measure of the proportion of variance in the dependent variable that can be accounted for or explained by the independent variable. Thus, effect size calculations assist in determining the practical significance of statistically significant treatment effects. This is particularly important in the case of studies utilizing large sample sizes, in which a statistically significant difference may result from changes too small to produce clinically meaningful change, and in studies utilizing small sample sizes, in which large, clinically meaningful changes may not produce a statistically significant result due to limited statistical power and increased probability of a Type II error. The latter case is particularly pertinent to the current review as several of the studies in the present review exhibited smaller sample sizes than what would be preferred; however, large sample sizes are often difficult to attain in clinical research. The use of effect size calculations will be particularly highlighted in studies utilizing small sample sizes due to the limitations imposed through resulting decreases in statistical power and increased risks of Type II errors.

By way of summary, the present review will describe the statistical results from quantitative studies that examined the effectiveness of various psychological treatments for Complex PTSD. Each of the studies included demonstrate some level of methodological limitation, as is the case with all research; simultaneously, none of the studies appear to demonstrate limitations in excess of those heretofore described unless independently noted through a discussion of possible confounds within the study. Any further mention of such limitations will be discussed in conjunction with each study's outcomes. Overall, results will be reported in terms of which of the above research questions the analyses purport to answer. While the majority of the studies are empirical and quantitative, one study included qualitative research procedures. Considering the study's singularity, the qualitative findings are reported in narrative format and any limitations of the qualitative methods will be reported in tandem.

Treatment of Complex PTSD

While it is clear that there are several methodological and statistical considerations in clinical research, the studies reviewed in this paper indicate that a variety of methods can be effective in the treatment of Complex PTSD. The sections that follow review relevant studies on the treatment of Complex PTSD by theoretical orientation. Treatment methods include Cognitive Behavioral Therapy, Eye Movement Desensitization and Reprocessing, Emotion Focused Therapy, Psychodynamic Psychotherapy, and a summary of general imperative interventions across all treatment orientations.

Cognitive Behavioral Therapy

Cognitive Behavioral Therapy is currently considered to be the standard of care when treating trauma disorders. Aaron Beck introduced cognitive therapy in the 1960s. Beck was first trained as a psychoanalyst but later discovered that by altering a patients' maladaptive thinking about themselves and others, patients experienced rapid decrease in symptomology. When cognitive therapy was first developed, it was intended to be a structured, short-term, present-oriented psychotherapy for depression (Beck, 1995). Over the last 50 years cognitive therapy has taken many shapes and forms. Two such examples include Ellis' (1962) Rational-Emotive Therapy and Meichenbaum's (1977) Cognitive-Behavioral Modification. An additional evolution of cognitive therapy included the incorporation of behavioral interventions such as behavioral activation and exposure methods, which created what is now known as Cognitive Behavioral Therapy. More recently developed psychotherapy orientations continue to demonstrate several similarities to that of traditional cognitive and cognitive-behavioral orientations. These include Eye Movement Desensitization and Reprocessing (Shapiro, 1995), Dialectical Behavioral Therapy (Linehan, 1993), and Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 2012).

Although cognitive therapy was first intended for the treatment of depression, its treatment effects have been studied with a variety of diagnostic presentations. Cognitive therapy has demonstrated efficacy in the treatment of major depressive disorder (Dobson, 1989), generalized anxiety disorder (Butler, Fennell, Robson, & Gelder, 1991), panic disorder (Barlow, Craske, Cerney, & Klosko, 1989), posttraumatic stress disorder (Dancu

& Foa, 1992), and several others diagnoses including but not limited to social phobia, substance abuse, obsessive-compulsive disorder, recurrent depression, chronic pain, and schizophrenia (Beck, 1995).

Beck (1995) outlined 10 principles that are characteristic of cognitive behavioral therapy. These included: (a) an evolving formulation of the patient and his or her problems in cognitive terminology; (b) a strong therapeutic alliance; (c) an emphasis on collaboration and active participation; (d) specific goals; (e) an emphasis on the present; (f) psychoeducation in order to teach the patient to be his or her own therapist to prevent relapse; (g) time limitations; (h) structured sessions; (i) showing patients how to identify, evaluate, and respond to their dysfunctional thoughts and beliefs; and (j) the use of a variety of techniques to change thinking, mood, and behavior.

Cognitive behavioral therapy for trauma includes all of the 10 principles as outlined by Beck (1995) but also comprises several key additional components. These consist of stress inoculation training, imaginal exposure, prolonged exposure (PE), and in vivo exposure. Stress inoculation training is utilized in order to prepare patients for imaginal, prolonged, and in vivo exposures so that the patient is able to use various coping skills if exposure becomes emotionally overwhelming. Foa et al. (1999) described stress inoculation training as including breathing training, deep muscle relaxation, cue-controlled relaxation, thought stopping, cognitive restructuring, guided self-dialogue, covert modeling, role-plays, and homework practicing coping skills. Imaginal and prolonged exposures often involve the patient's recollection and experiencing of the trauma as vividly as possible in the present tense. PE as developed by Foa and Rothbaum

(1998) includes the aforementioned components but also breathing training, psychoeducation, and discussion and processing after the imagined exposure. In vivo exposure involves patients approaching avoided but safe places associated with the trauma (McDonagh et al., 2005). As elucidated, cognitive behavioral therapy for trauma includes not only the major tenants of cognitive behavioral therapy but also exposure to and reprocessing of the trauma as its primary intervention approach. This is true as well for cognitive behavioral therapy for Complex PTSD.

What follows is a review of two outcome studies demonstrating the efficacy of cognitive behavioral therapy for individuals suffering from Complex PTSD. Additionally, a study examining the efficacy of a multi-modal approach utilizing individual and group cognitive behavioral therapy is reviewed.

Cognitive Behavioral Therapy: Exposure Treatment

McDonagh et al. (2005) utilized a randomized clinical trial to compare the efficacy of Exposure-Based Cognitive Behavioral Therapy (CBT) and Present-Centered Therapy (PCT) to each other and a third, wait-list control condition in treating adult women diagnosed with PTSD secondary to childhood sexual abuse.

Participants of the study included 74 women with histories of CSA who met *DSM-IV* (1994) criteria for PTSD. The Clinician Administered PTSD Scale (CAPS; Weathers, Keane, & Davidson, 2001) was used in order to determine PTSD diagnosis, the Evaluation of Lifetime Stressors (ELS; Krinsley et al., 1994) was used to assess participants' trauma history, and the Structured Clinical Interview for *DSM-IV* (1994) Disorders (SCID; Spitzer, Williams, Gibbon, & First, 1994) was used to diagnose Axis I

and II conditions other than PTSD. To be included in the study, some of the participants' intrusive and avoidance symptoms of PTSD must have been related to the CSA. Additionally, the participants must have had at least one memory of the CSA. Exclusion criteria included use of medication with significant autonomic nervous system effects, pregnancy, cardiovascular disease, hypertension requiring medication management, current diagnosis of bipolar, psychotic, and dissociative spectrum disorders, current alcohol or drug abuse, withdrawal from a depressive substance in the last three months, presence of a relationship with an abusive partner, and active suicidality or two or more suicidal behaviors (e.g., suicide gestures or attempts) within the last year. The participants were randomly assigned to one of three groups: Cognitive Behavioral Therapy (CBT), Present-Centered Therapy (PCT), and a Wait List (WL) control group.

The CBT and PCT treatments were both manualized and included 14 individual sessions. The first seven sessions for both treatment conditions were 2 hours long and the remaining seven sessions were 1.5 hours long. McDonagh et al. (2005) utilized longer sessions in order provide adequate time for the use of Prolonged Exposure (PE) interventions, which require the attenuation of anxiety during exposure sessions.

The CBT treatment was a modified version developed by Foa et al. (1999). The treatment included three intervention strategies including: (a) prolonged exposure (PE); (b) in vivo exposure; and (c) cognitive restructuring (CR). PE began during session 4 and included, "(a) calling to mind the traumatic event with as much vividness as possible, (b) recounting the memory in the present tense to the therapist, preferably with eyes closed, and (c) repeatedly going over the memory until the distress decreased" (McDonagh et al.,

2005, p. 518). The most distressing memories were identified as “hot spots.” The participants completed PE with each of these hot spots until the memory was notably less distressing. During in vivo exposure, “therapists helped each participant create a hierarchy of avoided, but likely safe, situations to approach between sessions” (McDonagh et al., 2005, p. 518). The CR component involved “teaching and reinforcing self-monitoring of thoughts and emotions, identifying automatic thoughts that accompany distressing emotions, learning about different types of cognitive distortions, and working to dispute the distress-enhancing cognitions” (McDonagh et al., 2005, p. 518). In addition to these primary interventions, participants were provided with psychoeducation, breathing retraining, and were assigned homework, which included review of video recorded sessions of PE.

The PCT treatment focused primarily on psychoeducation about PTSD and common symptoms associated with CSA, training in problem-solving skills, and journal writing. PCT also included empathy, unconditional positive regard, and genuineness. McDonagh et al. 2005 noted that PCT was specifically designed to omit the primary intervention approaches for the CBT group (i.e., PE, in vivo exposure, CR, and breathing retraining). The WL group was notified that they would have the option of participating in either CBT or PCT after the completion of the postwait assessment.

The therapists in the study were all female clinicians with prior experience working with trauma. The therapists administering the CBT treatment included three psychologists; the PCT therapists were three clinical social workers. Experienced

clinicians watched video recorded sessions and rated the presence of specific interventions during each session in order to measure and assure treatment adherence.

There were eight dependent measures used in the study. The assessment schedule included testing points at pretreatment and posttreatment for all three groups. Testing points were also at 3-month and 6-month follow-up for the CBT and PCT groups but not for the control group.

The assessment measures used demonstrated adequate psychometric properties. The primary outcome measure included the CAPS, with both the PTSD diagnosis and severity score utilized in analyses. Based on the review of 56.4% of the CAPS interviews, this measure demonstrated adequate to high inter-rater reliability, with $k = .66$ and $k = .98$ for diagnosis and severity ratings, respectively. The following seven self-report measures were also utilized in this study: the Beck Depression Inventory (BDI; Beck, Steer, & Garbing, 1988), the State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, & Lushene, 1970), the Traumatic Stress Institute Beliefs Scale (TSI; Pearlman, 2001), the Dissociative Experiences Scale (DES; Carlson et al., 1993), the Cook-Medley Hostility Scale (COOK; Cook & Medley, 1954), the State-Trait Anger Expression Inventory (STAXI; Spielberger, 1988), and the Quality of Life Inventory (QOLI; Frisch, Cornell, Villanueva, & Retzlaff, 1992).

Treatment effects were examined by comparing scores derived at pretreatment and posttreatment for all three groups. Treatment effects were also examined by comparing scores derived at posttreatment, 3-month follow-up, and 6-month follow-up for the CBT and the PCT groups.

Statistical analyses were conducted by using a repeated measures analysis of variance (MANVOA). The treatment group served as the between-subjects variable and time served as the within-subjects variable. For significant interactions of group and time, researchers conducted subsequent post hoc analyses (Tukey) to examine pairwise differences between groups. Additionally, Cohen's *d* was calculated to assess effect sizes for seven of the eight dependent measures.

MANOVA results comparing scores derived at pretreatment and postreatment for all the groups indicated a significant Group x Time interaction for the CAPS PTSD severity scores, ($F(2, 54) = 4.51$, $p < .05$), the STAI, ($F(2, 50) = 3.23$, $p < .05$), and the TSI, ($F(2, 51) = 3.22$, $p < .05$). There were no significant interactions observed on the BDI, DES, COOK, STAXI, and the QOLI. Post hoc analyses of CAPS PTSD severity scores and TSI scores indicated that while the CBT and the PCT groups did not significantly differ from each other, they both exhibited significantly greater improvements than did the control group. Post hoc analysis for the STAI indicated that only the CBT group was significantly greater than the control group. These results indicated that the CBT and the PCT groups experienced significantly more change from the pretest to posttest on three of the eight dependent measures than did the control group participants, indicating significant reduction in severity of trauma-related symptoms, state-level anxiety, and cognitive distortions related to trauma.

McDonagh et al. (2005) noted that MANOVA results comparing scores derived at posttest, 3-month follow-up and 6-month follow-up on all dependent measures for the CBT and the PCT groups indicated significant main effects for time on the STAI and

QOLI, indicating anxiety-reduction and improvements in quality of life for both the CBT and PCT groups (p. 519). However, group STAI and QOLI means listed in Table 4 of the article (p. 522) seem to illustrate a relative stability in scores over time. The means from Table 1 of the article are listed below:

Table 1

STAI and QOLI Means

	STAI Means				QOLI Means		
CBT	39.4	37.4	38.2	CBT	47.1	52.8	49.3
PCT	46.4	46.4	46.6	PCT	38.0	37.2	35.8

These means suggest that there was not a significant difference in scores across time (i.e., posttherapy to 3-month follow-up to 6-month follow-up). Inspection of the means suggests that the only significant effect is between groups (i.e., CBT verses PCT). Furthermore, the listed main effect is labeled as a between-groups effect (i.e., "*F*(group)") and medium to large effect sizes were listed later in the article for the comparison of CBT and PCT at posttest, 3-month follow-up, and 6-month follow-up. These factors seem to suggest that an error was made in reporting the results and that the significant main effect was for group, not time. This interpretation of the reported results would indicate significant effects for group on the STAI ($F(1, 30) = 4.20$, $p < .05$), and the QOLI ($F(1, 30) = 8.03$, $p < .01$), with PCT participants reporting greater mean state-level anxiety and lower quality of life than CBT participants. There were no other

significant Group x Time interactions on any measure. These results indicated that the treated participants in both the CBT and the PCT groups maintained their gains at 3-month follow-up and 6-month follow-up.

Chi-squared analyses were also conducted to compare treatment efficacy of CBT, PCT, and WL conditions. Of participants who completed treatment, there were no significant differences in percent of participants who no longer met criteria for PTSD posttreatment ($\chi^2(2, N = 57) = 3.07, p > .05$), with 47.1%, 35.0%, and 20.0% no longer meeting PTSD criteria in the CBT, PCT, and WL condition, respectively. At 3-month follow up, however, a significantly greater percentage of CBT treatment completers no longer met criteria for PTSD (82.4%) than did PCT treatment completers (42.1%), with ($\chi^2(1, N = 36) = 6.12, p < .01$). At 6-month follow-up, results similarly showed significantly greater reduction in PTSD diagnoses for the CBT participants than the PCT participants, ($\chi^2(1, N = 36) = 4.36, p < .05$), with 76.5% of the CBT participants no longer meeting criteria for PTSD and 42.1% of the PCT participants no longer meeting criteria for PTSD. These results indicated a higher rate of remission for participants who completed the CBT treatment in comparison to participants who completed the PCT treatment.

Effect sizes were calculated using Cohen's D for between group differences for seven (i.e., CAPS, BDI, STAI, TSI, DES, COOK and the STAXI) of the eight dependent measures in order to further compare treatment effects between the treatment conditions (i.e., CBT, PCT, and WL). Medium to large effect sizes were noted for all posttreatment comparisons of CBT with the WL conditions ($d > 0$ .74), with the exception of a small-

to-medium effect for STAXI ($d = 0.41$). Similarly, medium to large effect sizes were noted for all posttreatment comparisons of PCT and WL conditions ($d > 0.59$), with the exception of a small effect for STAXI ($d = 0.16$). Effect sizes for CBT and PCT comparisons fell in the small range ($d > 0.50$) for all posttreatment, 3-month follow-up, and 6-month follow-up comparisons, with the exception of results for four measures. Medium to large effect sizes were found for STAI scores ($d = 0.54$, 0.76, and 0.64, at posttreatment, 3-month follow-up, and 6-month follow-up, respectively) with CBT participants reporting lower state-level anxiety than PCT participants. Medium to large effect sizes were also found for CAPS severity ratings ($d = .61$) and TSI scores ($d = .60$) at 3-month follow-up, and BDI ($d = .55$) and STAXI ($d = .58$) at 6-month follow-up, with results favoring CBT treatment.

Of concern, 41.4% of the women in the CBT group dropped out, including all 4 participants diagnosed with borderline personality disorder who were assigned to that condition. This was a significantly greater dropout rate than that found for PCT (9%) or the WL (13%), with $\chi^2(2, N = 74) = 9.23$, $p < .02$. Researchers noted the dropout group reported higher frequency of childhood physical abuse (Fisher's exact test, $p < .02$), greater perceived threat during the worst CSA event ($\chi^2(1, N = 74) = 4.63$, $p < .05$), and greater physical injury during the worst CSA event ($\chi^2(1, N = 74) = 5.94$, $p < .02$), than did treatment completers. Amongst participants assigned to the CBT condition, participants who dropped out of treatment reported higher levels of depression and anxiety than did participants who completed treatment, but no significant differences in PTSD severity. As such, researchers stated that CBT may not be "well tolerated among

women with more complex clinical presentations" (McDonagh et al., 2005, p. 522). McDonagh et al. noted that because of this high drop out rate "comparison between CBT and the other two groups are less scientifically sound than those comparing PCT and WL, in which dropouts were few" (p. 521).

Cognitive Behavioral Therapy: Skills Training

Cloitre, Cohen, Koenen, & Han (2002) utilized a randomized control trial study design to investigate the efficacy of a phase-based treatment for the treatment of posttraumatic stress disorder related to childhood physical and sexual abuse (CA). The experimental, phase-based treatment included Skills Training in Affective and Interpersonal Regulation (STAIR) and subsequent prolonged exposure interventions (STAIR-Modified PE).

Participants of the study included 58 women with histories of CA and who met criteria for PTSD in relation to childhood physical and/or sexual abuse. Trauma history and diagnosis was determined using two clinician-administered instruments including the Childhood Maltreatment Interview Schedule (Briere, 1992) and the Clinician Administered PTSD Scale (CAPS; Blake et al.). Study participants were also required to have at least one clear memory of the abuse. Exclusion criteria included current diagnoses of psychosis, substance dependence, an eating disorder, a dissociative disorder, Bipolar I Disorder, organic mental disorder, and/or Borderline Personality Disorder, as well as a suicide attempt or inpatient hospitalization within the last three months. Participants were randomly assigned to one of two conditions: (a) the STAIR-Modified

PE condition which was the active treatment group (n = 31) or (b) the minimal attention wait list condition (n = 27).

The treatment included 16 sessions over the course of 12 weeks. The treatment was broken down into two phases. The first phase included eight 1-hour sessions of STAIR. The second phase included twice weekly 1.5-hour sessions of a modified version of PE. All therapy sessions were audiotaped and monitored for treatment adherence.

STAIR is a cognitive-behavioral intervention that aims at developing emotion management and interpersonal skills (Cloitre et al., 2002). This intervention was specifically developed based on generic cognitive behavioral and dialectical behavioral therapies (Linehan, 1993) in order to specifically target the noted affect-regulation and interpersonal difficulties within the CA trauma population (Cloitre et al., 2002). Accordingly, each session of STAIR focused on these skill deficit areas and included the following topics:

> (1) Labeling and identifying feelings, (2) emotion management, (3) distress tolerance, (4) acceptance of feelings and enhanced experiencing of positive emotions, (5) identification of trauma-based interpersonal schemas and their enactment in day-to-day life, (6) identification of conflict between trauma-generated feelings and current interpersonal goals, (7) role plays related to issues of power and control, and (8) role plays related to developing flexibility in interpersonal situations involving power differentials. (Cloitre et al., 2002, p. 1069)

STAIR was used in the initial phase of treatment in order to better prepare participants to engage in and benefit from the modified PE portion of treatment (Phase 2).

Modified PE included prolonged imaginal exposure techniques as developed by Foa and Rothbaum (1998). In this technique clients were asked to repeatedly describe their traumatic events in an emotionally-detailed and engaged manner (Cloitre et al.,

2002). PE techniques were modified to meet the needs of the specific treatment population through eliminating in vivo exposure elements and including three additional components: (a) A "postexposure stabilization check" that encouraged participants to use coping skills to supplement their emotion-regulation abilities postexposure; (b) a "postexposure emotion focused processing intervention" to help participants identify the "presence and intensity of fear, anxiety, dissociation, and sadness during the exposure;" and (c) participant identification of " negative interpersonal schemas embedded in the narrative" and therapist-facilitated contrasting of these maladaptive interpersonal schemas with more adaptive schemas generated during STAIR (Cloitre et al., 2002, p. 1069). For homework, the participants were also encouraged to apply coping skills to current difficulties, application of interpersonal schema-based work to current relationships, and review of audio taped narratives at least once a day (Cloitre et al., 2002).

Therapists included five female doctoral-level clinical psychologists. The therapists were trained using manuals of the treatment approach and were supervised by Cloitre and trained by Edna Foa in Prolonged Exposure (PE) during two full day workshops.

Eleven dependent measures were used in the study. Clinician-administered measures were administered at pretreatment and posttreatment to both groups, while self-report measures were administered at pretreatment, midtreatment, and posttreatment for both groups. Testing points were also completed at 3-month follow-up and 9-month

follow-up for the treatment group. In addition, participants completed a therapeutic alliance measure following each therapy session.

The included assessment measures demonstrated acceptable psychometric properties. Both a clinician-administered measure and a self-report measure were used to investigate PTSD symptoms: the Clinician-Administered PTSD Scale (CAPS; Blake et al. 1995) and the Modified Posttraumatic Stress Disorder Symptom Scale (MPSS-SR; Falsetti, Resnick, Resick, & Kilpatrick, 1993). Six additional self-report measures were used to investigate emotional functioning. These included the General Expectancy for Negative Mood Regulation Scale (NMR; Cantanzaro & Mearns, 1990); the Anger Expression subscale (Ax/Ex) from the State-Trait Anger Expression Inventory (Spielberger, 1991); the Toronto Alexithymia Scale – 20 – Item Version (TAS-20; Bagby, Parker & Taylor, 1993); the Dissociation Scale (DISS; Briere & Runtz, 1990); the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock & Erbaugh, 1961); and the State-Trait Anxiety Inventory (STAI; Spielberger, 1983). For each of these measures, higher scores indicated greater difficulty with affect-regulation with the exception of the NMR, on which higher scores indicate better emotion-regulation. Three measures were also used to investigate interpersonal functioning; these included the Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988); the Social Adjustment Scale – Self Report (SAS-SR; Weissman & Bothell, 1976); and the Interpersonal Support Evaluation List (ISEL; Cohen & Hoberman, 1983). High scores on the SAS-R and ISEL indicate better interpersonal functioning while high scores on the IIP are indicative of more interpersonal difficulties than are lower scores. Finally, the

Working Alliance Inventory (WAI; Tracey & Kokotovic, 1998) was utilized to assess therapeutic alliance.

Treatment effects were examined by comparing scores derived at pretreatment, midtreatment, and posttreatment for both groups on the 11 dependent measures. Treatment effects were also examined by comparing scores derived at posttreatment, 3-month follow-up, and 9-month follow-up for the treatment group on the eleven dependent measures. Three separate multivariate analyses of variance (MANOVAs) were conducted for each of the following three conceptually-determined groups of dependent variables; PTSD symptoms, affect-regulation difficulties, and interpersonal difficulties. Subsequent repeated-measures ANOVAs were utilized when Wilks's Lambda indicated significant Group x Time interactions. The treatment group served as the between-subjects variable and time served as the within-subjects variable for each analysis. Pairwise t-tests were used to investigate long-term effects at follow-up. Additionally, Cohen's *d* was calculated to assess effect sizes.

MANOVA results comparing scores derived at pretest, midtest, and posttest indicated significant Group x Time interactions for the PTSD symptom measures (Wilks' $\Lambda = 12.61$, $p < .01$), affect-regulation measures (Wilks' $\Lambda = 2.85$, $p < .01$) and interpersonal measures (Wilks' $\Lambda = 4.68$, $p < .01$). Subsequent repeated measures ANOVAs were conducted for each individual dependent measure and indicated significant Group x Time interactions for all measures ($p < .04$ for all analyses). Results indicated a significant decrease in scores on all dependent measures from pretreatment to posttreatment for the treatment group in comparison to the wait list group. Results further

indicated that the STAIR modified-PE group exhibited significant improvements between both pretreatment and midtreatment and midtreatment and posttreatment on two measures of emotion-regulation (BDI and STAI; $p < .02$ for all analyses), between pretreatment and midtreatment for two other measures of emotion-regulation (NMR and Ax/Ex: $p < .02$ for all analyses), and between midtreatment and posttreatment for the final two emotion-regulation measures (DISS and TAS-20; $p < .01$ for all analyses) and a self-report measure of PTSD symptoms (MPSS-SR; $p < .01$). Results indicated no significant differences in scores from pretreatment to midtreatment or from midtreatment to posttreatment for the wait list group. Researchers calculated Cohen's *d* to assess the effect sizes of differences between STAIR-modified PE and wait list control groups at posttreatment. Effect sizes for the PTSD measures were large and ranged from 1.03 to 1.30. Effect sizes for the affect regulation measures were moderate to large, ranging from .73 to 1.60. Effect sizes for the interpersonal functioning measures were also large and ranged from .82 to .96. These results indicate that the treatment group experienced significant change from the pretest to the posttest and that the treatment group reported significantly better emotion-regulation and interpersonal functioning and significantly lower PTSD symptoms than the wait-list control group at posttreatment.

Chi-squared analyses were also conducted to compare remission rates and end-state functioning of the STAIR modified PE condition and the wait-list condition. Researchers utilized means in normative female samples to define good end-state functioning as indicated by the following scores: BDI < 10, MPSS-SR < 20, and STAI-S < 40. Based on these guidelines, a significantly greater percent of participants in the

STAIR modified PE condition exhibited good end-state functioning (46%) compared to participants in the wait-list condition (4%) ($\chi^2(1, N = 46) = 10.74, p > .01$). Researchers also compared posttreatment PTSD diagnostic status, as assessed by the CAPS. Results indicated that a significantly greater proportion of participants in the STAIR modified PE condition no longer met criteria for PTSD (77%) than in the wait-list condition (25%) ($\chi^2(1, N = 46) = 12.28, p > .01$). These results indicate a significantly higher rate of PTSD symptom remission and return to normative functioning in regards to depressive and anxious symptoms for participants who completed the STAIR modified PE treatment in comparison to wait-list control participants.

Researchers compared scores derived at posttest and at 3-month follow-up for the treatment group on all the dependent measures using pairwise *t* tests. Results indicated that scores on the CAPS decreased significantly from posttest to 3-month follow-up for the treatment group ($t(29) = 2.23, p = .04$). This indicates that the treatment group continued making improvement in PTSD symptoms reduction from posttest to 3-month follow-up. On the remaining dependent measures there were no significant differences in scores from posttest to 3-month follow-up. This indicates that the treated participants maintained treatment gains from the end of treatment to the 3-month follow-up testing.

Researchers also utilized pairwise *t* tests to compare scores derived at posttest to scores at 9-month follow-up for the treatment group on all dependent measures. Results indicated that the scores on the CAPS were lower than those derived at posttest ($t(16) = 2.82, p = .01$), indicating the treatment group maintained posttreatment improvements noted at the 3-month follow-up. Furthermore, CAPS scores at the 9-month follow-up (*M*

= 22, *SD* = 14.5) were lower than those at the 3-month follow-up (*M* = 26, *SD* = 17.4). The researchers, however, did not indicate conducting analyses of this difference so it is unclear if this is a statistically significant improvement from the 3-month follow-up. Significant decrease in scores between posttreatment and 9-month follow-up were also observed for the interpersonal measures, including the IIP ($t(15) = 2.40$, $p = .03$), the SAS-SR ($t(16) = 2.21$, $p = .04$), and the ISEL ($t(16) = 3.29$, $p = .01$). These results indicate that the treatment group significantly improved in regards to interpersonal functioning between posttreatment and 9-month follow-up. There were no further significant differences between posttreatment and 9-month follow-up scores on the remaining dependent measures. This indicates that the treated participants maintained treatment gains from the end of treatment to 9-month follow-up.

To examine the contributions of phase-based changes to PTSD reduction, researchers calculated Phase 1 (STAIR) change scores for dependent measures, Phase 2 (Modified PE) change scores for PTSD scores, and Phase 1 therapeutic alliance scores (defined as the average WAI score for Sessions 3, 4, and 5). Partial correlations between Phase 1 change scores and Phase 2 PTSD reduction change scores and between Phase 1 therapeutic alliance scores and Phase 2 PTSD reduction change scores were then examined while statistically controlling for PTSD scores at the start of Phase 2. Results indicated that Phase 2 PTSD symptom reduction was uniquely predicted by Phase 1 therapeutic alliance scores ($r = -.62$, $p < .03$), and Phase 1 NMR change scores ($r = -.47$, $p < .03$). No other Phase 1 change scores were significant predictors of Phase 2 reductions in PTSD symptoms. These results suggest that the establishment of a strong

therapeutic relationship and development of negative mood regulation skills during Phase 1 are particularly important for PTSD symptom reduction during Phase 2 STAIR modified PE interventions. This finding confirms the researchers hypothesis that the STAIR program would contribute to participants' making better use of the Modified PE.

Cognitive Behavioral Therapy: Cognitive Processing and Group Treatment

Chard (2005) investigated the effectiveness of cognitive processing therapy for the treatment of posttraumatic stress disorder among individuals with a history of childhood sexual abuse (CSA).

Participants of the study included 71 women with histories of CSA. In order to be included in the study, the women were required to have met criteria for a diagnosis of PTSD, report at least one incident of child sexual abuse, and recall at least one memory of the abuse. Exclusion criteria included ongoing trauma, substance dependence, suicidal intent, and serious medical conditions. The participants were randomly assigned to one of two groups: the cognitive processing therapy for sexual abuse survivors group (CPT-SA, $N = 36$) or a minimal attention group (MA, $N = 35$).

The CPT-SA treatment model used was based on Resick and Schnicke's (1993) cognitive processing therapy for rape victims (Chard, 2005). This model was used because it targets specific trauma symptoms typically associated with child abuse survivors. Additionally, CPT-SA was based on information processing, developmental, and self-trauma theories (Chard, 2005). As a result of the trauma treatment developing out of such theories, Chard (2005) opined that the treatment would address the "roles of fear processing, attachment, cognitions, and development play in the creation and

maintenance of symptoms" (p. 967). Thus, CPT-SA treatment in the study included 17 weeks of manualized group and individual therapy. The participants attended a 90-minute group each week and a 60-minute individual therapy session for the first nine weeks and the 17th week.

Chard (2005) divided treatment into eight different segments, which included both individual and group therapy. During the first week of treatment participants were educated about PTSD, provided the rationale of treatment, and began to establish rapport with the individual therapists and group members. Additionally, participants were educated about how one develops "rules" and "beliefs" about self, others, and the world.

During the second week of treatment participants explored their developmental history and investigated various rules that were formulated during their history. For homework during that week, participants were asked to write about an experience during childhood that shaped their beliefs about self, others, and the world. During the third week participants were asked to review their rule and explore their thoughts, feelings, and relationships. During the fourth week, the participants began the exposure portion of treatment in which they were asked to write about the most traumatic incident during childhood. From week five to week eight the participants read their traumatic accounts in individual therapy and discussed the process of doing homework in group therapy.

During the eighth and ninth week of treatment the participants were taught the Challenging Questions and the Disruptive Thinking Patterns (Chard, 1997) in order to explore their thought patterns as a result of the trauma. From weeks 10 to 16, the participants were expected to challenge their thoughts and beliefs by using the

Challenging Beliefs Worksheet (Chard, 1997). This was utilized in order to examine "their rules about safety, trust, power/control, self-esteem, communication, intimacy, and social support" (Chard, 2005, p. 967). The 17th and final segment included a final meeting with the individual therapist in order to review the new impact of event statement and discuss relapse prevention. Of note, Chard (2005) stated, "Unlike CPT's focus on schema-discrepant beliefs, CPTS-SA focuses on schema-discrepant and schema-congruent beliefs, because many of these beliefs are created during childhood and in the abuse context" (p. 967).

The therapy groups were led by six graduate students in psychology and the author, all of whom had experience in cognitive behavioral interventions and specific training in conducting CPT-SA treatment. Graduate students received individual supervision on cases related to the study. Client sessions were videotaped and reviewed by an independent-rater, also trained in CPT-SA methods, in order to control for treatment adherence across sessions. The mean adherence rating for the therapists was 98%.

Four dependent measures were used to assess treatment effects. The assessment schedule included testing points at pretreatment and posttreatmet for both groups. Testing points were also at 3-month follow-up and 1-year follow-up for the CPTS-SA group only.

The assessment measures used demonstrated acceptable test-retest reliability. The following measures were used to assess treatment effects in each condition: the Clinician Administered PTSD Scale for *DSM-IV* (1994): One-Week Symptom Scale (CAPS-SX; Blake et al., 1995); the Modified PTSD Symptoms Scale (MPSS; Falsetti et al., 1993);

the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996); and the Dissociative Experience Scale-II (DES-II; Bernstein & Putman, 1986).

Treatment effects were examined by comparing pretreatment and posttreatment scores in each condition on the four dependent measures using four ANCOVAs. Additionally, 3-month follow-up and 1-year follow-up scores for the CPTS-SA group were examined using pairwise *t* tests in order to investigate stability of treatment effects. Cohen's *d* and eta-square (η^2) were calculated to assess effect sizes. Cohen's *d* was used in order to "compare differences between treatment participants and wait-listed participants at posttreatment, without controlling for pretreatment scores" (Chard, 2005, p. 968). Chard (2005) utilized η^2 once the pretreatment scores were controlled.

Scores derived at pretreatment and posttreatment for both groups were compared using four ANCOVAs. Results indicated significant differences in scores at posttest in favor of the CPTS-SA group on the CAPS-SX ($F(1, 54) = 95.96$, $p < .001$, $d = 1.52$, $\eta^2 = .65$); the MPSS ($F(1, 54) = 121.34$, $p < .001$, $d = 1.55$, $\eta^2 = .70$); the BDI-II ($F(1, 54) = 71.18$, $p < .001$, $d = 1.42$, $\eta^2 = .58$); and the DES-II ($F(1, 52) = 68.76$, $p < .001$, $d = .91$, $\eta^2 = .32$). Therefore, the results indicated that the treatment condition's mean scores were significantly lower than the control condition's in the general areas of PTSD, depressive, and dissociative symptomology after receiving the treatment, and the treatment had a moderate to large effect on the participants' symptomology.

Assessment data was gathered for 28 of the CPTS-SA participants at a 3-month follow-up. Follow-up data indicated that treatment effects remained stable over time. There was a significant difference between scores from posttreatment to 3-month follow-

up on the CAPS-SX ($t = 2.43$, $p = .02$). This indicates that not only did treatment effects remain stable but that the CPTS-SA participants continued to show improvement with regard to PTSD symptoms. There were no other significant differences in scores from posttest to 3-month follow-up on the other dependent measures, indicating the stability of treatment effects from posttreatment to 3-month follow-up.

Assessment data was gathered for 27 of the CPT-SA participants at a 1-year follow-up. Comparisons between the 3-month follow up and the 1-year follow-up scores were also made. There were no significant differences in scores from the 3-month follow-up to1-year follow-up on the other dependent measures, suggesting that treatment gains measured at posttreatment remained stable for at least one year.

In summary, there were significant differences in scores between groups at posttreatment on all four dependent measures in favor of the CPTS-SA group. Moreover, effect sizes were moderate to large at posttreatment. Finally, 3-month and 1-year follow-up data indicated that the treatment group maintained their gains at least one year after treatment. As such, the treatment group exhibited less symptomology in the areas of PTSD, depressive, and dissociative symptomology at 1-year follow up in comparison to the time at which they began the treatment.

Eye Movement Desensitization and Reprocessing

Eye Movement Desensitization and Reprocessing (EMDR) was first developed by Francine Shapiro in 1987 when she discovered that moving her eyes back and forth while remembering a distressing experience helped alleviate the severity of the feelings

associated with that experience (Edmond et al., 2004). Shapiro (1989) then began studying her new technique, which was originally called Eye Movement Desensitization (EMD) with individuals that had traumatic memories associated with the Vietnam War, childhood sexual molestation, sexual or physical assault, or emotional abuse. The results of her study indicated that after a single session the participants demonstrated decreased symptoms and "altered their cognitive assessment of the situation" (Shapiro, 1989, p. 1). The results also indicated stability of therapeutic effects at a 3-month follow up (Shapiro, 1989). Subsequent to this study several investigators demonstrated the efficacy of EMDR for the treatment of PTSD (Ironson, Freud, Strauss, & Williams, 2002; Nijdman, Gerson, Reitsma, de Jong, & Olff, 2012; Seidler & Wagner, 2006). EMDR, although first used in the treatment of PTSD has been used for a variety of other problems including agoraphobia, panic disorder, child trauma, learning difficulties, sexual abuse, dissociative identity disorder, somatic disorder, chronic depression, obsessive-compulsive disorder, smoking cessation, and eating disorder (Greenwald, 1994).

Shapiro and Laliotis (2011) stated that the paradigm for EMDR is such that psychopathology is viewed as the incomplete processing of early traumatic and/or disturbing experiences via the brain's information processing system. Accordingly, the "hallmark of EMDR therapy is the emphasis on the physiologically stored memory as the primary foundation of pathology, and the application of specifically targeted information processing as the primary agent of change" (Shapiro & Laliotis, 2011, p. 1). The overall goal of EMDR, as stated by Shapiro and Laliotis (2011) is:

> To address the current problems of daily living by accessing the dysfunctionally stored memories that are being triggered by the client's current life conditions,

> and engage the natural neural processes by which these memories are transmuted into appropriately stored memories. The end result is an assimilation of the new information into extant memory structures. (p. 3)

As outlined by Shapiro and Laliotis (2011), the application of EMDR as a comprehensive treatment includes eight distinct phases including: (a) client history, (b) preparation, (c) assessment, (d) desensitization, (e) installation, (f) body scan, (g) closure, and (h) reevaluation. Each one of these phases has coinciding purposes and procedures.

Shapiro and Laliotis (2011) outlined the following as the primary purpose of each phase of treatment. Shapiro and Laliotis (2011) reported that the purpose of history taking is to obtain background information, identify suitability for EMDR, and identify "processing targets" from the client's positive and negative life experiences. The purpose of preparation is to prepare the clients for EMDR processing of targets and to stabilize the client and increase access to positive emotions. Assessment, on the other hand, is to access the processing target by stimulating primary aspects of the memory. The fourth phase of desensitization is used to process experiences and triggers toward an adaptive resolution, to fully assimilate the memories, and to incorporate new templates for positive experiences. Installation, the fifth phase, is important to increase connection to positive cognitive networks and increase the effects within associated memories. The purpose of the body scan is to complete processing of residual disturbance associated with the target memory. The seventh phase of closure is to stabilize the client at the completion of the session and between sessions. Finally, the purpose of reevaluation is to evaluate treatment effects and instill processing over time.

To date, there are few investigators that have studied the effectiveness of EMDR for the treatment of Complex PTSD. Consequently, what follows is one study that investigated the effectiveness of EMDR with adult female survivors of childhood sexual abuse. This parent study is followed by a second, qualitative study investigating the participants' perceptions of the effectiveness of EMDR and Eclectic Therapy.

EMDR: Quantitative Outcomes

Edmond, Rubin, & Wambach (1999) investigated the effectiveness of EMDR with adult female survivors of childhood sexual abuse.

The participants of the study included 59 women with sexual abuse histories. Inclusion criteria included individuals who had no history of EMDR treatment and who had no contraindications for EMDR treatment. Contraindications included ocular problems, suicidal ideation, serious medical conditions, poor ego strength, and severe mental illness such as psychosis (Edmond et al., 1999). Participants were randomly assigned to one of the three groups: (a) individual EMDR treatment (n = 20); (b) Routine Individual Treatment (n = 20); or (c) delayed treatment control group (n = 19). There were no significant differences between groups with respect to demographic characteristics, abuse specific variables, and pretest scores (Edmond et al., 1999).

Three conditions were included in the study, EMDR, Routine Individual Treatment (i.e., eclectic), and a no treatment condition. In both of the treatment conditions (EMDR and Routine Individual Treatment), participants attended six, 90-minute individual therapy sessions. The first session was similar for both groups, in that it was intended to "establish rapport, confirm the treatment target, obtain pretest scores on

the subjective process measures, and review the treatment procedures" (Edmond et al., 1999, p. 109). The first session was also used to create a safe environment. For the Routine Individual Treatment this was accomplished through visualization, guided imagery, and hypnosis. For the EMDR group this was accomplished by using EMDR procedures. The remaining five sessions were either EMDR or Routine Individual Treatment. The third and final group received no treatment and served as a control group. However, this group was not measured at the three month follow up, and only served as a control group for the pre-test to post-treatment phase.

The EMDR treatment was concordant with an 8-phase based model presented by Shapiro (1995). These phases included: (a) client history and development of a treatment plan; (b) preparation of the client; (c) assessment of target issues; (d) desensitization of target material by the use of bilateral eye movements; (e) installation of a desired cognition; (f) body scan for residual issues needing resolve; (g) closure; and (h) re-evaluation of target complaints (Edmond et al., 1999).

The researchers identified Phase 3 (assessment) and Phase 4 (desensitization) of the EMDR treatment to be of particular importance. During Phase 3 the treatment targets were identified. The targets included the "presenting problem, the memory connected to the presenting problem, a picture or image of the memory to be held in mind (both negative and desired positive self-assessments associated with the memory), the emotions connected to the memory, as well as any accompanying physical sensations" (p. 104). Also during this phase the participants were asked to hold in mind the picture or image associated with the memory and the positive self-assessment associated with the memory.

They were then asked, during each session, to rate on a scale from 1 to 7 how true their positive self-perception was. The rating was called the Validity Of Cognition (VOC). Additionally, the participants were asked to focus on their emotions and negative self-perceptions associated with the memory. The participants were then asked to rate on a scale of 0 to 10 how distressing the emotions were. The rating was called the Subjective Units Of Distress (SUDS). Once the VOC scores reached either a 6 or a 7 and the SUDS scores were at a 0 or a 1, the targeted issues were considered to be resolved (Edmond et al., 1999). The Routine Individual Treatment group was also asked to record their VOC and SUDS scores. These scores were later used as subjective outcome measures.

During Phase 4 of EMDR treatment, the participants were asked to hold in mind all the identified target components. The therapists then induced "saccadic eye movements" by having the participants follow the therapists' fingers in repeated bilateral movements. The distance between the therapists' fingers and the participants' faces was typically around 12 to 14 inches. The speed, number, and direction of eye movements varied dependent on the participants' needs.

For the EMDR group, randomly selected video taped sessions of participants were reviewed by an EMDR trainer in order to determine adherence to treatment delivery.

The Routine Individual Treatment, on the other hand, was defined by Edmond et al. (1999) as a "variety of methods, techniques, and theories incorporated into a treatment approach designed to resolve a broad range of symptoms and target problems resulting from sexual abuse trauma and routinely used by therapists with adult female survivors of childhood sexual abuse" (p. 106). The therapists were asked to record the interventions

they used after each session in their process notes. The researchers noted that there were 20 different interventions used. These interventions included: support, information, ego strengthening, interpretation, cognitive restructuring, problem solving, dreamwork, neurolinguistic programming, psychoeducation, behavior modification, gestalt, hypnosis, artwork, assertiveness training, observation of children, writing assignments, relaxation exercises, guided imagery and visualization (Edmond, Rubin, & Wambach, 1999). Of note, several of these interventions were also used in the EMDR treatment. These included: support, information, ego strengthening, cognitive restructuring, keeping a journal, visualization, and dreamwork.

The treating therapists consisted of four female, European-American therapists. The therapists all had their master's degree in either social work or psychology. All the therapists completed level-two (advanced) EMDR training. Each therapist was randomly assigned five EMDR and five routine individual treatment participants.

Four dependent measures were included in the study. The assessment schedule included testing points at pretest, posttest, and follow-up. The assessment measures used demonstrated acceptable test-retest reliability. The following measures were used to assess treatment effects: the State Anxiety Scale of the State-Trait Inventory (STAI; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983); the Impact of Event Scale (IES; Horowitz, Wilner, & Alvarez, 1979); the Beck Depression Inventory (BDI; Beck & Steer, 1993); and the Belief Inventory (BI; Jehu, Gazan, & Klassen, 1985). Additionally, the Subjective Units Of Distress (SUDS) and the Validity Of Cognition (VOC) units were used as subjective outcome measures.

Differences between pretest, posttest, and follow-up scores for the three groups on all dependent measures were examined through a multivariate analysis of variance (MANOVA). In order to protect against Type I error, researchers used a Pillai-Bartlett trace. Individual univariate analyses of variance for each dependent measure at posttest and follow-up were also conducted. Effect sizes were also calculated in order to summarize treatment effects. MANOVAs and univariate analyses of variance were conducted on the two subjective outcome measures (the SUDS and VOC scores) for the EMDR and the Routine Individual Treatment groups at posttest and follow-up.

MANOVA results comparing scores derived at pretest and posttest for all three groups indicated significant differences in scores (Pillais = .399, $n = 59$, $F(8) = 3.37$, $p < .002$). Subsequent univariate analyses of variance indicated that scores on the BDI were not significantly different between groups at posttest ($p < .07$). Posttest scores on the STAI improved significantly for both the EMDR and the Routine Individual Treatment groups in comparison to the control group ($p < .001$). Posttest scores on the IES improved significantly for both the EMDR and the Routine Individual Treatment groups in comparison to the control group ($p < .001$). Posttest scores on the BI improved significantly for both the EMDR and the Routine Individual Treatment groups in comparison to the control group ($p < .01$). Results further indicated an overall effect size of 1.46 for the EMDR group on all dependent measures at posttest. There was not a significant difference in scores on any dependent measure between the EMDR and the Routine Individual Treatment groups at posttest. These results suggest that both the

EMDR and the Routine Individual Treatment groups experienced significant change in scores from pretest to posttest in comparison to the control group.

MANOVA results comparing the SUDS and VOC scores between the EMDR and Routine Individual Treatment groups indicated significant differences between groups from pretest to posttest (Pillais = 3.41, $n = 40$, $F(2) = 9.32$, $p < .001$). The SUDS posttest mean was significantly better for the EMDR group in comparison to the Routine Individual Treatment group ($p < .001$). The VOC posttest means were significantly better for the EMDR group in comparison to the Routine Individual Treatment group ($p < .001$). The overall effect size for the EMDR group on the SUDS and VOC at posttest was large at 1.36. These results indicate that the EMDR group experienced significant change in scores from pretest to posttest, in other words, a significant decrease in subjective distress over recalled memories, in comparison to the Routine Individual Treatment group.

MANOVA results at follow-up indicated significant differences in scores between treatment groups (Pillais = .319, $n = 34$, $F(4) = 3.39$, $p < .05$). Subsequent univariate analyses of variance at follow-up indicated a significant difference in scores between the EMDR and the Routine Individual Treatment groups on the BDI in favor of the of the EMDR group ($p < .001$) with a large effect size of 1.29. Follow-up scores on the STAI indicated a significant difference in scores between the EMDR and the Routine Individual Treatment groups in favor of the EMDR group ($p < .01$) with a large effect size of 1.02. Follow-up scores on the IES indicated no significant difference in scores between the EMDR and the Routine Individual Treatment group ($p = .11$) with a

moderate effect size of .56. Follow-up scores on the BI indicated no significant differences in scores between the EMDR and the Routine Individual Treatment group (p = .08) with an effect size of .63. Results further indicated an overall effect size of 1.08 for the EMDR group on all dependent measures at follow-up. These results indicate that the change experienced by the EMDR group from posttest to follow-up was only significantly different for two (BDI and STAI) of the four dependent measures. The control group was excluded at the follow-up in order to make more direct comparisons between the treatment groups.

MANOVA results comparing the SUDS and VOC scores between the EMDR and the Routine Individual Treatment groups indicated significant differences from pretest to follow-up (Pillais = .345, n = 34, $F(2) = 8.16$, $p < .001$). The SUDS follow-up means were significantly better for the EMDR group in comparison to the Routine Individual Treatment group ($p < .001$) with a large effect size of 1.35. The VOC follow-up means were significantly better for the EMDR group in comparison to the Routine Individual Treatment group ($p < .01$) with a large effect size of 1.06. The overall effect size for the EMDR group on the SUDS and the VOC at follow-up was large at 1.38. These results indicate that the change experienced by the EMDR group from posttest to follow-up was significantly greater than that experienced by the Routine Individual Treatment group on the subjective outcome measures.

In summary, on the objective dependent measures the EMDR group did not demonstrate significantly greater improvement in comparison to the Routine Individual Treatment group at posttest. Both groups, however, did demonstrate significant

improvement on all measures in comparison to the control group at posttest. At follow-up the EMDR group did demonstrate significantly greater change in scores in comparison to the Routine Individual Treatment group on two dependent measures, the BDI and the STAI. Interestingly, results from the subjective outcome measures favored the EMDR group at both posttest and follow-up. With respect to this finding, Edmond et al. (1999) stated:

> Although the SUDS and VOC have many limitations, if we accept the notion presented in the EMDR training, that a SUDS scores of zero or one, in conjunction with a VOC score of six or seven, indicates resolution of the targeted traumatic memory, then at posttest 65 percent of the EMDR participants reached resolution compared with 25 percent of the survivors in the routine individual treatment ($p < .05$). (p. 113)

EMDR: Qualitative Outcomes

As a result of the unexpected findings between the EMDR and Routine Individual Treatment groups in the original study, Edmond et al. (2004) conducted a qualitative study exploring participants' perceptions of the effectiveness of EMDR and Eclectic Therapy for childhood sexual abuse trauma. The data analyzed in this study was from posttreatment interviews that were conducted during the parent study (Edmond et al., 1999). Since the parent study lacked statistically significant differences in scores at posttreatment and follow-up between the EMDR and Eclectic Therapy groups, Edmond et al. (2004) were interested in the "true impact of the treatment" (p. 264). They stated that the analysis of the qualitative semistructured interviews would provide "an opportunity to gain deeper insight into the effectiveness of each treatment from the perspective of the survivors" (p. 264).

The participants of the study included 38 individuals from the parent study. Of the 38 participants 18 were from the EMDR treatment group and 20 were from the eclectic therapy (previously termed Routine Individual Treatment) group.

Edmond et al. (1999) created a semistructured interview with 14 open-ended questions called the Client's Perceptions Questionnaire. This interview was completed at the original posttreatment assessment. Sample questionnaire inquiries included: "How are you doing now as compared to when you entered the study?" "In what way if any was the therapy helpful to you?" "Did it have any effect on the issues that you wanted to address?" "Do you think that the benefits gained will be lasting?" "Do you think you will need more therapy to resolved your sexual abuse issues?" "What are your thoughts/feelings about your therapist?" "How did the therapy that you received in the study compare to other therapy or counseling that you have received?" "What did you like or value the most about the therapy you received?" "What did you dislike or find least helpful about the therapy you received?" (p. 264)

The interviews were coded by the study's third author who was not affiliated with the parent study and was unaware of the outcomes. The researchers made this choice in an attempt to control for researcher bias. It is appropriate to note, however, that limiting thematic interpretation to an individual researcher may also limit the degree to which themes may emerge, as well as limiting the data and researcher triangulation (Denzin, 1978). The authors did not comment on their use of reflexivity or discrepant case analysis (Morrow, 2005) within thematic development, which are often used to limit researcher bias as well as allow disconfirming evidence to emerge alongside themes. All of these

techniques, which were not mentioned or used are usually used to ensure thematic accuracy in qualitative interpretations of data.

The coding of the interviews were sequenced in five different stages: (a) Attention was paid to fine details and individual utterances during the interview; (b) the fine details and utterances were further developed within the context of the whole transcript; (c) the researcher then looked for interconnected observations across the other interviews; (d) patterns and themes were clearly defined and rated for degree of importance; and (e) the themes from the interviews were translated into theses (Edmond et al., 2004).

After the interviews were analyzed and coded, eight categories were discovered in Stages 2 and 3 of the coding process. Edmond, Sloan, and McCarty (2004) listed them as follows:

> (a) Relationship with the therapist and its ties to reports of success; (b) change experienced (interpersonal, intrapersonal, mood/emotional, and physical); (c) nature of change (deep or day-to-day coping); (d) responsibility for change (self or other); (e) finished with therapy for the issue (yes/no); (f) got what you needed (or not); (g) level of functioning expressed; and (h) willingness to use the therapy again (or not). (p. 265).

Additionally, three main themes/codes were discovered during Stages 4 and 5. These included: (a) perceived relational significance of the treatment; (b) perceived nature of change as a result of treatment; and (c) perceived need for additional therapy or not (Edmond et al., 2004).

The aforementioned coding categories were broken down into two major findings: (a) Client-Therapist Relationship and (b) Nature of Change. With respect to the eclectic group's perceptions of the client-therapist relationship, "The entire eclectic group either fully or partially attributed the success of their therapy to their relationship with their

therapist" (Edmond et al., 2004, p. 265). Researchers stated that this finding was evident "in the way the survivors in the eclectic group talked about their therapeutic gains in connection to the support, acceptance, validation, and nonjudgment that they received from their therapist" (p. 265). With respect to the EMDR group's perceptions of the client-therapist relationship, the participants "did not attribute the success they experienced in therapy to either the personal qualities of the therapist or to the therapeutic relationship, but rather to the technical EMDR process and/or to how well the respective therapist followed the procedural protocols" (p. 266).

With regard to the second finding, the EMDR and the eclectic groups had different perceptions and descriptions of the nature of change they experienced. The eclectic group attributed their change to the gathering of new coping skills and improvements in mood, behavior, and overall functioning. With respect to new coping skills, the participants reported imagery, relaxation, and cognitive strategies as helpful (Edmond et al., 2004). They also reported a reduction of negative feelings, feeling more at ease about the trauma, having greater impulse control, and the need for less medication (Edmond et al., 2004). Furthermore, participants reported a sense of empowerment as a result of the new skills they learned and the supportive nature of the therapeutic relationship. Edmond, Sloan, and McCarty (2004) noted that the participants often used language such as they are "better," they can "deal" with it, and things are "more manageable." The reason Edmond, Sloan, and McCarty (2004) made note of these findings was because the trauma did not seem to be resolved but rather more manageable.

The researchers stated that "their therapy may have been a healing experience, however they do not yet seem healed" (p. 267).

The EMDR group described the nature of their change much differently. Edmond, Sloan, and McCarty (2004) reported that the EMDR participants appeared to endorse changes at a "deeper" and "more profound level" (p. 267). One participant explained the nature of change by use of analogy. She stated, "instead of working from the outside layers of an onion to reach the core inside as traditional therapy does, EMDR allows you to go straight to the core, resolve the issue, and lets the changes reverberate through the onion effecting all the outer layers" (p. 267). Several participants made note of a cessation of feelings associated with the trauma. This is in contrast to that of the eclectic group wherein they gained a greater ability to manage and regulate their feelings. One EMDR participant, in fact, reported having no feelings associated with the trauma. For instance, she stated, "I just almost have no feelings about it. It's not like I have happy feelings now, I just have no feelings about it. I'm not even angry about it. I don't know why, and I don't care why. It's not my worry" (p. 267). Additionally, participants reported changes in their perceptions of self and others. They reported less guilt and feelings of responsibility for the traumatic experience. The participants attributed the loss of guilt solely to the EMDR intervention and not to the nature of the therapeutic relationship.

Although on objective measures the treatment effects for the EMDR group and the eclectic group seemed comparable, subjective outcome measures from the parent study, and the subjective descriptions of their therapeutic experiences shed light on subtle

nuanced changes that occurred. Edmond et al. (2004) made note that "the data indicated that survivors experience a deeper sense of trauma resolution with EMDR than is found among those who received eclectic therapy" (p. 270). The authors also noted that although there seems to have been qualitative differences between groups, both reported comparable levels of satisfaction with their treatment (Edmond et al., 2004). In summary both EMDR and Eclectic Therapy proved to be effective in treating adult survivors of childhood abuse. Subjectively, however, the EMDR participants seemed to experience deeper change in comparison to the Eclectic Therapy group.

Emotion Focused Therapy

Emotion Focused Therapy (EFT) is a process-experiential approach grounded in emotion theory. EFT is an empirically supported, emotion-focused, humanistic treatment (Elliot, Watson, Goldman, Greenberg, 2004). For instance, Elliot et al. (2004) stated that EFT "integrates person-centered, gestalt, and existential therapies but brings them up to date with contemporary psychological thinking" (p. 4). Unique to EFT is its perspective that emotion is adaptive in nature and that it is a source for meaning, direction, and growth (Elliot et al., 2004). Elliot et al. (2004) outlined five specific process-experiential tasks that are characteristic of an EFT approach: (a) Empathy based tasks; (b) relational tasks; (c) experiencing tasks; (d) reprocessing tasks; and (e) enactment tasks. These tasks aim at activating the adaptive quality that primary emotions carry in order to establish a greater sense of integration, coherence, and wholeness of self.

Emotion Focused Therapy for Trauma (EFTT) is much like traditional EFT but targets the psychological disturbances often associated with complex trauma (Paivio & Pascual-Leone, 2010). Paivio and Pascual-Leone (2010) stated:

> EFTT particularly focuses on resolving issues with past perpetrators of abuse and neglect, usually attachment figures. Clients not only are disturbed by their current problems but have been unable to heal these specific emotional injuries. Resolving issues with significant others, together with cultivating a strong therapeutic relationship, translates into reduced symptom distress, increased self-esteem, and improvements in global interpersonal functioning. (p. 4)

EFTT is a phase-based approach to treating complex trauma. Phase 1 aims at cultivating the therapeutic alliance. Phase 2 aims at reducing fear, anxiety, and avoidance associated with the imaginable confrontation (IC) task. These first two phases typically strengthen the patients' sense of self before having them engage in Phase 3, which includes resolution through anger. In Phase 3, clients are encouraged to experience and express their adaptive anger toward their past offenders in order to hold them accountable for their actions. Additionally, during Phase 3 clients are encouraged to experience and express their adaptive sadness in order to grieve losses (Paivio & Pascual-Leone, 2010). The goals for Phase 3 are accomplished via the IC procedure wherein the patient is encouraged to imagine the perpetrator in an empty chair and then to attend to and express their emotional experience (e.g., anger and sadness) to the other. Phase 4 pays particular attention to the termination of therapy and is "about completing the resolution process, consolidating client changes, saying goodbye, and bridging to the future" (Paivio & Pascual-Leone, 2010, p 277).

What follows is a review of two outcome studies demonstrating the effectiveness and efficacy of EFTT for individuals suffering from Complex PTSD. Additionally, a

study examining client-identified helpful events in emotion-focused therapy for child abuse trauma is reviewed.

EFT: Quantitative Outcomes

Paivio and Nieuwenhuis (2001) examined the efficacy of Emotion-Focused Therapy for Adult Survivors of Child Abuse (EFT-AS).

Participants of the study included 46 women admitted for psychotherapy at a university counseling center. To be included in the study, participants were required to meet specific inclusion and exclusion criterion. Exclusion criteria included taking psychoactive medication, presence of crisis, lack of recollection of child abuse, extreme emotional dysregulation, risk of aggressive/self harm behavior, involvement in violent relationships, and drug or alcohol problems. Inclusion criteria consisted of participant motivation, capacity for alliance formation, ability to focus on a circumscribed traumatic event, and capacity and agreement to express emotions associated with the trauma.

Treatment consisted of 20 one-hour, weekly sessions of Emotion Focused Therapy for Adult Survivors of Child Abuse EFT-AS. The treatment was a manualized therapy which integrated principles derived from traditional emotion focused therapy and process experiential therapies (Paivio & Nieuwenhuis, 2001). The treatment included three "interrelated therapy tasks" and a final phase for "integration" and "termination."

The first task included the establishment of a safe and collaborative therapeutic relationship. Paivio and Nieuwenhuis (2001) accomplished this task via "empathic responding to the client's presently felt subjective experience" (p. 122). The second task involved encouraging the clients to overcome avoidance or defensive processes (i.e.,

overcontrol of emotion and guilt and shame linked to the abuse). Paivio and Nieuwenhuis (2001) accomplished this task by utilizing an integration of Gestalt and imagery techniques. The third task centered on resolving issues with past perpetrators. This was accomplished by "accessing *maladaptive* aspects of the memory or meaning system, such as fear/insecurity and shame, and accessing previously inhibited *adaptive* emotional responses, such as anger and sadness, so that the associated adaptive information [could] be used to modify meaning" (Paivio & Nieuwenhuis, 2001, p. 122).

An imaginal confrontation technique (i.e., Gestalt technique of empty chair) was utilized in order to access previously unacknowledged or restricted adaptive emotions that needed to be communicated to the imagined other (this usually occurred at Session 4). In the case that clients became emotional dysregulated or overwhelmed, regulatory techniques such as provision of structure, breathing regulations, and present centeredness were implemented (Paivio & Nieuwenhuis, 2001).

The final phase of treatment focused on integrating the past therapy experiences into a new view of self, others, and abusive events. In order to accomplish this, a final imaginal confrontation took place during the termination session.

The treating therapists (7 female, 3 male) included six doctoral level and three master's level students in clinical psychology and educational psychology programs. The first author, Paivio, was also a treating therapist. The therapists received 54 hours of training in EFT-AS. Training included review of the treatment manual, review of videotapes sessions of expert clinicians, and supervised practice. The therapists were also supervised by the first author who had up to 14 years of experience with the population.

Using the EFT Checklist (Paivio, 1996) two coders viewed videotaped sessions to determine adherence to the treatment protocol.

Groups were determined by the time at which the participant was admitted to the counseling center. The first 22 participants admitted for treatment began EFT-AS immediately. The remaining 24 admissions served as the wait list control group. After a 20-week waiting period, the wait group then received the EFT-AS treatment. Chi-square analyses of variance indicated that there were no significant differences between groups with respect to demographics and clinical characteristics.

Seven dependent measures were included in the study. For the EFT-AS group, testing points for the dependent measures were at pretreatment, posttreatment, and at 9-month follow-up. For the control group, testing points were at prewait, postwait/ pretreatment, posttreatment, and at 9-month follow-up.

The assessment measures used demonstrated acceptable test-retest reliability. The following measures were used to assess treatment effects: The Impact of Event Scale (IES; Horowitz, 1986); The Symptom Checklist-90-Revised (SCL; Derogatis, 1993); The Target Complaints Discomfort questionnaire (TC; Battle et al., 1966); The Inventory of Interpersonal Problems (IIP; Horowitz et al., 1988); The Resolution Scale (RS; Singh, 1994); and The Structural Analysis of Social Behavior – Intrex questionnaire (SASB-A & SASB-C; Benjamin, 1988).

Therapy effects were examined through three sets of statistical analyses. First, researchers compared pre- and posttreatment means on the dependent measures for the EFT-AS group to the pre- and postwait means for the wait group. Second, researchers

compared means derived at prewait, postwait/pretreatment, and posttreatment for the wait group. Third, means for both groups derived at pretreatment, posttreatment, and 9-month follow-up (Mean = 35 weeks) were compared. Statistical analyses were conducted using repeated measures MANOVAs and subsequent univariate *F* tests.

The researchers ran a repeated measures MANOVA comparing pretreatment to posttreatment scores for the treatment group and prewait to postwait scores for the wait group. Comparisons yielded a significant Group x Time interaction ($F(6,31) = 4.76$, $p < .01$) indicating a significant treatment effect. After univariate *F* tests, results indicated that there was a significant interaction on all the dependent measures with the exception of the SASB-C measure, which yielded an effect size of .33. This indicates that the treatment group scores significantly improved, whereas the wait group scores did not. Pre-post effect sizes for the EFT-AS group were all large, ranging from 1.03 to 5.71 with the exception of one, which fell at .33 for the SASB-C measure. The average effect size across all dimensions was 1.53.

The researchers ran another repeated measures MANOVA comparing scores from prewait, postwait/pretreatment, and posttreatment for the wait group. Results indicated a significant overall effect for time (F (14, 40) = 4.60, $p < .001$). After univariate *F* tests, results indicated significant effects on all dependent measures with the exception of the SASB-C measure, consistent with treatment results from the initial treatment group. Additional statistical analyses indicated that the treatment effects were largely a result of the difference in scores between pre- and posttreatment. Researchers ran another repeated measures MANOVA comparing scores between the immediate treatment group (EFT-AS

group) and the delayed treatment group (wait group). Results indicated that there was not a significant Group x Time interaction, indicating that treatment had a similar effect for both groups.

In summary, the EFT-AS group demonstrated significant change in scores from pretest to posttest and a greater rate of change over the wait period for the control group. Moreover, after the control group received treatment, they demonstrated a significant change in scores from pretest to posttest.

In order to evaluate overall change, the researchers ran a repeated measures MANOVA comparing scores derived at pretreatment, posttreatment, and 9-month follow-up for all participants. Results indicated a overall effect for time ($F(14, 62) = 3.86$, $p < .001$). Indicating a significant treatment effect. After univariate F tests, results indicated that there was a significant effect for time on all the dependent measures with the exception of the SASB-C measure. In order to investigate what time period accounted for the change, subsequent univariate analyses were conducted. Results indicated that the significant effect was due to pretreatment to posttreatment changes in scores, not posttreatment to follow-up changes in scores. There were no significant differences in scores between posttreatment and follow-up. Accordingly, treated participants maintained their gains from the end of treatment to the follow-up testing, and the most significant gains in functioning were made during treatment periods. Further, treated participants were also functioning at follow-up better than they were at pretreatment.

EFT: Comparison of Two Types of Treatment

Paivio, Jarry, Chagigiorgis, Hall, & Ralston (2010) explored the efficacy of two different versions of emotion-focused therapy for resolving child abuse trauma.

The participants included 45 adult individuals (24 female, 21 male) admitted for psychotherapy at a university counseling center. To be included in the study, participants were required to meet specific inclusion and exclusion criterion. Exclusion criteria included severe emotion dysregulation, risk of harm to self or others, self-injurious behavior, substance abuse within the last six months, current crises, current domestic violence, and serious symptoms or serious impairment in functioning, as indicated by a Global Assessment of Functioning (GAF) score less than 50. Participants were also excluded if they were receiving other psychosocial treatment, had recent changes in their psychoactive medication treatment (dose change within the last two months), or had been diagnosed with a psychotic disorder, bipolar I disorder, or an eating disorder. Participants were also excluded if they were unwilling to process the past abuse or lacked conscious memory of their childhood abuse. Inclusion criteria included motivation, ability to form an alliance, and capacity to focus on and explore the past child abuse.

Paivio et al. (2010) utilized a dismantling study design to compare two treatment conditions: standard EFTT utilizing Imaginal Confrontation (IC) and an alternate EFTT approach utilizing Empathic Exploration (EE) in the absence of IC. In the standard Emotion-Focused Therapy for Trauma, Imagined Confrontation (EFTT-IC), therapists asked participants to imagine a neglectful or abusive other and then guided participants in attendance to and expression of evoked thoughts and feelings through the use of various

procedures, such as experiential focusing and two-chair enactments. As a result, IC procedures and other exposure-based therapies are often stressful and emotionally overwhelming for adult survivors of childhood abuse, resulting in substantial treatment non-participation rates (e.g., 33% of participants in Paivio and Nieuwenhuis' 2001 study). Paivio et al. (2010) developed the alternate Emotion-Focused Therapy for Trauma, Empathic Exploration (EFTT-EE), which is identical to standard EFTT in many respects but explores traumatic experiences exclusively through interactions with an empathic therapist rather than interactions with an imagined other (i.e., IC procedures). Paivio et al. (2010) compared treatment outcomes of these two treatments in order to identify treatment effects due to the IC component and to explore the effectiveness of the less invasive and evocative EE treatment. Both treatments were manualized, semi-structured approaches occurring in 16 to 20 weekly, 1-hour sessions.

The phases of treatment focused on "(a) cultivating the alliance, (b) reducing maladaptive fear and shame, (c) resolving issues with perpetrators, and (d) termination" (Paivio et al., 2010, p. 358). The first few sessions focused primarily on alliance formation, which was accomplished by empathically responding to the participants' feelings, this was emphasized throughout treatment as well. Additionally, anxiety regulation skills including breath training, relaxation, and present-centered focus, was used throughout treatment.

In the EFTT-IC condition, the IC procedure was introduced during Session 4. Participants were invited to imagine the perpetrator in an empty chair, focus on their internal experience, and express their thoughts and feelings to the other. Paivio et al.

(2010) stated that the therapist operations during the IC procedure were delineated as follows:

> Promote psychological contact with the imagined other, evoke episodic memories associated with the abuse, promote expression of feelings, help clients overcome blocks to experiencing, differentiate feelings (e.g., anger, sadness) and associated meanings, promote a sense of entitlement to unmet needs, and explore shifting perceptions of self and imagined others. (p. 358)

Likewise, in the EFTT-EE condition, the EE procedure was introduced during Session 4. Participants were invited to spend the session focusing on their experience of the abuse. Paivio et al. (2010) stated that the process differed from IC in that the participants were "encouraged to vividly remember abusive/neglectful others and express their feelings to the therapist rather than engage in a dialogue with an imagined other in an empty chair" (p. 358).

There were 11 treating therapists in the study (7 female, 4 male). Therapists included one master's level student and six doctoral level students in clinical psychology. Four therapists were postdoctoral psychologists, including Paivio, a registered psychologist. The therapists all had prior experience treating individuals with histories of childhood abuse. The therapists received about 39 hours of training from the first author, Paivio. Training included review of the treatment manual, role-plays, and review of video taped sessions. During the study the therapists had weekly individual and group supervision, which included review of video recordings of sessions to monitor treatment adherence.

Participants were randomly assigned to one of two conditions: the EFTT-IC condition ($N = 20$) or the EFTT-EE condition ($N = 25$). Participants were assigned in

pairs to assure that each therapist was assigned equal number of participants in each condition. Seven dependent measures were administered at four testing points: pretreatment, midtreatment, posttreatment, and follow-up (completed between 28 and 96 weeks posttreatment, $M = 46.38$, $SD = 22.11$). The assessment measures used demonstrated acceptable test-retest reliability. The following measures were used to assess treatment effects in each condition: The Impact of Event Scale (IES; Horowitz, 1986); The State-Trait Anxiety Inventory (Spielberger et al., 1970); The Beck Depression Inventory, Second Edition (BDI-II; Beck et al., 1996); The Target Complaints (Discomfort) Scale (TCD; Battle et al., 1966) rated by participants for various problems including "negative self-esteem, interpersonal problems, emotion regulation difficulties, unresolved feelings about childhood abuse, and symptom distress" (Paivio et al., 2010, p. 356); The Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1989); The Inventory of Interpersonal Problems (IIP; Horowitz et al., 1988); and The Resolution Scale (RS; Singh, 1994). At each testing point, participants completed two RS questionnaires, one for each of two relationships they wished to focus on in therapy, and scores were averaged to calculate mean RS scores at each testing point; one RS was completed for the abuse perpetrator while the other was generally completed for "a nonprotective mother" (Paivio et al., 2010, p. 356).

Treatment effects were examined by comparing pretreatment, midtreatmnet, posttreatment, and follow-up scores in each condition on the seven dependent measures. Statistical analyses were conducted by using repeated measures multivariate analyses of

variance (MANOVAs) and follow-up univariate analysis with Bonferroni corrections for Type I error; Cohen's *d* and η^2 were calculated to assess effect sizes.

Scores derived at pretreatment, midtreatment, and posttreatment for both groups were compared using a repeated measures MANOVA. Results indicated a steady rate of improvement among both treatment groups on all the dependent measures, resulting in a significant overall effect for time, $F(7, 37) = 26.32$, $p < .001$. There was not a significant effect for group, $F(7, 37) = 1.53$, $p = .19$, or for the interaction of group and time, $F(7, 37) = 1.80$, $p = .12$. Follow-up pre-post univariate analyses with Bonferroni corrections for Type I error indicated significant improvement on all measures for both groups. Comparisons of calculated effect sizes indicated that the IC condition exhibited slightly larger average effect sizes (Cohen's $d = 1.67$; $\eta^2 = .91$) than those found for the EE condition (Cohen's $d = 1.24$; $\eta^2 = .81$)

Fourteen participants completed follow-up data for the IC group and 23 for the EE group. The average follow-up time for both groups was approximately 46 weeks (*SD* = 22.11) and did not differ between groups. Researchers compared scores for both groups derived at pretreatment, posttreatment, and follow-up using a repeated measures MANOVA. Results indicated a significant overall effect for time, $F(14, 22) = 10.00$, $p < .001$, but non-significant effects for group, $F(7, 29) = .89$, $p = .19$, and for the interaction of group and time, $F(14, 22) = 1.77$, $p = .12$. Follow-up pariwise comparisons indicated significant improvement on all seven dependent variables from pretreatment to posttreatment and from pretreatment to follow-up (Paivio et al., 2010). There was not a significant effect for time from posttest to follow-up, indicating that treatment gains were

maintained between posttreatment and follow-up. Univariate analyses utilizing a Bonferroni correction for Type I error were utilized to compare pretreatment, posttreatment, and follow-up scores separately for each treatment condition; results indicated significant gains in all seven dependent measures for participants in the EE condition and six of the dependent measures for participants in the IC condition. State-level anxiety, as assessed by the State-Trait Anxiety Inventory, was not significantly different between pre-test and follow-up for participants in the IC condition. Effect size calculations again evidenced slightly greater effect sizes for the IC condition (Cohen's *d* = 1.59; η^2 = .95) than for the EE condition (Cohen's *d* = 1.29; η^2 = .88).

In summary, participants in both groups exhibited significant decreases in PTSD symptoms, anxiety, depression, distress from interpersonal difficulties, distress from childhood abuse-related relationships, and significant increases in self-esteem; with the exception of state-level anxiety in the IC condition, these gains were maintained from the end of treatment to the follow-up testing. EFTT-IC and EFTT-EE were not found to significantly differ in treatment outcomes, but EFTT-IC exhibited slightly greater effect sizes at both posttreatment and follow-up testing points.

EFT: Qualitative Outcomes

Prior to Holowaty and Paivio's (2012) study, no studies had examined clients' perceptions of the helpfulness of evocative/experiential-based interventions, such as the Imagined Confrontation (IC). Therefore, Holowaty and Paivio (2012) utilized archival data derived from the previously reviewed Paivio and Neiuwenhuis (2001) study to examine the characteristics of Emotion-Focused Therapy for Trauma (EFTT) identified

by clients as helpful. For further details about participants, methods, treatment detail, dependent measures, and subsequent outcomes, refer to the review in this paper of Paivio and Neiuwenhuis' (2001) study. Only the details of this study that were uniquely examined by Holowarty and Paivio (2012) or directly related to participant-identified helpful events will be included in this section.

In addition to the inclusion and exclusion criteria utilized by Paivio and Neiuwenhuis (2001), participants of the current study were required to have completed treatment and all self-report measures. Additionally, participants were required to identify helpful events in therapy that could be identified by researchers after reviewing videotaped therapy sessions. Identified events for eight participants could not be located by researchers, leading to the exclusion of these participants and resulting in a sample size of 29 individuals. Follow-up analyses utilizing chi-square and repeated measures MANOVAs indicated no differences between these eight excluded participants and the included study sample in terms of demographic variables, clinical characteristics, reported abuse, or pre-post outcomes on dependent measures.

Two primary types of measures were utilized in this study. The first were measures administered to participants to identify helpful therapy events. These were utilized in order to select two types of these events from videotaped therapy segments, these included: helpful events (HE) and control events (CE). The second type of measure central to the Holowaty and Paivio (2012) study were observer-rated measures that were utilized to rate HE and CE therapy segments in terms of participants' depth of emotional

experiencing and level of emotional arousal, which are processes identified as standard or "key" in emotion-focused therapy for trauma.

To facilitate identification of helpful therapy events, participants were administered the Helpful Aspects of Therapy Questionnaire (HAT; Elliot, 1985), a self-report questionnaire that consists of four open-ended questions: "(1) which therapy event they found most helpful, (2) what made it helpful, (3) how helpful was it on a scale from 1 to 9, and (4) during what session in therapy did the event occur" (Holowaty & Paivio, 2012, p. 59). The HAT was administered at mid treatment and at post treatment. Participants also completed the Post Treatment Interview (PTI; Holowaty & Paivio, 2000), a semi-structured interview that asks questions including: "(1) whether and how their views of self and other have changed, (2) to specify one particular event that contributed to these changes, (3) how that event was helpful, and (4) when that event occurred" (Holowaty & Paivio, 2012, p. 59). The PTI was completed one week after the post treatment dependent measures were administered. Of the 110 events identified by participants on the HAT and PTI, 54 events (49%) were able to be located on therapy videotapes and had clear beginning and end points. To control for participate variability in number of located HEs, researchers selected one HE for each participant, utilizing a hierarchical selection procedure that prioritized event identification on the HAT, repeated event identification, and posttreatment HAT responses. CEs were also selected by researchers using several criteria. CE sessions were selected to ensure phase of therapy matching between CE sessions and HE sessions for each participant, exclusion of first and last sessions, and exclusion of sessions in which identifiable HEs occurred. Specific

CE sessions were selected to ensure occurrence of CEs in the middle 40 minutes of session, identifiable themes (particularly those reflecting key EFTT processes), and comparable length as HEs.

Two observer-rated, process measures were also included in the study. These included the Client Experiencing Scale (EXP; Klein, Mathieu-Coughlan, & Kiesler, 1986) and the Emotional Arousal Scale (EAS; Machado, Beutler, & Greenberg, 1999). The EXP is a 7-point ordinal scale utilized by trained coders to rate each client verbalization during a given therapy segment in terms of depth of experiencing, defined as the extent to which the participant was self-reflective and created new meaning of internal experience (Holowaty & Paivio, 2012). Peak and modal (most frequent) EXP ratings for each therapy segment were utilized in analyses. The EAS is an ordinal rating scale designed to assess the level of emotional arousal during various segments of session, as evidenced by verbal and nonverbal indicators. Originally, a 7-point ordinal scale, the EAS was modified to utilize a 5-point ordinal scale for the current study. As with the EXP, trained coders viewed session recordings and rated each client verbalization; peak and modal EAS ratings were analyzed. Coders also identified the expressed emotion for each verbalization. Coders included two student raters who received 20 hours of training. Additionally, one of the primary researchers served as a reliability rater for both measures. Inter-rater reliability and proportion of agreement were moderate to high for peak and modal ratings of both measures, with proportion of agreement ranging from .70 to .85 and κ = .62 to .77. There was a 100% inter-rater agreement in identifying expressed emotions in therapy segments. These observer-rated

measures were included in the study in order to rate the depth of experiencing and the level of emotional arousal, identified as standard or "key" processes of emotion focused therapy for trauma, during participant identified helpful events and selected control events. Researchers then compared these ratings for HE and CE in order to investigate whether participant identified HEs corresponded with a greater depth of experiencing and level of emotional intensity than that exhibited during CEs.

Holowaty and Paivio (2012) hypothesized that participants would identify (a) greater focus on child abuse trauma, (b) greater depth of experiencing, and (c) higher levels of emotional arousal as helpful events in the course of their treatment.

To test the first hypothesis, results of the HAT and the PTI were utilized to categorize HEs and CEs into content categories, which were then grouped into three second-order categories: (a) direct focus on abuse; (b) indirect focus on abuse; and (c) non-abuse focus. Chi-square analyses were then utilized to assess for differences in content frequencies between HE and CE. Results indicated that a significantly greater proportion of HE (86.2%) than CE (27.6%) entailed a direct focus on child abuse trauma (χ^2 (1, n = 58) = 20.31, p < .001). In contrast, a larger proportion of CE (51.8%) than HE (13.8%) were categorized as involving an indirect focus on abuse (χ^2 (1, n = 58) = 9.47, p < .01). Due to no HE categorized as non-abuse focused, statistical assumptions underlying the use of chi-squared tests were violated and results of this third comparison inconclusive; however, 27.6% of CE were categorized as non-abuse focused in comparison to no HE. These results confirmed the researchers' first hypothesis, that the participants would identify a greater focus on child abuse trauma as helpful events.

For illustrative purposes, narratives of the participants self identified HEs are included. Eighteen participants (62.1%) reported that exploring child abuse material/memories was helpful. This was accomplished through the imagined confrontation (IC) task. An example of a participant's description of the IC intervention was: "Telling details of the sexual abuse incident and re-experiencing feelings of fear and shame, and anger toward my brother [perpetrator]." This participant stated that it was helpful because: "It made it more real and moved me out of denial so I didn't have to cover up for him anymore; I felt empowered and able to cry and feel supportive of myself" (Holowaty & Paivio, 2012, p. 62).

Four participants (13.8%) reported that allowing the experience of painful feelings and grieving for themselves was helpful. An example of a participant's description of experiencing painful feelings and grieving was: "[I] admitted feelings of worthlessness and shame, [I was angry] and ashamed of my father for a chaotic upbringing where my needs were never met and I never felt safe." This participant stated that admitting this was helpful because: "I exposed the shame and guilt and pain; it was a great relief and it caused me to grieve" (Holowaty & Paivio, 2012, p. 62).

Four other participants (13.8%) reported that exploring conflict within themselves (i.e., two-chair work) was helpful. With regard to exploring self-conflict, one participant stated:

> Two-chair dialogue with the critical part that sabatoges attempts at success, and connecting this to shame about my alcoholic family and fear of showing my true self helped me deal with my negative thinking and I don't have to beat myself up as much; getting out the pain and humiliation in my family. (Holowaty & Paivio, 2012, p. 63)

Chi-squared tests were also utilized to test for differences in which individuals (i.e., parent/parent figure, other family member, non-family member, non-interpersonal) the participants focused on during HE and CE and differences in emotions expressed during HE and CE. Results indicated no significant differences between HE and CE on these variables, with a majority of both HE and CE focusing on parents and parent figures (62.1% and 48.3%, respectively) and involving angry emotional expressions (48.3% and 51.7%, respectively).

To evaluate hypotheses two and three, ANOVAs were utilized to analyze differences in mean modal and peak EXP and EAS ratings of HE and CE. Results indicated that clients exhibited moderate depth of experiencing during both HE and CE, as evidenced by mean modal and peak EXP ratings, as assessed by EXP, and that HE and CE did not significantly differ in mean modal EXP rating ($F(1, 28) = 2.35$, $p > .05$), or mean peak EXP rating ($F(1, 28) = 2.96$, $p > .05$). Thus, results disconfirmed hypothesis two, that greater depth in experiencing would be present during participant-identified helpful events. This indicates that moderate levels of experiencing were identified to be helpful but no more helpful than the CE (standards elements of the treatment). In regards to hypothesis three, results indicated that participants exhibited significantly greater emotional arousal during HE than CE, as evidenced by significantly greater mean EAS modal ratings ($F(1, 28) = 13.69$, $p < .001$), and significantly greater mean EAS peak ratings ($F(1, 28) = 15.02$, $p < .001$). Therefore, results confirmed hypothesis three, that higher levels of emotional arousal were present during participant-identified helpful events. Other expressed emotions aside from anger in HE and CE include sadness (17.2%

and 27.6%, respectively), fear (17.2% and 17.2%, respectively), and hurt (6.9% and 0%, respectively).

In summary, participants identified HE as including higher emotional arousal and a more direct focus on the abuse. Participants were about as likely to identify anger, deeper processing, and focus on parents or parent-like figures as HE as would be observed for CE.

Psychodynamic Psychotherapy

Psychodynamic therapy evolved out of psychoanalysis, which was founded by Sigmund Freud in the late 1800s. Psychoanalysis was initially a scientific method by which one explored unconscious material of the human mind and later became the stand-alone therapeutic method for mental illness in the early 1900s. Since its establishment, psychoanalysis has taken many shapes and forms including but not limited to Ego Psychology (Hartmann, 1939), Kleinian Theory (Klein, 1957), Interpersonal Theory (Sullivan, 1963), Object Relations Theory (Balint, 1968; Fairbairn, 1952; Winnicott, 1965), Self Psychology (Kohut, 1971), and Intersubjective Theory (Stolorow & Atwood, 1979).

Despite the breadth of approaches that are characterized as psychodynamic, there is, however, a general understanding that psychodynamic therapy across all subdivisions maintains several similar attributes. For instance, Blagys and Hilsenroth (2000), in an extensive review of the comparative psychotherapy process literature, identified seven interventions that characterized psychodynamic therapy: (a) a focus on affect and the

expression of patients' emotions; (b) an exploration of patients' attempts to avoid topics or engage in activities that hinder the progress of therapy; (c) the identification of patterns in patients' actions, thoughts, feelings, experiences, and relationships; (d) an emphasis on past experiences; (e) a focus on patients' interpersonal experiences; (f) an emphasis on the therapeutic relationship; and (g) an exploration of patients' wishes, dreams, or fantasies.

Psychodynamic therapy is one of the earliest approaches to treating posttraumatic stress disorders (Andrea & Pole, 2011). Historically, however, psychodynamic therapy has been largely understudied (Cloitre, 2009). Consequently, the effectiveness of psychodynamic therapy through a quantitative and/or empirical lens, until recent years, has been principally unknown. Nevertheless, despite its lack of quantitative support, psychodynamic therapy has been widely used among mental health professionals when treating trauma (Schottenbauer, Arknoff, Glass, & Gray, 2006). It has also been used and thought to be effective when treating complex trauma (Davies & Frawley, 1994).

Specific to psychodynamic therapy for trauma, Krupnick (2002) outlined a 12-session treatment model with a variety of treatment targets that are similar to important elements of psychodynamic therapy. These treatment targets include bringing unconscious conflicts into awareness, establishing a sense of meaning, purpose, and safety, exploring affects such as guilt and shame, developing insight into how threatening thoughts and feelings are kept from awareness and exploring the therapeutic relationship for reenactments of past trauma such as clients responding to their therapist as a result of unresolved feelings. Krupnick (2002) did note, however, that the outlined goals are more

specific to PTSD following exposure to a single traumatic event (i.e., tragic bereavement and assault) and that when treating Complex PTSD, a longer term and more comprehensive approach is indicated. Although, Krupnick (2002) suggests that a longer-term model is necessary, there has been recent evidence demonstrating the effectiveness of brief psychodynamic models when treating Complex PTSD.

What follows is a review of three outcome studies exploring the effectiveness of psychodynamic therapy for individuals suffering from Complex PTSD. Two studies demonstrated the effectiveness of two distinctive types of brief psychodynamic therapy and the last demonstrated effectiveness of an integrative approach in which both EMDR and psychodynamic therapy were the primary intervention approaches.

Psychodynamic Psychotherapy: Short-Term Treatment Outcomes

Price, Hilsenroth, Callahan, Petretic-Jackson, and Bonge (2004) investigated the effectiveness of individual Short-Term Psychodynamic Psychotherapy (STPP) with adult survivors of childhood sexual abuse (CSA).

The participants of the study included 27 patients consecutively admitted for individual psychotherapy at a university outpatient clinic. Upon admission participants were identified as a CSA patient (n = 12) or a non-CSA patient (n = 15). The study did not include a control group; therefore, all participants received the STPP treatment. The non-CSA group was utilized as a comparison group to determine differential rates of change and treatment effectiveness between the two groups. The researchers identified the use of a non-randomized clinical population as a "primary strength in evaluating real world clinical practice" (Price et al. 2004, p. 379).

Treatment consisted of once or twice weekly sessions of STPP. Researchers did not indicate how determinations of session frequency were made for each participant. They did note, however, that treatment duration was based on the clinician's judgment, progress, and patient preference. The mean treatment length was 26 sessions over a 6-month period of time. The nature of STPP treatment does not lend itself to manualization, allowing treatment to be more adaptable to client characteristics; however, in an effort to make treatment as consistent as possible, psychodynamic treatment was informed by a variety of treatment guidelines and manuals and all treating therapists were trained in providing STPP treatment. The most notable features of STPP included: (a) focus on affect and the expression of emotion; (b) the identification of patterns in actions, thoughts, feelings, experiences, and relationships; (c) focus on past experiences; (d) attention to interpersonal experiences; (e) emphasis on the therapeutic relationship/alliance; (f) exploration of wishes, dreams, or fantasies; and (g) exploration of attempts to avoid topics and/or engage in activities that may interfere with the therapy process (Price et al., 2004).

The treating psychotherapists were 12 advanced graduate students attending an American Psychological Association accredited clinical psychology doctoral program. In addition, the supervisor of the study was a treating psychotherapist. The student therapists acquired training in STPP prior to treating patients, and received approximately three and a half hours of supervision per week from licensed clinical psychologists also trained in STPP for treating participants in the study (1.5 individual hours and 2 group hours).

Determination of groups was made by whether or not patients reported a history of childhood sexual abuse or lack thereof. Therefore, two groups were identified, a group of participants who had survived childhood sexual abuse (CSA group) and those who had no history of childhood sexual abuse (non-CSA group). All participants received STPP treatment, which served as the independent variable in the study. Researchers assessed the impact of STPP treatment on participants' mental health symptoms, primarily symptoms of depression, anxiety, intensity of symptoms, and global and interpersonal functioning. Participants were assessed multiple times: at pretreatment, at Session 3, near the end of treatment, and posttreatment. Each point of measurement included a specific battery of assessment measures.

A total of seven dependent measures were used to assess treatment effects. The self-rated Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1993), the Social Adjustment Scale (SAS-G; Weissman & Bothwell, 1976), and three clinician-rated *DSM-IV* (1994) Rating Scales (GAF, GARF, SOFAS) were completed at pre- and post-treatment. A measure of interpersonal and personality functioning, the Social Cognition and Object Relations Scale (SCORS; Westen, 1995), and a measure exploring change attributed to psychotherapy, the Patient's Estimate of Improvement (PEI; Hatcher & Barends, 1996) were administered at the third session and at posttreatment. Additionally, the Combined Alliance Short Form (CASF; Hatcher, 1999; Hatcher & Barends, 1996; Hatcher, Barends, Hansell, & Gutfruend, 1995) was administered at the third session and late in treatment.

All clinician-rated scales were scored by both clinicians and external raters through analysis of videotaped sessions randomly presented to external raters. Researchers found high interrater reliability between clinicians' and external raters' evaluations.

A repeated-measures, one-way ANOVA was used to test the significance of the pretest to posttest change for the CSA group. The CSA participants experienced significant change in scores on four of the five measures administered at pre- and post-treatment. Results of the analyses of variance with repeated measures indicated a statistically significant decrease (at the .05 level) in symptoms as measured by both patient-rated (SCL-90-R subscales: GSI; DEP; I-S) and clinician-rated scales (GAF, GARF, SOFAS). Specifically, CSA participants rated significant decrease in overall symptom distress as measured by the SCL-90-R subscales Global Severity Index ($F(1, 11) = 8.11$, $p = .016$), Depression ($F(1, 11) = 9.56$, $p = .01$), and Interpersonal Sensitivity ($F(1,11) = 5.53$, $p = .038$). Clinician-rated scales indicated significant decrease in overall symptom distress as measured by the GAF ($F(1, 11) = 31.43$, $p < .001$), improved interpersonal functioning as measured by the GARF ($F(1,11) = 14.02$, $p = .003$), and improved social functioning as measured by the SOFAS ($F(1,11) = 5.05$, $p = .046$). Each of the measures administered at pre- and post-treatment further indicated that the treatment effect was moderate to large ranging from .66 to 1.74

Results indicated partial change in personality functioning scores from the third session to posttreatment. Only three of the eight subscales on the SCORS demonstrated statistically significant change. Specifically, the CSA group showed significant change in

Affective Quality of Representations ($F(1, 11) = 13.57$, $p = .003$), Experiences and Management of Aggressive Impulses ($F(1,11) = 9.16$, $p = .012$), and Self Esteem ($F(1,11) = 13.57$, $p = .004$). Six of the eight subscales indicated that the treatment effect was moderate to large ranging from .60 to 1.49.

The CSA participants experienced significant change in scores on five of the six subscales on the PEI from the third session to posttreatment. Specifically, CSA participants endorsed significant improvement in original complaints/symptoms ($F(1,11) = 20.48$, $p = .001$), feelings about themselves ($F(1,11) = 25.62$, $p < .001$), adaptive control over life ($F(1,11) = 17.49$, $p = .002$), tolerance of painful feelings ($F(1,11) = 11.30$, $p = .006$), and overall change ($F(1,11) = 13.15$, $p = .004$). Each of the six subscales on the PEI further indicated that the treatment effect was moderate to large ranging from .67 to 1.97.

Researchers used an ANCOVA to compare differential rates of change between groups on specific variables of interest, mainly differences in relational and interpersonal functioning. Price et al. (2004) reported no differences in "symptomatic distress, clinician-rated distress, relational and social/occupation functioning, personality functioning and most of the patients' estimates of improvement" (p. 387). The researchers did not include statistics on these findings. When third session to posttreatment values were covaried through univariate ANCOVAs, researchers noted a significant increase in positive feelings about the self among CSA participants as opposed to non-CSA participants ($F(1,26) = 5.036$, $p = .03$).

The researchers also compared the quality of therapeutic alliance between CSA survivors and non-CSA participants. Results from the patient-rated (CASF; $F(1,11) = 3.21$, $p = .10$) and clinician-rated (WAI; $F(1,11) = .42$), $p = .71$) measures indicated no significant differences between the CSA and non-CSA group in the quality of therapeutic alliance.

Overall, the research indicated significant improvement in symptom distress, interpersonal and social functioning and some aspects of personality functioning among CSA survivors after participating in STPP (Price et al., 2004).

The final point of measurement for participants was conducted immediately following the termination of treatment, and the researchers conducted no follow-up testing. Accordingly, it is undetermined whether or not participants maintained the gains made in treatment, and to what degree, after treatment.

Psychodynamic Psychotherapy: Brief Treatment Outcomes

Vitriol, Ballesteros, Florenzano, Weil, and Benadof (2009) examined the effectiveness of a brief psychodynamic psychotherapy model for women with severe depression and childhood trauma.

Participants in the study were women who sought treatment from a public health clinic in Chile. They had to be at least 20 years of age, diagnosed with severe depression, and have a history of childhood trauma. Participants met with one of three psychiatrists for an initial evaluation on the severity of their depression ($N = 154$). Those who were deemed severely depressed met with a clinical psychologist. The psychologist met with the patient to determine if she needed and was willing to talk about her past trauma. One

hundred thirty six patients agreed to meet with the psychologist, who gave each individual the Hamilton Depression Scale (Ham-D). Patients who scored 21 points or higher on the Ham-D, and answered positively to three or more items on the Marshall Scale, a screening scale for early trauma, were included in the study ($N = 87$). At the 3-month posttest evaluation, 91% of participants were assessed. Eighty-one percent of participants were evaluated at the six-month follow-up.

The psychodynamic treatment group first met individually with a psychodynamically oriented multidisciplinary team in order to determine the degree to which they had experienced, as adults, a pattern of mistreatment and aggression in their relationships. The authors opined that such a pattern was a repetition of childhood traumatic experiences (Vitriol et al., 2009).

After the initial meeting with the multidisciplinary team, the patients met weekly with an individual psychotherapist for three months. Treatment focused on "developing a cognitive understanding of personal characteristics and behaviors that allowed the repetition of traumatic experiences in the present" (Vitriol et al., 2009, p. 2). Additionally, "behavioral changes that would alter the relationship between the victim and aggressor were addressed" (Vitriol et al., 2009, p. 2). Finally, "Sexual trauma was validated as a real experience, and recollected memories were not challenged. Instead, the focus was on changing feelings of guilt and shame that could trigger new situations of abuse" (Vitriol et al., 2009, p. 2).

In addition to individual psychotherapy, the patients met monthly with a psychiatrist who educated them about their symptoms, and monitored their symptom

change, adherence to pharmacological treatment, and self-destructive behaviors. The treatment team social worker made home visits and phone calls as needed. The participants of the study were offered the opportunity to receive the "standard treatment" if at any time they no longer wished to discuss the trauma and its repetition. Standard treatment was described as following the clinical guidelines of the Chilean Ministry of Health. Further, Vitriol et al. (2009) stated that it was supportive, tailored to the patients' needs, and "was not routinely focused on traumatic experiences and their consequences" (p. 2).

The three senior psychiatrists who assessed participants' severity of depression had prior experience assessing and treating affective disorders. Only one of those psychiatrists was part of the multidisciplinary team that provided treatment. A psychodynamically-oriented psychologist and a social worker comprised the remainder of the treatment team.

Separate from the treatment team, an evaluation team was created, which included a clinical psychologist and two trained psychology students who were blind to the results.

The 87 participants were randomly assigned to the intervention treatment group ($N = 44$) or standard treatment group ($N = 43$). An assessment battery was administered to participants before treatment, at three months (posttreatment), and at six months (follow-up).

Lambert's Outcome Questionnaire (OQ-45.2; Lambert, 1991), the Post-traumatic Stress Treatment Outcome scale (PTO-8; Escalona, Tupler, Saur, Krishnan, & Davidson, 1997), and the Hamilton Depression Scale (Ham-D; Hamilton, 1960) were the three

measures used to assess participants' outcomes. The OQ-45.2 assessed three areas, including: psychiatric symptoms, interpersonal relationships, and social role functioning. A total score below 73 indicated remission, while a total score that was 17 points lower than baseline score was labeled as improvement.

The PTO-8 was used to assess the results of PTSD treatment and presence of PTSD symptoms associated with DSM-IV criteria. The PTO-8 required a score of 12 or higher to meet the diagnosis of PTSD. Participants who scored lower than 7 where considered to be in remission. To be considered in remission per the Ham-D, scores had to be below 8.

Results from the 3-month posttest assessment indicated significant differences in average scores between groups on the Ham-D ($t(85) = 2.69$, $p < .001$) and the OQ-45.2 ($t(85) = 1.98$, $p < .05$) favoring the intervention group. PTO-8 scores were gathered at posttest; however, the statistical analyses were not included in the study. Mean scores indicated a decrease from pretest to posttest for both the treatment group (pretest: $M = 16.59$; posttest: $M = 12.64$) and the control group (pretest: $M = 19.16$; posttest: $M = 14.98$). The researchers did not include the pretest to posttest within-group comparisons for the treatment group. What can be concluded is that the treatment group demonstrated significantly greater change in scores in comparison to the standard treatment group at posttest.

At the 6-month follow-up, researchers conducted MANOVA analyses, rather than t-tests, as they had at the 3-month mark. MANOVA results for each group indicated significant improvement in scores on the Ham-D, OQ-45, and PTO-8 for both the

intervention and control group. Results indicated that Ham-D scores decreased significantly for the intervention group (Pillai's trace = .49, $F(2, 42) = 38.85$, $p < .01$) and the control group (Pillai's trace = .51, $F(2, 41) = 21.39$, $p > .01$). Total scores on the OQ-45.2 decreased significantly for the intervention group (Pillai's trace = .42, $F(2, 42) = 18.60$, $p < .001$) and the control group (Pillai's trace = .21, $F(2, 41) = 5.70$, $p < .01$). Further, PTO-8 scores decreased significantly for the intervention group (Pillai's trace = .36, $F(2, 42) = 11.82$, $p < .01$) and the control group (Pillai's trace = .33, $F(2, 41) = 10.38$, $p < .01$). These results indicated that the treated participants maintained their gains from treatment.

At 6-month follow-up there was a significant difference in Ham-D scores between groups favoring the intervention group over the control group ($t(85) = 2.41$, $p < .01$). As was the case for Ham-D scores, there was a significant difference in OQ-45.2 scores favoring the intervention group ($t(85) = 2.16$, $p < .05$). The OQ-45.2 scores on the interpersonal relationships (IR) and social role functioning (SRF) subscales improved significantly only for the intervention group (IR; Pillai's trace = .37, $F(2, 42) = 12.71$, $p < .01$; SRF: Pillai's trace = .32, $F(2,42) = 9.99$, $p < .01$). The difference on PTO-8 scores between the intervention and control group was not significant ($p = .058$). Therefore, with the exception of PTO-8 scores, the change experienced by the treatment group was significantly greater than that experienced by the comparison group.

At the 6-month follow-up assessment, a significantly greater number of participants in the intervention group met criteria for remission over the control group, as measured by the results from the OQ-45.2 and the Ham-D (OQ-45.2: Intervention Group

39%, Control Group 14%, $p < .05$; Ham-D: Intervention Group 22%, Control Group 5%, $p < .05$).

In summary, both intervention approaches demonstrated effectiveness in reducing average scores from pretest to posttest and follow-up. There were, however, significant differences in average scores between groups, which often favored the treatment group. Although Vitriol et al. (2009) stated a strength of the study being its external validity, there were several components to the treatment making it difficult to determine which aspect of treatment was the impetus for change in the participants.

Psychodynamic Psychotherapy: Combined Brief and EMDR Outcomes

Sachsse, Vogel, and Leichsenring (2006) investigated the effectiveness of a psychodynamically oriented trauma-focused inpatient treatment for women suffering from complex posttraumatic stress disorder and co-morbid borderline personality disorder, self-mutilating behavior, and depression.

The initial sample consisted of 153 women admitted to an inpatient hospital for stabilization. In order to qualify for the study, all women completed a diagnostic evaluation, and on the Russel Scale (Russell, 1986) reported a history of severe to extreme childhood sexual abuse, severe physical domestic violence, or neglect. Women included in the study had a history of self-mutilation ($M = 6.65$ times per month) and long-term inpatient treatment ($M = 87.10$ days in the year previous to the study). Most of the women were given multiple diagnoses, most notably Complex PTSD, Major Depression, and Borderline Personality Disorder. The mean age of the women was 32.4 years ($SD = 8.24$).

Researchers conducted the trauma treatment in an inpatient setting because participants' "social environment and/or self-management were not stable enough for such ambulatory intervention" (p. 128). The trauma-treatment included both Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 1995) and "stabilizing" psychodynamic therapy (Sachsse et al., 2006). Treatment on average consisted of two sessions of EMDR (individual trauma-exposure) per month and three to four individual psychodynamic sessions for "working-through" and "reorientation" (Sachsse et al., 2006, p. 129). The researchers stated that EMDR sessions often trigger regressive ego states, in that, when recalling and reprocessing the trauma there is often a regression to the age that the trauma occurred. In order to maintain a working alliance during these regressive states, they treated primitive transference and projective identification via imaginative states, similar to work in play therapy (Sachsse et al., 2006). The researchers then "transformed these phenomena into an imaginative space ('working with the inner child')" (p. 129). They described the therapy process as progressing "in flexible dynamic cycles consisting of stabilization, EMDR, working through, stabilization, and so on" (p. 129). Although the authors' summary of the treatment is seemingly vague the researchers adhered to a treatment manual that was published in German (Psychodynamic Imaginative Trauma Therapy, PITT; Reddemann, 2004).

The study was sequenced in the following way: (a) participants' admission to an inpatient hospital for a 2 week stabilization and diagnostic evaluation; (b) discharge and subsequent 7.5-month wait period which included outpatient treatment as usual (TAU);

(c) readmission to the inpatient hospital for the trauma treatment (IV); and (d) one-year follow-up testing. All participants were included in each sequence of the study.

The initial population included 153 women admitted to a psychiatric hospital for the two week stabilization and diagnostic assessment (Phase 1), 66 of which dropped out of the study, which was attributed to the severity of the population, leaving 87 participants (Group 1, $N = 87$). These 87 participants were then discharged after stabilization and entered a 7.5-month waiting period during which time 9 more patients dropped out. The remaining 78 participants received outpatient treatment as usual (TAU). The details of TAU were not included in the study. The TAU group served as the "nonrandomized control group for the trauma-therapy treatment program" (Sachsse et al., 2006, p. 128). All the participants were then re-admitted to the hospital for the trauma-focused inpatient treatment, which served as the independent variable (Phase 2). During Phase 2, 3 more participants dropped out of the study, leaving 75 completers of Phase 2 (Group 2, $N = 75$). After the completion of the trauma-focused treatment, a one-year follow up was completed with 30 patients (Group 3, $N = 30$).

An assessment battery consisting of five self-report instruments were administered at four testing points (t1, t2a, t2b, and t3). The first point of measure was during the beginning of Phase 1, admission and diagnostic assessment (t1), the second during the first week of Phase 2, post TAU/pre-trauma treatment (t2a), the third in the last week of Phase 2, post-trauma treatment (t2b), and the last at 1-year follow-up (t3). Comparisons of testing scores between t1, t2a, t2b, and t3 were made to determine the effectiveness of treatment. Two clinician-report scales were also included in the study.

Points of measure were at pretreatment, posttreatment, and 1-year follow up. Also at 1-year follow up two semi-structured interviews were conducted to determine the number of self-mutilating behaviors and the necessity for follow up inpatient or outpatient treatment. In order to test their hypotheses, statistical data analysis was completed using two-sided t-tests and multivariate analyses of variance.

The instruments in the study included the Borderline Personality Inventory (BPI; Leichsenring, 1997, 1999); the Dissociative Experiences Scale (DES; Bernstein & Putman, 1986); the Impact of Events Scale (IES; Horowitz et al., 1979); the Symptom Check List (SCL-90-R; Derogatis, 1983); and the Beck Depression Inventory (BDI; Beck et al., 1961). The two clinician-rated scales used in the study included the Global Assessment of Functioning Scale (GAF; APA, 1994); and the Clinical Global Impressions (CGI; APA, 1994).

The researchers hypothesized that the 2-week stabilization period in Phase 1 and the subsequent treatment as usual (TAU) would not result with significant therapeutic effects. MANOVA results comparing the scores attained from the assessment battery administered during Phase 1 (t1) to those attained during the repeated assessment before starting Phase 2 (t2a) indicated that stabilization, the waiting period, and TAU did not yield statistically significant differences in scores ($F(13, 77) = 0.687$, $p = .756$).

Planned *t*-tests were used to test the significance of the pretreatment (t2a) to posttreatment (t2b) change for the trauma treatment in Phase 2. Due to the multitude of statistical tests being performed (13 in total), Bonferroni adjustments were used to decrease the possibility of Type I error. Therefore, values were considered to be

significant when $p \leq .0038$. The treatment group experienced significant change in scores on three of the five measures administered at pre- and post-treatment. Results indicated significant improvement in scores on the primitive defense mechanism subscale (splitting and projection) of the BPI ($t(74) = 3.89$, $p < .0008$), the total score of the DES ($t(74) = 3.19$, $p < .0038$), the absorption scale of the DES ($t(74) = 3.83$, $p < .0008$), and the avoidance scale of the IES ($t(74) = 4.07$, $p < .0008$). The treatment effect for each of these scales was moderate to large ranging from .52 to .77. Accordingly, participants demonstrated a decrease in the use of defense mechanisms, decrease in dissociation, and improved stress tolerance posttreatment.

The researchers also compared GAF and CGI scores derived at pre- and post-treatment. Results yielded significant improvement in patients' overall level of functioning (GAF: $t(74) = -5.27$, $p < .003$, $d = 1.38$) and severity of illness (CGI: $t(74) = 6.15$, $p < .003$, $d = 1.62$).

MANOVA results comparing scores at posttreatment (t2b) and at 1-year follow-up (t3) indicated no significant differences on all measures administered at posttreatment and 1-year follow up (F (7, 29) = 28.454, $p = .143$). Thus the participants maintained their gains from the end of treatment to the 1-year follow-up. Researchers also compared GAF and CGI scores at posttreatment (t2b) and at 1-year follow-up (t3). Results indicated significant improvement in patient's overall level of functioning (GAF: $t(29) = -8.31$, $p <.003$, $d = 2.18$) and severity of illness (CGI: $t(29) = 10.38$, $p < .003$, $d = 2.73$). Thus not only did participants maintain their gains but made significant improvement between discharge and 1-year follow-up on these two clinician-rated measures.

The researchers also compared data gathered at pretreatment (t2a) and follow-up (t3). The number of self mutilating behaviors reduced significantly from about 7 (M = 6.65) times per month prior to treatment to less than once (M = .68) per month post treatment ($t(29)$, $p < .01$, $d = .92$). The annual number of psychiatric hospitalizations one year prior to treatment reduced significantly from a mean of 87.10 days to a mean of 9.27 days between discharge and 1-year follow-up ($t(29)$, $p < .01$, $d = 1.24$). The results indicated that the treated participants were functioning at follow-up better than they were at the pretreatment. Thus, they further postulated that participants had also improved significantly above and beyond what they would have had they continued TAU.

In summary, Phase 1 (stabilization) and the outpatient TAU did not yield statistically significant results. Phase 2 (inpatient trauma treatment) did yield statistically significant results that were durable over time. There are, however, several confounds in the design of this study. First, because all participants received TAU and the inpatient trauma treatment it cannot be concluded what caused the significant changes in scores. The researchers attempted to control for this problem by comparing scores pre- and post-TAU. Results indicated no significant differences in scores, however, the possibility exists that positive residual effects of the TAU may have carried over into the inpatient trauma treatment, thus increasing it's therapeutic effects. Moreover, because there were several components to the treatment (i.e., hospitalization, EMDR, psychodynamic sessions) it is impossible to ascertain what was the driving force behind the change experienced by the participants. What can be concluded is that the treatment was

effective, but what cannot be concluded is what element of the treatment was the effective component.

General Treatment Techniques

In addition to reviewing the aforementioned outcome studies, this paper aims to incorporate supplementary research that explores the opinions of both clinicians and individuals suffering from Complex PTSD with respect to what constitutes effective treatment. Consequently, the following sections examine two survey studies of such characteristics. The first study is an expert clinician survey conducted by leading experts in the field of Complex PTSD. This study elicited responses from experts in PTSD and Complex PTSD as to what symptoms were most frequently associated with Complex PTSD and what interventions were effectively and safely used to target such symptoms. The second study is a qualitative analysis of clinicians' and patients' perceptions about the benefits and challenges that either facilitate or impinge upon the therapeutic process.

Expert Clinician Survey

Initiated by the International Society for Traumatic Stress Studies Complex Trauma Task Force, Cloitre et al. (2011) conducted an expert clinician survey that was aimed at gathering opinions regarding the prevalence of various symptoms associated with Complex PTSD and best practices for the treatment of Complex PTSD.

Participants in the study included 25 experts in the treatment of Complex PTSD and 25 experts in the treatment of PTSD. The process of participant selection was based on peer nomination. In order to determine experts in the field, each member of the task

force identified 10 clinical experts in the field of Complex PTSD and 10 clinical experts in the field of PTSD. To be included in the study, the nominated participants must have had at least two published peer-reviewed journals describing, evaluating, and treating PTSD or Complex PTSD. Participants were also chosen based on their theoretical orientations because the researchers were intentional in attempting to assess perspectives and general treatment protocols across different treatment orientations. Additionally, those participants who were chosen as experts in PTSD were delineated from the experts in Complex PTSD through their publication histories, in that their publications and research were required to discuss only the treatment of PTSD without overlap on treating Complex PTSD. This was done in order to assess perspectives from two distinct groups.

The researchers developed a Complex PTSD symptom profile derived from conventional PTSD symptom measures (Foa, 1995) and symptoms of Complex PTSD as described by Briere (1995). The symptom profile consisted of 11 sets of symptoms: (a) re-experiencing; (b) avoidance/emotional constriction; (c) hyperarousal; (d) affective dysregulation; (e) behavioral dysregulation; (f) relational difficulties; (g) attentional disturbance; (h) state-like dissociation; (i) dissociative disturbance; (j) disturbance in system of meaning; and (k) chronic pain (Cloitre et al., 2011). The participants were asked through an expert consensus mail-in survey to "provide ratings regarding the most appropriate treatment approach, the general efficacy of various interventions for complex PTSD as a whole, and the efficacy, safety, and acceptability of the interventions for each of the 11 symptom sets individually" (Cloitre et al., 2011, p. 618). In order to control for participant response bias "the treatments were not referred to by specific names (e.g.,

prolonged exposure), but rather were identified in a generic way (e.g., exposure therapy)" (Cloitre et al., 2011, p. 618).

The response options in the survey included a 1 to 9 rating scale for the appropriateness, effectiveness, safety, and acceptability of a technique for each of the 11 symptom sets. Cloitre et al. (2011) defined the various scales as follows: A score of 7 to 9 indicated that the expert believed the particular intervention to be "usually appropriate" and "a first-line treatment you would often use;" a score of 4 to 6 indicated that the intervention was "reasonable," "a second-line treatment," and "a treatment you would sometimes use under certain conditions;" a score of 2 to 3 indicated that the intervention was "usually inappropriate," and "a treatment you would rarely use;" and finally, a score of 1 indicated that the intervention was "extremely inappropriate," and was "a treatment you would never use in regard to its overall appropriateness" (p. 618).

Cloitre et al. (2011) also used a 1 to 9 rating scale for the frequency of symptoms and the degree to which each of the 11 symptom sets contributed to impairment. Ratings for the frequency of symptoms were as follows: A score of 7 to 9 indicated that the symptom was "usually or almost always present;" a score of 4 to 6 indicated that the symptom was "sometimes present;" and a score of 1 to 3 indicated that the symptom was "almost never or rarely present" (p. 618). Ratings for the level of impairment were as follows: a score of 7 to 9 indicated that the symptom was a "substantial contributor [or the] most important contributor to impairment;" a score of 4 to 6 indicated that the symptom was a "moderate contributor to impairment;" and a score from 1 to 3 indicated that the symptom was a "minimal or modest contributor to impairment" (p. 618).

The data was analyzed by calculating means, standard deviations, confidence intervals (CI), and distribution rating in percent for each item. Cloitre et al., 2011 stated:

> The interpretation of the ratings was based on the CI for each item, which provides a statistically calculated range in which there is a 95% chance that the mean score would fall within the range if the survey were repeated with a similar group of experts…It was required that an item be assigned to the category into which the lowest value of the CI fell. Thus, for example, for an intervention to be classified as first line, the entire CI had to exceed 6.5. In the case where the CI straddled second- and first-line categories, the item was designated as a high second-line choice. The range for second line was 3.5 to 6.49, and if any portion of the CI fell below 3.5 an item was designated as third line. (p.619)

Presence of Complex PTSD symptoms. The researchers first explored the degree to which participants viewed various symptoms to be present among those suffering from Complex PTSD and the degree to which those symptoms contributed to impairment. With regard to the frequency of the presence of symptoms among those suffering from Complex PTSD, results indicated that the participants rated affect dysregulation (93%), relationship disturbance (87%), avoidance (84%), re-experiencing (80%), hyperarousal (78%), and disturbances of meaning (76%) as usually or always present. Fewer participants rated behavioral dysregulation (60%), attentional difficulties (53%), somatic symptoms (49%), dissociative symptoms (48%), and identity dissociation/disturbances (27%) as usually or always present.

Contributors to impairment. Cloitre et al. (2011) reported that the findings for impairment were similar to those of frequency. The two symptoms ranked highest with regard to being a significant contributor to impairment were affect dysregulation (94%) and relationship disturbance (94%). Symptoms contributing to lesser degrees of impairment, relatively speaking based on experts' opinions, included behavioral

dysregulation (78%), re-experiencing (69%), avoidance and dissociation (67%), hyperarousal (65%), disturbances in systems in meaning (59%), identity disturbance (52%), attentional problems (42%), and somatic symptoms (35%).

Overall approach to treatment. The researchers investigated the degree to which various approaches were viewed to be first line, second line, or third line treatments. Percents in parentheses are reported in order of first line, second line, and third line treatment interventions as identified by participants. In order to be considered a first line treatment, the entire confidence interval of the calculated mean was required to be at or above 6.5, if any part of the confidence interval fell below 6.5 the treatment was considered to be a second line treatment, and any mean with a confidence interval falling at 3.49 or below were considered to be third line approaches to treatment. A sequenced treatment approach, which was described as including two phases wherein phase one focused on patient safety, symptom stabilization, and improvement in basic life skills, and phase two involved the exploration of the traumatic memories in order to decrease distress related to the memories, to reappraise their meaning, and to integrate them into a more coherent and positive identity (Cloitre et al., 2011), was viewed to be a first line intervention (M = 8, SD = 1.6) by the majority of participants (85%, 15%). This is consistent with other literature suggesting that a phase-based treatment approach is likely most effective (Courtois & Ford, 2009). A coping skills approach (M = 5.3, SD = 2.2, 34%, 40%, 26%), and a combined processing and skills approach (M = 4.3, SD = 2.4, 27%, 23%, 50%) were viewed to be second line treatments. Lastly, a memory processing approach (M = 2.7, SD = 2.1) was considered a third line treatment by the majority of

participants (7%, 17%, 76%). In summary, the general consensus among the expert clinicians was that a sequenced treatment approach was viewed as a first line treatment strategy.

Effectiveness of interventions. The researchers also investigated the degree to which the expert clinicians rated various interventions as being effective. Effectiveness was defined as the likelihood of decreasing "complex trauma symptoms by 75% and improving general functioning" (Cloitre et al., 2011, p. 620). Results indicated that narration of trauma (M = 7.3, SD = 1.4), and emotion regulation interventions (M = 7.0, SD = 1.5) were viewed to be the most effective interventions among clinicians. Interventions including cognitive restructuring (M = 6.7, SD = 1.8), and education about trauma (M = 6.6, SD = 2.1) were also highly endorsed as being effective treatments, bordering between first line and highly rated second line treatments among the participants. Interventions which were viewed to be high second line interventions included anxiety/stress management (M = 6.0, SD = 1.9), interpersonal/social skills (M = 5.8, SD = 1.8), and meditation/mindfulness (M = 5.6, SD = 2.0). Finally, interventions that were ranked as low second line/high third line interventions included sensorimotor/movement (M = 4.3, SD = 2.4), bilateral stimulation (M = 4.3, SD = 2.4), and case management (M = 4.1, SD = 1.7).

Safety of interventions. The safety of various interventions was also of interest to the researchers. Safety was defined as being "unlikely to increase severity of symptoms, impulsive behaviors, or suicidality" (Cloitre et al., 2011, p. 621). The safest interventions were considered to be education about trauma (M = 8.2, SD = 1.0),

anxiety/stress management (*M* = 7.8, *SD* = 1.5), cognitive restructuring (*M* = 7.4, *SD* = 1.4), emotion regulation interventions (*M* = 7.0, *SD* = 1.5), and interpersonal/social skills (*M* = 7.0, *SD* = 1.5). Interventions that bordered between third line and second line interventions with respect to safety included case management (*M* = 6.9, *SD* = 2.1), meditation/mindfulness (*M* = 6.6, *SD* = 1.8), and narration of trauma (*M* = 6.5, *SD* = 1.6). Finally, interventions viewed to be second line, or least safe, included bilateral stimulation (*M* = 5.3, *SD* = 2.4), and sensorimotor/movement strategies (*M* = 5.1, *SD* = 2.4).

Acceptability of interventions. The researchers also investigated the acceptability of various interventions according to the expert clinicians. Acceptability was defined as "whether an intervention was likely to promote patient engagement, responsiveness, and retention in treatment" (Cloitre et al., 2011, p. 619). The most acceptable interventions included education about trauma (*M* = 8.0, *SD* = 1.4), emotion regulation interventions (*M* = 7.1, *SD* = 1.2), and anxiety/stress management (*M* = 7.1, *SD* = 1.7). Interventions bordering between first line and second line acceptability included cognitive restructuring (*M* = 6.9, *SD* = 1.7), interpersonal/social skills (*M* = 6.7, *SD* = 1.5), meditation/mindfulness (*M* = 6.3, *SD* = 1.9), narration of trauma memory (*M* = 6.2, *SD* = 1.6), and case management (*M* = 6.2, *SD* = 2.0). Lastly, bilateral stimulation (*M* = 5.0, *SD* = 2.3) and sensorimotor/movement strategies (*M* = 4.8, *SD* = 2.0) were ranked as second line interventions.

Cloitre et al. (2011) observed that emotion focused and emotion regulation interventions were the only interventions ranked as first line treatments for effectiveness,

safety, and acceptability. Interventions that were ranked as first line and high-end second line interventions across all domains included education about trauma, anxiety/stress management, and cognitive restructuring.

Preferred treatment modality. The researchers also investigated the preferred type of modality (i.e., individual, group, or combined individual and group) for the treatment of Complex PTSD. Individual treatment was ranked as a first line approach for the initial phase of treatment (M = 8.7, SD = 0.6). A combination of individual and group therapy (M = 6.7, SD = 2.1) and structured group therapy (M = 6.4, SD = 2.3) bordered between a first line and a second line intervention. An open, unstructured group (M = 3.7, SD = 1.9) and self-help (M = 3.3, SD = 1.6) were rated between second and third line interventions. With regard to the preferred format for processing trauma memories, an individual modality was viewed to be a first line treatment (M = 8.6, SD = 0.6,), combined individual and group was rated between a first line and a second line treatment (M = 6.3, SD = 2.4), and lastly, a purely group format bordered between a second line and a third line treatment (M = 3.5, SD = 2.1).

First line interventions for specific symptom sets. Finally, the researchers reported which interventions were ranked as first line and high second line interventions for treating the specific symptoms sets. For the sake of efficiency, only the first line interventions are included here. For *reexperiencing*, first line interventions included education about trauma and narration of trauma memory; *avoidance/constriction* symptoms contained education about trauma and emotion regulation interventions; *hyperarousal* included education about trauma, emotion regulation interventions, and

anxiety/stress management; *affect dysregulation* involved education about trauma and emotion regulation interventions; *relationship difficulties* included education about trauma, interpersonal skills training, and cognitive restructuring; *disturbances in meaning* was comprised of education about trauma and cognitive restructuring; *behavioral dysregulation* involved education about trauma and emotion regulation interventions; *attentional disturbance* included education about trauma and emotion regulation interventions; *somatic symptoms* focused on education about trauma and emotion regulation interventions; and *identity disturbance* included education about trauma.

Overall, the expert clinicians "indicated a strong preference for tailoring interventions to specific symptoms" (Cloitre et al., 2011, p. 621). For instance, "emotion focused interventions were the most strongly recommended intervention for affect dysregulation symptoms, interpersonal effectiveness skills training for relationship disturbances, cognitive restructuring for disturbances in systems of meaning, narration of trauma for reexperiencing symptoms" (Cloitre et al., 2011, p. 621) and so on. Notably, the most frequently ranked first line and high second line interventions (not listed in this review) included: psychoeducation, emotion regulation interventions, narration of trauma, and cognitive restructuring.

Summary. The researchers discovered that 9 of the 11 symptom domains included in the study were ranked as usually or always present with patients suffering from Complex PTSD. Results also indicated that the majority of the participants were in favor of a "treatment approach that was sequenced and involved the use of multiple types of interventions tailored to the most prominent symptoms" (Cloitre et al., 2011, p. 624).

Exemplifying this finding in more detail and because the expert clinicians preferred specific techniques for various symptom sets, the researchers argued for the importance of "selecting interventions specific to the prominence of a particular presenting problem" (Cloitre et al., 2011, p. 624). While the researchers argued for the need to tailor interventions to particular symptoms, they also acknowledged that emotion regulation, cognitive restructuring, and narration of trauma were repeatedly ranked as first line or high second line interventions, thus "suggesting their importance as core interventions for clinicians to have available in the treatment of complex trauma clients" (Cloitre, et al., 2011, p. 624).

Clinician and Patient Survey

Chouliara et al. (2011), using Interpretative Phenomenological Analyses (IPA), qualitatively investigated childhood sexual abuse survivors' (CSA) and mental health professionals' perceptions of talking therapy services. The researchers were primarily interested in two major themes that emerged from the participants' narratives: aspects of psychotherapy which were particularly helpful or aspects that participants found to be hindering (Chouliara et al., 2011). Based on the patients' and clinicians' perceived helpful and hindering aspects of talking therapy, the researchers made recommendations for good practice with the CSA population (Chouliara et al., 2011).

Participants of the study included 13 female CSA survivors and 31 clinicians (21 females, 6 males) working in the field of CSA. The CSA participants were recruited from a wide range of mental health clinics across Scotland. Of the 31 clinicians, 15 worked in volunteer settings and 16 worked in statutory settings. To be included in the study the

CSA participants were required to be over 18-years-old, had been in therapy services for CSA related issues, and were able to agree to the terms of informed consent. For the clinicians to be included in the study, they must have been working in the National Health Services in Ireland (either volunteer or non-voluntary sectors), and had prior experience working with the CSA population.

Of the clinicians included in the study, the majority self-identified as cognitive behavioral (n = 13) and person-centered therapists (n = 15). Other orientations included art therapy (n = 1), cognitive-analytical therapy (n = 2), compassionate mind therapy (n = 1), dialectic-behavior therapy (n = 3), interface intervention model (n = 1), and solution-focused therapy (n = 1). Chouliara et al. (2011) made note that although clinicians endorsed a particular orientation, they "indicated that they did not utilize one single approach at all times but rather they adopted an 'eclectic' approach, combining elements of different approaches to best fit the needs of individual clients" (p. 131).

Researchers used a semistructured interview design so that the participants were allowed the opportunity to openly respond to the questions asked of them. The interview was based on content derived from literature in the areas of CSA (Draucker, 1997; Draucker, Martsolf, & Poole, 2009) and the researchers' experiences with the CSA population. When the interview was conducted the researchers were intentional about adhering to "principles of sensitive interviewing," such that if participants were feeling distressed during the interview they were able to take breaks as needed, and were able to choose the location where the interview was to take place. Researchers stated, "these measures facilitated the establishment of rapport between researcher and participants and

ensured prolonged engagement of the researcher" (Chouliara et al., 2011, p. 132). The interviews lasted around 40 to 60 minutes.

The researchers articulated four reasons for utilizing IPA for the study: (a) "IPA focuses explicitly on the links between how people describe their experiences, their cognition, and their behavior;" (b) "IPA is particularly suitable for research in applied psychology and mental health because it shares something of the realist ontology of the social cognitive paradigm;" (c) "IPA, with its phenomenological focus, centers on the lived experiences of the participants, taps into their expertise, and illuminates how they have experienced health services and what their views are;" and (d) IPA "is an idiographic approach, it allows us to appreciate the phenomenon under study at the level of the individual as well as the wider group of participants" (Chouliara et al., 2011, p. 132).

Each individual interview was read several times and subsequently coded for emergent themes. Themes that were recurrent "were then identified across transcripts, and links between these themes were established" and "repetitions of the emergent themes across individual transcripts were taken as indicative of their status as recurrent themes, reflecting a shared understanding by participants of the issues under investigation" (Chouliara et al., 2011, p. 133).

Two main themes emerged from the data: (a) Benefits from talking therapy; and (b) Challenges of using/providing services (Chouliara et al., 2011).

Benefits of therapy. With respect to the first theme the researches stated, "All survivors acknowledged that talking therapy, despite being a long, complex, and

demanding process in most cases, had a profound impact on survivors and was paramount in their recovery" (Chouliara et al., 2011, p. 135). The participants identified six benefits from talking therapy, the first being a *trusting therapeutic relationship*. The survivors reported that a trusting relationship was developed via confidentiality, lack of judgment, safety, transparency, flexibility about time of session, and the therapist's listening (Chouliara et al., 2011). The clinicians held a similar opinion, in that the development of a trusting therapeutic relationship needed to include all the aforementioned qualities. Clinicians and survivors also identified the *safety to disclose* as an important aspect of treatment. Safety to disclose was developed when the survivors felt listened to, heard, and not judged (Chouliara et al., 2011). *Breaking isolation* was also an important aspect of beneficial therapy. For example, what survivors found particularly helpful was having someone to talk to and knowing where to find support (Chouliara et al., 2011). *Enhancing self-esteem* and *sense of self* was also an emergent theme. For instance, several survivors noted that talking therapy helped them to feel better about themselves and to take better care of themselves (Chouliara et al., 2011). Survivors also identified *contextualizing the abuse* as a key aspect of successful talk therapy. This helped them accept the reality of the abuse, accept themselves, connect past, present, and future, and make connections between feelings, thoughts, and behaviors (Chouliara et al., 2011). Clinicians noted the utility of educating survivors about the effects of abuse in order to normalize it and minimize stigma (Chouliara et al., 2011). Finally, *participants identified movement toward recovery* as a helpful aspect of therapy. For instance, "many survivors identified healing the wounds of the past as one of the

most important benefits of talking therapy" (Chouliara et al., 2011, p. 139). The survivors described the movement toward recovery as "learning to live with what happened, managing retraumatization, and reducing the frequency and intensity of acute episodes" (Chouliara et al., 2011, p. 139). The clinicians often stated that witnessing their clients' move toward recovery was the affirming and rewarding aspect.

Challenges of therapy. The participants identified six challenges to using/providing services. Chouliara et al. (2011) noted: "All survivors seemed to view their journey through talking therapy as a particularly challenging experience overall" (p. 140). The theme *Difficulties of trauma-focused work* was noted as a challenge for both survivors and clinicians. The survivors noted that the challenges included appropriate timing and depth of work and that it was important to be prepared and have the option to step away from the trauma work (Chouliara et al., 2011). Survivors noted that trauma-focused work also often increased and worsened symptoms during exposure. The clinicians identified trauma-focused work as challenging and beneficial. For instance, clinicians feared destabilizing their clients, and were concerned about the timeliness of their interventions. They noted that educating/preparing their clients for the work was advantageous. Another component of talk therapy that was described to be a challenge for survivors was *contact between appointments.* In particular, survivors reported that a challenge was the lack of support between sessions, which would have increased emotion regulation (Chouliara et al., 2011). Survivors that had the option of contacting their therapist between sessions reported feeling reassured, less isolated, and cared for (Chouliara et al., 2011). *Continuity and consistency* was also identified as a challenge to

treatment, in that time restrictions of sessions impinged on survivors' willingness to engage with session material. Survivors reported that they preferred to have the same therapist over the course of their treatment, and that when treatment was consistent they felt valued. The survivors also stated that a barrier to treatment was related to *service accessibility in acute episodes.* For example, some survivors reported that services were less readily available during times of acute stress, when services are of chief importance (Chouliara et al., 2011). *Hearing and managing disclosures* was an area identified by clinicians as being exceptionally challenging. Most the clinicians "identified hearing survivors' disclosures as challenging and difficult, because of the 'horrific,' 'disturbing,' and helpless nature of the stories, which seem to touch professionals on a deep human level" (Chouliara et al., 2011, p. 144). Clinicians reported that to work effectively with disclosures, survivors should be empathically heard and treated with care and tenderness (Chouliara et al., 2011). Clinicians and survivors alike reported that *dealing with child protection issues* is a challenge to talk therapy services. For instance, clinicians endorsed feeling "disloyal" and "very exposing" when required to make child abuse reports (Chouliara et al., 2011). Furthermore, survivors reported that child protection issues were "scary" and that these issues should have been handled in a more "sophisticated manner" (Chouliara et al., 2011). The last area identified as a challenge area was *resource availability and service accessibility.* The majority of clinicians reported that the survivor population needed more resources (e.g., facilities being understaffed and accessibility of resources based on geographic dwelling place).

Taking into consideration the complexities with which the survivor population presents to therapy, and informed by clinicians' and survivors' perceptions of the benefits and challenges of the psychotherapy process, the researchers offered several treatment recommendations in order to address the findings of their qualitative analysis. Chouliara et al. (2011) made recommendations in hopes to "improve several aspects of clinical practice and service experience, including contact, time restrictions and management, decision for trauma-focused work, crisis support, disclosures, child protection issues, and resources" (p. 151).

Recommendations for treatment. The researchers made specific recommendations and corresponding anticipated outcomes for each of the seven challenges to the therapeutic process as previously delineated. With respect to *contact*, the researchers suggested working toward a standardized form of appropriate contact between sessions in hope to increase consistency across sessions. *Time restrictions and management* was also seen to be a barrier to treatment. To work around this issue, the researchers recommended that clinicians increase flexibility on time constraints, and address individual needs with the goal of increased engagement in therapy, the development of a strong therapeutic alliance, and greater levels of consistency and continuity. A third challenge presented to therapists and survivors alike was related to *trauma-focused work*. The researchers opined that by collaboratively deciding on the timing and depth of trauma work, there would be minimal risk for retraumatization and avoidance, and likely increased engagement in therapy. An added concern was with respect to *crisis support.* The recommendations for this challenge included increased

support and alternative support for survivors outside of session. This would help clients access support during crisis, and manage self-harm and helplessness more effectively. *Disclosures* were also viewed to be a difficulty for survivors and clinicians. To work through the challenges that surface around disclosures, the researchers suggested that clinicians respond appropriately and empathically, receive adequate supervision/consultation, and seek out additional prospects for professional and personal growth. This would contribute to greater self-care, reduced risk of vicarious traumautization, and increased sensitivity to trauma treatment. A sixth concern was *child protection* issues. To combat this dilemma, it was recommended that clinicians receive adequate supervisory and consultative support as well as emotional support during abuse reporting circumstances. These various forms of support would be experienced as empowering for clinicians and give them the confidence to work through these challenges. Lastly, the availability of *resources* was of primary concern for survivors and clinicians. The researchers advised that clinicians and communities should increase services for survivors, especially for communities that are especially difficult to reach. This might greater assist young survivors, those from rural communities, and those from low socioeconomic status.

Summary. The researchers concluded that there are several barriers to treatment and several aspects of treatment that benefit CSA survivors. Many of the benefits are derived from the therapeutic relationship and the ways in which the therapist can provide a safe and stable environment for CSA trauma and memories to be worked through. However, this is only possible if the barriers to treatment, largely centered around the

access to and availability of the therapist and the dysregulation associated with disclosing and re-experiencing trauma, can be modulated in appropriate ways. The researchers included methods of addressing these issues, and what is clear from the study is that treatment needs to be more flexible, more supportive, and more individually tailored to individuals' needs when CSA survivors begin to work through their trauma histories.

Psychotherapy Integration

Thus far, this paper has explored the etiology, various definitions, and the multifaceted symptom clusters associated with Complex PTSD. It has also critically reviewed several treatment orientations that have demonstrated various levels of efficacy and effectiveness in the treatment of Complex PTSD, and provided supplementary research exploring clinicians' and survivors' perceptions of necessary interventions to utilize in providing effective treatment. With the goal of working toward a conceptually based, integrative process for treating Complex PTSD, the ensuing sections of this paper will: (a) address differences in language when conceptualizing about psychotherapy integration; (b) investigate the prevalence of psychotherapy integration among practicing professionals; (c) define various types of psychotherapy integration and their application to the research reviewed in this paper; and (d) argue for the necessity of the use of an assimilative integration process in clinical work to best meet the multilayered needs of individuals suffering from Complex PTSD.

Integrative Psychotherapy and Psychotherapy Integration

In recent decades, there has been a shift in language from "eclectic psychotherapy" to "integrative psychotherapy" and more recently to "psychotherapy integration." Wachtel (2010) elucidated what difficulties faced the Society for the Exploration of Psychotherapy Integration (SEPI) when deciding the name of their organization. The founders of the society were conflicted between the aforementioned name and the "Society for the Exploration of Integrative Psychotherapy." The terminology used in each name holds a certain implication such that "psychotherapy integration" implies a process and "integrative psychotherapy" implies a product (Wachtel, 2010). For the purpose of this current paper, the terminology preferred is "psychotherapy integration" because the aim is not to create an end product but rather to facilitate a process wherein clinicians may think critically about tailoring treatment to their patients' needs rather than superimposing a "closed system" of psychotherapy onto the patient. In other words, this paper will attempt to view integration or integrating as "an ongoing aim or effort, or put differently, [as] a road to a destination, a destination which may not even be known or visible as one proceeds" (Wachtel, 2010, p. 411).

Wachtel (2010) stated that theoretical orientations are often akin to ethnicity insofar as clinicians may see themselves as belonging exclusively to one group or another. As such, "One 'belongs' to the psychoanalytic or cognitive-behavioral or humanistic-experiential world, and one 'betrays' that belonging [when utilizing another orientation] at a potential risk to many valued relationships and to the sense of belonging itself" (p. 410). Wachtel (2010) further postulated that when clinicians adhere too rigidly

to a single theoretical orientation, they are prone to develop "tunnel vision" at the sacrifice of seeing the whole clinical picture. This is likely because "the world is certainly more complicated and difficult to fully comprehend once one removes the blinders that have simplified it" (p. 410). Therefore, considering the multidimensional symptomatology and coping mechanisms employed by individuals with Complex PTSD, it seems particularly relevant that clinicians broaden their clinical picture and treatment methods by way of psychotherapy integration.

The Prevalence of Psychotherapy Integration

It is important to begin by examining the research on how clinicians are already implementing integrative processes in treatment. For example, Thoma and Cercero (2009) conducted a national survey investigating the "extent to which therapists endorse techniques outside of their self-identified orientation and which techniques are endorsed across orientations" (p. 1). First, the researchers conducted an extensive literature review exploring various treatment orientations. After the search, the researchers opined that there were eight theoretical orientations that had a "distinct theory of change." These included: behavioral, cognitive, constructivist, existential, gestalt, humanistic, psychodynamic, and systems therapies. From these orientations, the researchers derived 67 specific techniques that were subsequently included in a survey. The Therapist Techniques Survey Questionnaire (TTSQ) came out of this project by Thoma and Cercero (2009) and had four sections: "(a) demographic information, (b) psychotherapy techniques, (c) relationship factors, and (d) orientation questions" (p. 409). The survey

was sent to 1,500 licensed doctoral level psychotherapists; 201 of the surveys were finished completely and included in the study.

The researchers were first interested in the degree to which psychotherapists would endorse techniques that coincided with their own theoretical orientations. Results indicated that therapists of a particular orientation tended to endorse intervention techniques that corresponded with that specific orientation. For instance, cognitive-behavioral and eclectic therapists endorsed more cognitive and behavioral interventions than did the humanistic and psychodynamic therapists. Psychodynamic therapists endorsed psychodynamic techniques more often than cognitive-behavioral, humanistic, and eclectic therapists, and so forth.

Second, researchers were interested in the degree to which therapists would endorse techniques from outside their particular orientation. Results indicated that all clinicians of a given orientation endorsed several therapeutic techniques outside of their own orientation.

Lastly, the researchers were interested in which techniques were endorsed most frequently across orientations. Results indicated that Rogerian techniques including empathy, positive regard, and genuineness were strongly endorsed by all psychotherapist groups. Empathy received the highest mean score of any other technique. The cognitive technique called “challenging maladaptive or distorted beliefs” was also highly endorsed across orientations, except for the humanistic therapists. The most highly endorsed behavioral technique was “planning alternative behaviors” and “scheduling pleasurable activities.” The most popular psychodynamic technique was “working through” and

"applying insight." "Exploring childhood experiences" was also highly endorsed across all orientations. The most frequently endorsed existential technique was "facilitating the discovery of meaning or purpose." The constructivist technique called "positive reframing to help change a client's narrative" was most popular among the constructivists. And finally, the most highly endorsed systems technique was "encouraging the client to examine their own role in a maladaptive family pattern."

In summary, the researchers discovered that among doctoral level psychotherapists, there was a "notable willingness of therapists to endorse techniques outside of their own pure-form orientation" (Thoma & Cercero, 2009, p. 412). Therefore, while this is not an indication that all clinicians are utilizing the process of psychotherapy integration, it is an indication that clinicians have recognized that patients may respond differently to varying interventions, and they practically responded to the need for flexibility in their use of treatment orientations. It is arguable then, that the process of psychotherapy integration becomes even more imperative in the treatment of less discrete syndromes such as Complex PTSD.

Types of Psychotherapy Integration

In order to argue for a particular type of integrative approach, it is first important to define the various types of psychotherapy integration in the literature. There are four predominant integration approaches, these include: (a) Technical/Prescriptive Eclecticism; (b) Theoretical Integration; (c) Assimilative Integration; and (d) a Common Factors approach to integration (Norcross & Halgin, 2005). There are indeed other types that are manipulations of the aforementioned, such as Principle-Based Assimilative

Integration (Boswell, Nelson, Nordberg, Mcaleavey, & Gastonguay, 2010). For the sake of simplicity, the four most predominant integrative styles will be explored in the following sections.

Technical/Prescriptive Eclecticism. Technical/Prescriptive Eclecticism is an integrative approach that "attempts to select the best method of treatment for the person and problems presented" (Scaturo, 2012, p. 185). For example, if a technical eclecticist were to read the studies presented in the current paper, he or she might choose the treatment approach that may best fit the needs of their particular patient. Others may also choose the treatment that demonstrated the most substantial therapeutic effects.

Theoretical Integration. Theoretical Integration, as opposed to Technical/Prescriptive Eclecticism, "attempts to blend two or more therapeutic approaches with the goal of arriving at an improved form of treatment" (Scaturo, 2012, p. 185). Since the studies reviewed in this paper all demonstrated some degree of efficacy and/or effectiveness, a theoretical integrationist would be likely to blend Cognitive Behavioral Therapy with the Emotion Focused Therapy. Or, one might blend Psychodynamic Therapy with EMDR. Whichever the choice, there is a blending of two or more approaches into a new, cohesive, theoretically sound treatment approach. An example of theoretical integration is Accelerated Experiential Dynamic Therapy (AEPD) developed by Fosha (2000). In this treatment approach, Fosha (2000), with a theoretical base for doing so, blended aspects of psychodynamic therapies and process-experiential therapies to create a unique form of treatment.

Assimilative Integration. Whereas Theoretical Integration works toward a blending of two or more therapeutic approaches into a new cohesive theoretically based treatment, Assimilative Integration "attempts to arrive at a synthesis with firm grounding in a single method of treatment with a willingness to selectively include other therapeutic perspectives" (Scaturo, 2012, p. 185). Boswell et al. (2010) stated that a "principle-based" assimilative integrative approach is "organized around identifying therapeutic commonalities, principles of change that cut across different orientations, and using these principles to determine when and how to assimilate exogenous techniques into a primary treatment frame" (p. 3). An assimilative integrationist who has a firm grounding in Cognitive Behavioral Therapy may read the aforementioned studies and begin to incorporate the empathic exploration technique into his or her repertoire of therapeutic interventions for those patients that do not respond well to prolonged exposure. As such, the therapist may decide to incorporate an exogenous technique such as the empathic exploration technique from EFTT so that the patient may still reprocess the trauma but in a less invasive way. To further elucidate this integrative approach, Ringel (2012) wrote a case study wherein an assimilative integrative treatment model for trauma was utilized. The treating therapist appeared to exhibit a firm grounding in relational psychodynamic therapy but later (around two years into treatment) incorporated EMDR to more specifically target and reprocess the traumatic memories stored in the patient's right hemisphere.

Common Factors Approach. The Common Factors approach is quite different than the aforementioned forms of integration. This approach "emphasizes the core

ingredients that different forms of therapy have in common with another (e.g., the therapeutic alliance)" (Boswell et al., 2010, p. 185). In general, all orientations have specific "common factors" that account for the variance in most research studies, the primary common factor being the therapeutic relationship. Factors most often affecting the therapeutic relationship include genuineness, empathy, and unconditional positive regard. If a common factors integrationist were to read the studies explicated in the current paper, he or she might notice that a common factor across these studies is the exploration and processing of the trauma. While this is a common factor among orientations, individual theoretical orientations process trauma differently. The CBT approach utilizes prolonged and in vivo exposures, EFTT utilizes the imagined confrontation task (IC) or the empathic exploration technique (EE), EMDR utilizes bilateral stimulation in order to assimilate the traumatic memories, and Psychodynamic Therapy utilizes exploration of the trauma and how it is re-enacted in various relationships over time both inside and outside the analytic dyad. As such, the common factor across the studies would be that the processing of the trauma is a key effective element in the treatment of Complex PTSD. Accordingly, this approach would be intentional about incorporating some form of trauma reprocessing into the treatment strategy.

A Conceptually Based Approach to an Integrative Process

Given the variety of approaches to integration and the possible clinical benefits of engaging in the process of psychotherapy integration, this final section aims to contend that an assimilative approach to psychotherapy integration, while being grounded in a

conceptual understanding of Complex PTSD and the patient's presenting complaint, may in fact be the most effective in real world clinical practice. Accordingly, it is argued that effective integrated treatment will exhibit: (a) a thorough assessment of symptomology resulting in a conceptual understanding of the patient's functioning and subsequent needs (i.e., a thorough case conceptualization based on clinical data gathered via interview and/or psychological testing); and (b) implementation of treatment wherein there is a certain level of adherence to one's particular orientation while also incorporating research-based intervention approaches and/or techniques that will appropriately supplement treatment.

Assessment and case conceptualization. As already mentioned, there are no psychological instruments designed specifically to assess for the presence of Complex PTSD. Nevertheless, a thorough assessment is necessary in order to develop a clear picture of the patient's functioning in each symptom domain (e.g., affective, cognitive, interpersonal, intrapersonal, somatic, behavioral) in order to develop a conceptual understanding of the patient's particular needs assumed to be met through treatment. In other words, a thorough understanding of the patient's presenting problem is necessary in order to develop a working treatment plan, whether that be an explicit plan or one that the clinician holds tentatively in his/her own mind. For instance, Courtois and Ford (2009) stated in regard to the assessment and treatment of individuals suffering from Complex PTSD, that, "Obviously, treatment goals are linked to the integrated assessment findings and to the client's identified needs" (p. 89).

As a result of the lack of instruments to assess symptoms of Complex PTSD, the clinician must be intentional and thorough in the assessment approach. For example, as was the case with the research reviewed in this paper, the clinician may opt to administer a brief battery of tests in order to investigate the presence of symptoms in various domains (e.g., presence of PTSD symptoms, affect regulation problems, degree of dissociation). Other clinicians may opt to start with a biopsychosocial interview that is modified to include questions about various symptoms expected to be present among the survivor population. Courtois and Ford (2009) stated, "the recommended strategy is to start with a general biopsychosocial assessment and move toward trauma-focused screenings, tests, and[/or], interviews, as indicated" (p. 89). This assessment and subsequent case conceptualization then informs the implementation of treatment.

Implementation of a flexible treatment. Once an assessment and some conceptual understanding of the patient's needs and consequent treatment goals have been ascertained, the clinician is to use this understanding to tailor treatment to that particular patient. For example, if assessment data and history point to a particular affective or interpersonal regulatory problem, it may be in the best interest of the patient for the clinician to begin treatment with skills training in affective and/or interpersonal regulation (STAIR; Cloitre, Cohen, & Koenen, 2006). Other patients may present with overregulated affect wherein interventions that will facilitate the experience and expression of affect may be important (EFTT; Paivio & Nieuwenhuis, 2001). Still others may present with dissociation, depersonalization, and/or derealization such that early phases of treatment should pay particular attention to grounding exercises and bodywork.

This is not to say that a different theoretical orientation need be used to address symptoms in each different domain. On the contrary, each orientation has methods of addressing each of these symptom domains to some degree. Just as Boswell et al. (2010) stated, "many techniques of divergent origins can be technical manipulations of the same therapeutic function" (p. 5). For instance, if a traumatized patient exhibits an irrational negativistic view of self and others, a CBT therapist may utilize cognitive restructuring in order to alter maladaptive thoughts and beliefs; a Psychodynamic therapist can accomplish the same therapeutic goal by exploring the transferential relationship and offering interpretations that link ones early experience to their current perception and experience of self and others. Does this mean that each orientation can accomplish the same therapeutic functions via technical manipulations? Generally speaking, it is possible; however, each patient is unique and will respond differently to divergent techniques. Accordingly, an assimilative integrative approach to treatment would be one that is a process by which the therapist allows him or herself to be flexible in tailoring treatment to the patient's individual needs; if a Psychodynamic therapist is exploring the transference in order to uncover internalized views of self and others and finds him or herself treating a patient that does not respond well to that intervention approach (e.g., the patient is low functioning and cannot tolerate an intervention that may evoke some degree of regression), he or she should be flexible in adapting other interventions that may be more suitable for that individual person. It is possible, however, that these adjustments in interventions may borrow or be technical manipulations from a different orientation temporarily employed in the treatment to meet the individual needs of the

client. As a more specific example, individuals suffering from Complex PTSD need to reprocess their trauma (the intended therapeutic function). If a patient does not respond well to an intervention, such as prolonged exposure (as is often the case as demonstrated by high dropout rates), a less invasive approach should be used, for example empathic exploration of the trauma.

The different theoretical orientations presented in this paper have shown themselves to be effective in treating Complex PTSD. Thus, while each orientation may have a way of addressing different symptom domains, each theoretical orientation has its own relative strength and weakness in conceptualizing and targeting each symptom. For instance, EFTT at a conceptual and scientific level (e.g., being grounded in emotion theory) likely exhibits a more in-depth understanding of the emotional processes at play for those suffering from Complex PTSD. As such, EFTT likely holds more effective intervention strategies to access and process emotions associated with the trauma. Psychodynamic Therapy at a conceptual level likely exhibits a more in depth understanding of the intrapsychic processes at play and how they are re-enacted interpersonally. Consequently, Psychodynamic Therapy is likely more effective in exploring the intrapsychic world of the patient and linking that to his or her own relational patterns. CBT likely has a greater understanding of cognitive distortions and the interventions to target those. Finally, EMDR likely has a greater understanding of the brain processes including memory systems and how those memories can be activated, processed, and integrated via bilateral stimulation. Clinicians may keep in mind these relative strengths when considering alternative interventions for each respective patient.

The various possibilities of presenting complaints are as vast as the number of individuals seeking treatment. Consequently, one must be versatile in his or her therapeutic approach insofar as the clinician must have an understanding of what specific interventions are purported to be effective in managing or treating various psychological problems. It is important to note, however, that the goal of treatment is not a trial-by-error approach wherein the clinician bandages each symptom via the use of divergent theoretical techniques. Rather, these preliminary considerations and interventions are intended to "shore up" the patient's internal and external resources and to further develop inherent capacities (e.g., affect and interpersonal regulation, mentalization, integration) to move into later stages of treatment (i.e., trauma reprocessing).

As has been discussed, there is a necessity on the part of the clinician to be well versed in a range of evidence-based intervention approaches for various psychological problems; however, the clinician must work from an orientation that he or she knows well. Only then can the clinician ascribe interventions from divergent theoretical orientations to the treatment approach. By doing this, the clinician maintains some level of integration and cohesion within him or herself that will then lead the patient to feel that the treatment is not artificially fractured and disjointed. In other words, if a clinician, in a disorderly fashion, implements various therapeutic techniques without a solid theoretical framework through which the clinician works, the patient will likely end up feeling dysregulated, confused, and subsequently misunderstood. This is the reason that an assimilative integrative approach is likely most appropriate for those suffering from Complex PTSD. It lends itself to a certain degree of fluidity in order to target the

multifaceted symptom presentations of those suffering from Complex PTSD. At the same time, it maintains adherence to one's own theoretical orientation, which will subsequently be experienced as regulating and containing for the patient.

Boswell et al. (2010), although not speaking directly to Complex PTSD treatment, also contend that an assimilative integrative approach is most advantageous. They stated: "We think that case formulations and treatment plans are optimized when anchored within a specific theoretical approach (e.g., cognitive-behavioral, psychodynamic, humanistic), while simultaneously incorporating techniques from other orientations that might address the observed limitations of one's preferred approach" (pp. 3-4). In order to target each symptom domain and acknowledge various limitations of each theoretical orientation, the treatment must lend itself to a particular kind of flexibility that is still experienced by the patient as integrated, cohesive, and whole. For instance, Boswell et al. (2010) stated: "Competence is achieved when psychotherapists can employ the appropriate evidence-based practices in a responsive and coherent manner" (p. 9).

In further support of an assimilative approach, if the aim of treatment is to essentially create new ways of being and relating, as is often the case for most individuals, treatment should presumably model such goals, and the clinician should be open to new ways of being and relating with each particular patient. Scaturo (2012) also argued for this type of flexibility in treatment:

> In sum, the emotional disturbance of our young patient will *of course* show up intrapsychically, interpersonally, behaviorally, [somatically], and cognitively. Intervention at any of these levels of theoretical abstraction is reasonable. The recognition of each of these levels of intervention affords the clinician the option to attempt intervention at one level of conceptualization and, in the event that this course of treatment is less than successful, "go back to the case formulation

> drawing board" as needed to see if intervention at another level of conceptualization is possible and perhaps more effective. Recognition of all of these facets, addressing and integrating elements of each in the course of the patient's treatment, provides a comprehensiveness of care that every patient deserves and every trainee should be able to conceptualize. (p. 189)

This quote illustrates the importance of working at multiple layers of abstraction (e.g., affective, cognitive, behavioral, etc.) or targeting each symptom domain via the use of "intervention at another level of conceptualization" (Scaturo, 2012, p. 189). This approach may be misconstrued as a trial-by-error method wherein the clinician fails to achieve a particular therapeutic goal via a particular intervention and subsequently "picks" another technique. In some instances, resistance to treatment may be the moderating variable by which the intervention approach was ineffective. Thus, it is important for the clinician to reflect on the dynamics of the interpersonal exchange in the therapeutic dyad in order to explore the degree to which the failure of a particular intervention approach can be attributed to treatment resistance or a poor match between the patient's need and the intervention to meet the need.

Summary of an Integrative Approach

Each individual suffering from Complex PTSD will present to treatment differently. He or she will exhibit a multiplicity of mild to severe symptoms that are affective, cognitive, intrapersonal, interpersonal, somatic, and behavioral in nature. The most comprehensive and integrated treatment approach would be one that addresses each symptom cluster while also rendering the space for the patient to be seen as a whole rather than a conglomeration of symptoms "needing treatment." The way in which this may be accomplished is through a thorough assessment of the patient's needs and the

tailoring of treatment to best meet those needs. This is not to be achieved by treating each particular symptom via the use of diverse theoretical interventions without a basis in one particular approach, but through adherence to one's own theoretical orientation. This will offer a sense of competence and cohesion, while simultaneously assimilating other intervention approaches as needed (e.g., prolonged exposure, imagined confrontation, empathic exploration of the trauma, exploring relational patterns replicating the trauma) in order to meet particular needs of the patient and/or to address limitations of a particular theoretical orientation.

> A competent integrative psychotherapist is aware of the change process he or she is attempting to facilitate, the client characteristics that indicate (or contraindicate) the use of a specific technique (or set of techniques) to facilitate this process, as well as when and how to effectively employ these interventions. (Boswell et al., 2010, p. 5)

As was previously stated, the aim of this section is not to prescribe a particular type of psychotherapy or develop an integrated treatment product, but rather to argue for a process orientated, flexible approach to treatment that may better meet the various troubles with which the trauma survivor presents. Moreover, although this paper argues for the implementation of a particular "type" of integration (i.e., assimilative) that presumably may best meet the needs of trauma survivors, this is merely one possible processes-oriented approach among several that are likely to be just as uniquely advantageous. This paper also does not aim to argue that pure form psychotherapies are arguably less effective; this paper has reviewed several orientations that have demonstrated efficacy and effectiveness in treating Complex PTSD. However, in some of the studies reviewed, high attrition rates were of concern. Ostensibly, a more flexible

approach may have provided the space for an exploration of what was not working within the treatment in order to adapt to the need of that particular individual.

There is an old Latin proverb that states, “Cave ab homine unius libri” which translates to mean, “Be cautious of the man of one book.” Scaturo (2012) applied this concept to patients and other “mental health consumers” and stated, “Be cautious of the psychotherapist with one manual” (p. 187).

Conclusion

The objective of this paper was to identify the important elements of effective treatments for Complex PTSD in order to make an argument for the use of an integrated treatment approach rooted in a conceptual understating of the multifaceted symptoms and subsequent needs of this clinical population.

In order to accomplish this objective, this paper reviewed various etiological factors and definitions of Complex PTSD, and the pervasive symptoms coupled with this psychopathological syndrome. It also summarized several outcome studies from divergent theoretical orientations demonstrating variant levels of efficacy and effectiveness, and addressed the nuanced methodological and statistical limitations embedded in the design of these studies. Supplemental research exploring expert clinicians’ and survivors’ perceptions on effective treatments, and the benefits and challenges associated with talking therapy services, was also included in order to offer the reader insight into real world clinical practice that was not simplified by laboratory constraints. After these quantitative and qualitative research findings were elucidated, the

paper then argued that an Assimilative Integrative approach to treatment would likely best meet the needs of those tormented by Complex PTSD.

In concluding this paper, the reader is reminded of the quote that introduced the acknowledgments of this paper. Dostoevsky stated, “Don’t let us forget that the causes of human actions are usually immeasurably more complex and varied than our subsequent explanations of them.” While this paper aimed to narrow, simplify, and explain Complex PTSD and investigate evidence-based treatments for this construct, the human condition is “immeasurably more complex” than scientific investigation lends itself to, *ipso facto* the reader is urged to blend this scholarly information with an artful form of relating, seated in an unassuming, subjectively centered treatment approach in order to foster a deeper, more authentic encounter with those individuals seeking healing, growth, and above all, human connectedness.

REFERENCES

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

American Psychiatric Association. (to be released 2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Andrea, W. D., & Pole, N. (2011). A naturalistic study of the relation of psychotherapy process to changes in symptoms, information processing, and physiological activity in complex trauma. *Psychological Trauma: Theory, Practice, and Policy, 4*, 438-446. doi: 10.1037/a0025067

Bagby, M. R., Parker, J. D. A., & Taylor, G. (1993). The twenty-item Toronto alexithymia scale: I. Item selection and cross-validation of the factor structure. *Journal of Psychosomatic Research, 38,* 23-32. doi: 10.1016/0022-3999(94)90005-1

Balint, M. (1968). *The basic fault.* London, UK: Tavistock.

Barlow, D., Craske, M., Cerney, J. A., & Klosko, J. S. (1989). Behavioral treatment of panic disorder. *Behavior Therapy, 20,* 261-268. doi: 10.1016/S0005-7894(89)80073-5

Battle, C., Imber, S., Hoen-Saric, R., Stone, A., Nash, E., & Frank, J. (1966). Target complaints as criteria of improvement. *American Journal of Psychotherapy, 20,* 184-192.

Beck, A. T., & Steer, R. A. (1993). *Manual for the Beck depression inventory.* San Antonio, TX: Psychological Corporation.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Beck depression inventory-II manual* (2nd ed.). San Antonio, TX: Psychological Corporation.

Beck, A. T., Steer, R. A., & Garbing, M. G. (1988). Psychometric properties of the Beck depression inventory: Twenty-five years of evaluation. *Clinical Psychology Review, 8,* 77-100. doi: 10.1016/0272-7358(88)90050-5

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventoryfor measuring depression. *Archives of General Psychiatry, 4,* 561-571. doi: 10.1001/archpsyc.1961.01710120031004

Beck, J. (1995). *Cognitive therapy: Basics and beyond.* New York, NY: Guilford Press.

Benjamin, L. S. (1988). *SASB short form users manual.* Salt Lake City, UT: Intrex Interpersonal Institute.

Bernstein, E. M., & Putman, F. W. (1986). Development, reliability and validity of a dissociation scale. *Journal of Nervous and Mental Disease, 174,* 727-735. doi: 10.1097/00005053-198612000-00004

Blagys, M. D., & Hilsenroth, M. J. (2000). Distinctive of short-term psychodynamic-interpersonal psychotherapy: A review of the comparative psychotherapy process literature. *Clinical Psychology: Science and Practice, 7,* 167-189. doi: 10.1093/clipsy/7.2.167

Blake, D. D., Weather, F. W., Nagy, L. M., Kaloupek, D. G., Gusman, F. D., Charney, D. S., & Keanne, T. M. (1995). The development of a clinician-administered PTSD scale. *Journal of Traumatic Stress, 8,* 75-90. doi: 10.1002/jts.2490080106

Boswell, J. F., Nelson, D. L., Nordberg, S. S., McAleavey, A. A., & Gastonguay, L. G. (2010). Competency in integrative psychotherapy: perspectives on training and supervision. *Psychotherapy Theory, Research, Practice, Training, 47,* 3-11. doi: 10.1037/a0018848

Briere, J. (1992). *Child abuse trauma: Theory and treatment of the lasting effects*. Newbury Park, CA: Sage.

Briere, J. (1995). *Trauma symptom inventory (TSI).* Odesssa, FL: Psychological Assessment Resources.

Briere, J. (2002). Treating adult survivors of severe childhood abuse and neglect: Further development of an integrative model. In J. E. B. Myers, L. Berline, J. Briere, C. T. Hendrix, T. Redi, & C. Jenny (Eds.), *The APSAC handbook on child maltreatment* (2nd ed.). (pp. 175-202). Newbury Park, CA: Sage.

Briere, J, & Runtz, M. (1990). Augmenting Hopkins SCL scales to measure dissociative symptoms: Data from nonclinical samples. *Journal of Personality Assessment 55,* 376-379. doi: 10.1207/s15327752jpa5501&2_35

Briere, J., & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment.* Thousand Oaks, CA: Sage.

Brown, D. P., & Fromm, E. (1986). *Hypnotherapy and hypnoanalysis.* Hillsdale, NJ: Erlbaum Associates.

Butler, G., Fennell, M., Robson, D., & Gelder, M. (1991). Comparison of behavior therapy and cognitive-behavior therapy in the treatment of generalized anxiety disorder. *Journal of Consulting and Clinical Psychology, 59,* 167-175. doi: 10.1037/0022-006X.59.1.167

Cantanzaro, S. J., & Mearns, J. (1990). Measuring generalized expectations for negative mood regulation: Initial scale development and implications. *Journal of Personality Assessment, 54,* 546-563. doi: 10.1207/s15327752jpa5403&4_11

Carlson, E. B., Putnam, F. W., Ross, C. A., Torem, M., Coons, P., Dill, D. L. (1993). Validity of the dissociative experiences scale in screening for multiple personality disorder: A multicenter study. *American Journal of Psychiatry, 150,* 1030-1036.

Chard, K. M. (1997). *Cognitive processing therapy for sexual abuse: Therapist adherence and competence protocol.* Unpublished manuscript, University of Kentucky.

Chard, K. M. (2005). An evaluation of cognitive processing therapy for the treatment of posttraumatic stress disorder related to childhood sexual abuse. *Journal of Consulting and Clinical Psychology, 73,* 965-971. doi: 10.1037/0022-006X.73.5.965

Chouliara, Z., Karatzias, T., Scott-Brien, G., MacDonald, A., MacArthur, J., & Frazer, N. (2011). Talking therapy services for adult survivors of childhood sexual abuse (CSA) in Scotland: Perspectives of service users and professionals. *Journal of Child Sexual Abuse, 20,* 128-156. doi: 10.1080/10538712.2011.554340

Classen, C. C., Pain, C., Field, N. P., & Woods, P. (2006). Posttraumatic personality disorder: A reformulation of complex posttraumatic stress disorder and borderline personality disorder. *Psychiatric Clinics of North America, 29,* 87-112. doi: 10.1016/j.psc.2005.11.001

Cloitre, M. (2009). Effective psychotherapies for posttraumatic stress disorder: A review and critique. *CNS Spectrums, 14*, 32-43.

Cloitre, M. Cohen, L. R., & Han, H. (2002). Skills training in affective and interpersonal regulation followed by exposure: A phase-based treatment for PTSD related to childhood abuse. *Journal of Consulting and Clinical Psychology, 5,* 1067-1074. doi: 10.1037/0022-006X.70.5.1067

Cloitre, M., Cohen, L. R., & Koenen, K. C. (2006). *Treating survivors of childhood abuse: Psychotherapy for the interrupted life.* New York, NY: Guilford Press.

Cloitre, M., Courtois, C. A., Charuvastra, A., Carapezza, R., Stolbach, B. C., & Green, B. L. (2011). Treatment of complex PTSD: Results of the ISTSS expert clinician survey on best practices. *Journal of Traumatic Stress, 24,* 615-627. doi: 10.1002/jts.20697

Cloitre, M., Stolbach, C. B., Herman, J. L., van der Kolk, B., Pynoos, R., Wang, J., & Petkova, E. (2009). A developmental approach to complex PTSD: Childhood and adult cumulative trauma as predictors of symptom complexity. *Journal of Traumatic Stress, 22,* 399-408. doi: 10.1002/jts.20444

Cohen, S., & Hoberman, H. (1983). Positive events and social supports as buffers of life change stress. *Journal of Applied Social Psychology, 13,* 99-125. doi: 10.1111/j.1559-1816.1983.tb02325.x

Cook, W., & Medley, O. (1954). Proposed hostility and pharisaic-virtue scales for the MMPI. *Journal of Applied Psychology, 38,* 414-418. doi: 10.1037/h0060667

Courtois, J. D. (2006). Complex trauma, complex reactions: Assessment and treatment. *Psychological Trauma: Theory, Research, Practice, and Policy, 1,* 86-100. doi: 10.1037/1942-9681.S.1.86

Courtois, C A., & Ford, J. D. (2009). Defining and understanding complex trauma and complex traumatic stress disorders. In C. A. Courtois & J. D. Ford (Eds.), *Treating Complex Traumatic Stress Disorders: An Evidence Based Guide* (pp. 13-31). New York: Guilford Press.

Dancu, C. V., & Foa, E. B. (1992). Posttraumatic stress disorder. In A. Freeman & F. M. Dattilio (Eds.), *Comprehensive casebook of cognitive therapy* (pp. 79-88). New York, NY: Plenum Press.

Davies, J. M., & Frawley, M. G. *Treating the adult survivor of childhood sexual abuse: A psychoanalytic perspective*. New York, NY: Basic Books.

Denzin, N. K. (1978). *The research act: A theoretical introduction to sociological methods* (2nd ed.). New York, NY: McGraw Hill.

Derogatis, L. R. (1993). *SCL-90-R administration, scoring, and procedures manual for the revised version.* Towson, MD: Clinical Psychiatric Research.

Dobson, K. S. (1989). A meta-analysis of the efficacy of cognitive therapy for depression. *Journal of Consulting and Clinical Psychology, 57,* 414-419. doi: 10.1037/0022-006X.57.3.414

Draucker, C. B. (1997). The emotional impact of sexual violence research on participants. *Archives of Psychiatric Nursing, 13,* 161-169. doi: 10.1016/S08839417 (99)80002-8

Draucker, C. B., Martsold, D. S., & Poole, C. (2009). Developing distress protocols for research on sensitive topics. *Archives of Psychiatric Nursing, 23,* 343-350. doi: 10.1016/j.apnu.2008.10.008

Edmond, T., Rubin, A., & Wambach, K. G. (1999). The effectiveness of EMDR with adult female survivors of childhood sexual abuse. *Social Work Research, 23,* 103-116. doi:10.1093/swr/23.2.103

Edmond, T., Sloan, L., & McCarty, D. (2004). Sexual abuse survivors' perceptions of the effectiveness of EMDR and eclectic therapy. *Research on Social Work Practice, 14,* 259-272. doi: 10.1177/1049731504265830

Elliot, R. (1985). Helpful and nonhelpful events in brief counseling interviews: An empirical taxonomy. *Journal of Counseling Psychology, 32,* 307-322. doi: 10.1037/0022-0167.32.3.307

Elliot, R., Watson, J. C., Goldman, R. N., & Greenberg, L. S. (2004). *Learning emotion focused therapy*. Washington, DC: American Psychological Association.

Ellis, A. (1962). *Reason and emotion in psychotherapy.* New York, NY: Lyle Stuart.

Escalona, R., Tupler, L. A., Saur, C. D., Krishnan, R. R., & Davidson, J. R. T. (1997). Screening for trauma history on an inpatient affective-disorders unit: A pilot study. *Journal of Traumatic Stress, 10,* 299-305. doi: 10.1023/A:1024886314370

Fairbairn, W. R. D. (1952). *An object-relations theory of the personality.* New York, NY: Basic Books.

Falsetti, S. A., Resnick, H. S., Resick, P. A., & Kilpatrick, D. G. (1993). The modified PTSD symptoms scale: A brief self-report measure of posttraumatic stress disorder. *The Behavior Therapist, 16,* 161-162. doi: 10.1037/t05175-000

Fine, C. G. (1990). The cognitive sequelae of incest. In R. Kluft (Ed.), *Incest related syndromes of adult psychopathology* (pp. 161-182). Washington, DC: American Psychiatric Press.

Fish-Murray, C. C., Koby, E. V., & van der Kolk, B. A. (1987). Evolving ideas: The effect of abuse on children's thought. In B. A. van der Kolk (Ed.), *Psychological trauma* (pp. 89-110). Washington, DC: American Psychiatric Press.

Foa, E. B. (1995). *Posttraumatic stress diagnostics scale.* Minneapolis, MN: National Computer Systems.

Foa, E. B., Dancu, C. V., Hembree, E. A., Jaycox, L. H., Meadows, E. A., & Street, G. P. (1999). A comparison of exposure therapy, stress inoculation training, and their combination for reducing posttraumatic stress disorder in female assault victims. *Journal of Consulting and Clinical Psychology, 67,* 194-200. doi: 10.1037/0022-006X.67.2.194

Foa, E. B., & Rothbaum, B. O. (1998). *Treating the trauma of rape.* New York, NY: Guilford Press.

Fosha, D. (2000). *The transforming power of affect: A model for accelerated change.* New York, NY: Basic Books.

Frisch, M. B. Cornell, J., Villanueva, M., & Retzlaff, P. J. (1992). Clinical validation of the quality of life inventory: A measure of life satisfaction for use in treatment planning and outcome assessment. *Psychological Assessment, 4,* 92-101. doi: 10.1037/1040-3590.4.1.92

Greenwald, R. (1994). Eye movement desensitization and reprocessing (EMDR): An overview. *Journal of Contemporary Psychotherapy, 24,* 15-34. doi: 10.1007/BF02306581

Hamilton, M. (1960). A rating scale for depression. *Journal of Neurology, Neurosurgery, and Psychiatry, 23,* 56-61. doi: 10.1136/jnnp.23.1.56

Hartman, H. (1939). *Ego psychology and the problem of adaptation.* New York, NY: International Universities Press.

Hatcher, R. L. (1999). Therapists' views of treatment alliance and collaboration in therapy. *Psychotherapy Research, 9,* 405-423. doi: 10.1093/ptr/9.4.405

Hatcher, R. L., & Barends, A. W. (1996). Patients' view of the alliance in psychotherapy: Exploratory factor analysis of three alliance measures. *Journal of Consulting and Clinical Psychology, 64,* 1326-1336. doi: 10.1037/0022-006X.64.6.1326

Hatcher, R. L., Barends, A. W., Hansell, J., & Gutfruend, M. (1995). Patients' and therapists' shared and unique views of the therapeutic alliance: An investigation using confirmatory factor analysis in a nested design. *Journal of Consulting and Clinical Psychology, 63,* 636-643. doi: 10.1037/0022-006X.63.4.636

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2012). *Acceptance and commitment therapy: The process and practice of mindful change* (2nd ed.). New York, NY: Guilford Press.

Herman, J. L. (1992a). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress, 5,* 377-391. doi: 10.1002/jts .2490050305

Herman, J. L. (1992b). *Trauma and recovery: The aftermath of violence – From domestic to political terror.* New York, NY: Basic Books.

Holowaty, K. A., & Paivio, S. C. (2000). *Client perceptions of helpful therapy process in emotion-focused therapy for trauma.* Windsor, ON, Canada: Unpublished manuscript, University of Windsor.

Holowaty, K. A., & Paivio, S. C. (2012). Characteristics of client-identified helpful events in emotion-focused therapy for child abuse trauma. *Psychotherapy Research, 22,* 56-66. doi: 10.1080/10503307.2011.622727

Horowitz, L. M., Rosenberg, S. E., Baer, B. A., Ureno, G., & Villasenor, V. S. (1988). Inventory of interpersonal problems: Psychometric properties and clinical applications. *Journal of Consulting and Clinical Psychology, 56,* 885-892. doi: 10.1037/0022-006X.56.6.885

Horowitz, M. J., Wilner, N., & Alvarez, W. (1979). Impact of event scale: A measure of subjective stress. *Psychosomatic Medicine, 41,* 209-218.

Horowitz, M. D. (1986). *Stress response syndromes* (2nd ed.). Northvale, NJ: Aronson.

Ironson, G., Freud, B., Strauss, J. L., & Williams, J. (2002). Comparison for two treatments for traumatic stress: A community-based study of EMDR and prolonged exposure. *Journal of Clinical Psychology, 58,* 113-128. doi: 10.1002/jclp.1132

Jehu, D., Gazan, M., & Klassen, C. (1985). Common therapeutic targets among women who were sexually abused in childhood. *Journal of Social Work and Human Sexuality, 3,* 25- 45. doi: 10.1300/J291v03n02_03

Karen, R. (1994). *Becoming attached: First relationships and how they shape our capacity to love.* New York, NY: Oxford Press.

Kazdin, A. E. (2003) *Research design in clinical psychology* (4th ed.). Boston, MA: Allyn & Bacon.

Klein, M. (1957). *Envy and gratitude and other works: 1946 – 1963.* New York: Delacorte.

Klein, M. H., Mathieu-Coughlan, P., & Kiesler, D. J. (1986). The experiencing scales. In L. S. Greenberg & W. M. Pinsoff (Eds.), *The psychotherapeutic process: a research handbook* (pp. 21-71). New York, NY: Guilford.

Kohut, H. (1971). *The analysis of self.* New York: International Universities Press.

Krinsley, K. E., Weathers, F. W., Vielhauer, M. J., Newman, E., Walker, E. A., & Kaloupek, D. G. (1994). *Evaluation of lifetime stressors interview.* Unpublished manuscript, National Center for Posttraumatic Stress Disorder, Behavioral Science Division, Boston, MA.

Krupnick, J. L. (2002). Brief psychodynamic treatment of PTSD. *Journal of Clinical Psychology, 58,* 919-932. doi: 10.1002/jclp.10067

Lambert, M. (1991). Introduction to psychotherapy research. In L. Beutler, & L. Crago (Eds.), *Psychotherapy Research.* Washington DC: American Psychological Association.

Leichsenring, F. (1997). *Borderline – Persönlichkeits – Inventar (BPI), Manual.* Göttingen, Germany: Hogrefe.

Leichsenring, F. (1999). Development and first results of the borderline personality inventory: A self-report instrument for assessing borderline personality organization. *Journal of Personality Assessment, 73*(1), 45-63. doi: 10.1207/S15327752JPA730104

Linehan, M. M. (1993). *Cognitive-behavioral treatment for borderline personality disorder.* New York, NY: Guilford Press.

Machado, P., Beutler, L. E., & Greenberg, L. S. (1999). Emotion recognition in psychotherapy: Impact of therapist level of experience and emotional awareness. *Journal of Clinical Psychology, 55,* 39-57. doi: 10.1002/(SICI)1097-4679(199901)55:1<39::AID-JCLP4>3.0.CO;2-V

McDonagh, A., McHugo, G., Sengupta, A., Demment, C. C., Schnurr, P. P., Friedman, M., Ford, … Descamps, M. (2005). Randomized trial of cognitive-behavioral therapy for chronic posttraumatic stress disorder in adult female survivors of childhood sexual abuse. *Journal of Consulting and Clinical Psychology, 73,* 515-524. doi: 10.1037/0022-006X.73.3.515

Meichenbaum, D. (1977). *Cognitive-behavior modification: An integrative approach.* New York, NY: Plenum Press.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52,* 250-260. doi: 10.1037/0022-0167.52.2.250

Nijdam, M. J., Gerson, B. P. R., Reitsma, J. B., de Jong, A., & Olff, M. (2012). Brief eclectic psychotherapy vs. eye movement desensitization and reprocessing therapy for post-traumatic stress disorder: Randomized controlled trial. *The British Journal of Psychiatry, 200,* 224-231. doi: 10.1192/bjp.bp.111.099234

Norcross, J. C., & Halgin, R. P. (2005). Training in psychotherapy integration. In J. C. Norcross & M. R. Golfried (Eds.). *Handbook of psychotherapy integration.* (2nd ed.). (pp. 439-458). New York, NY: Oxford University Press.

Okiishi, J. C., Lambert, M. J., Eggett, D., Nielsen, L., Dayton, D. D., & Vermeersch, D. A. (2006). An analysis of therapist treatment effects: Toward providing feedback to individual therapists on their clients' psychotherapy outcomes. *Journal of Clinical Psychology, 62,* 1157-1172. doi: 10.1002/jclp.20272

Paivio, S. C. (1996). *Changing dysfunctional emotional processes stemming from childhood abuse.* Unpublished manuscript. University of Saskatchewan, Saskatoon, SK, Canada.

Paivio, S. C., Jarry, J. L., Chagigiorgis, H., Hall, I., & Ralston, M. (2010). Efficacy of two versions of emotion-focused therapy for resolving child abuse trauma. *Psychotherapy Research, 20,* 353-366. doi: 10.1080/10503300903505274

Paivio, S. C., & Nieuwenhuis, J. A. (2001). Efficacy of emotion focused therapy for adult survivors of childhood abuse: A preliminary study. *Journal of Traumatic Stress, 14,* 115-134. doi: 10.1023/A:1007891716593

Paivio, S. C., Pascual-Leone, A. (2010). *Emotion-focused therapy for complex trauma – An integrative approach.* Washington, DC: American Psychological Association.

Pearlman, L. A. (2001). Treatment of persons with complex PTSD and other trauma-related disruptions of the self. In J. P. Wilson, M. J. Friedman, & J. D. Lindy (Eds.), *Treating psychological trauma and PTSD* (pp. 205-236). New York, NY: Guilford Press.

Pelcovitz, D., van der Kolk, B. A., Roth, S., Mandel, F., Kaplan, S., & Resick, P. (1997). Development of a Criteria Set and a Structured Interview for Disorders of Extreme Stress (SIDES). *Journal of Traumatic Stress, 10,* 3-16. doi: 10.1023/A:1024800212070

Price, J. L., Hilsenroth, M. J., Callahan, K. L., Petretic-Jackson, P. A., & Bonge, D. (2004). A pilot study of psychodynamic psychotherapy for adult survivors of childhood sexual abuse. *Clinical Psychology and Psychotherapy, 11,* 378-391. doi: 10.1002/cpp.421

Reddemann, L. (2004). *Psychodynamisch Imaginative Traumatherapie. PITT-Das Manual.* Stuttgart, Germany: Pfeiffer bei Klett-Cotta.

Resick, P. A., Bovin, M. J., Calloway, A. L., Dick, A. M., King, M. W., Mitchell, K. S., Suvak, M. K., … Wolf, E. J. (2012). A critical evaluation of the complex PTSD literature: Implications for DSM-5. *Journal of Traumatic Stress, 25,* 241-251. doi: 10.1002/jts.21699

Resick, P. A., & Schnicke, M. K. (1993). *Cognitive processing therapy for rape victims: A treatment manual.* Newbury Park, CA: Sage.

Ringel, S. (2012). An integrative model in trauma treatment: Utilizing eye movement desensitization and reprocessing and a relational approach with adult survivors of sexual abuse. *Psychoanalytic Psychology.* Advance online publication. doi: 10.1037/a0030044

Rosenberg, M. (1989). *Society and the adolescent self image* (Rev. ed.). Middletown, CT: Wesleyan University Press.

Russell, D. E. H. (1986). *The secret trauma: Incest in the lives of girls and women.* New York, NY: Basic Book.

Sachsse, U., Vogel, C., & Leichsenring, F. (2006). Results of psychodynamically oriented trauma-focused inpatient treatment for women with complex posttraumatic stress disorder (PTSD) and borderline personality disorder (BPD). *Bulletin of the Menninger Clinic, 70,* 125-144. doi: 10.1521/bumc.2006.70.2.125

Scaturo, D. J. (2012). Supervising integrative psychotherapy in the 21st Century: Pressing needs, impressing possibilities. *Journal of Contemporary Psychotherapy, 42,* 183-192. doi:10.1007/s10879-011-9204-2

Schottenbauer, M. A., Arknoff, D. B., Glass, C. R., & Gray, S. H. (2006). Psychotherapy for PTSD in the community: Reported prototypical treatments. *Clinical Psychology & Psychotherapy, 13,* 108-122. doi: 10.1002/cpp.480

Seidler, G. H., & Wagner, F. E. (2006). Comparing the efficacy of EMDR and trauma-focused cognitive-behavioral therapy in the treatment of PTSD: a meta-analytic study. *Psychological Medicine, 36,* 1515-1522. doi: 10.1017/S0033291706007963

Shapiro, F. (1989). Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. *Journal of Traumatic Stress, 2,* 199-223. doi: 10.1002/jts.2490020207

Shapiro, F. (1995). *Eye movement desensitization and reprocessing: Basic principles: protocols, and procedures.* New York, NY: Guilford Press.

Shapiro, F., & Laliotis, D. (2011). EMDR and the adaptive information processing model: Integrative treatment and case conceptualization. *Clinical Social Work Journal, 39,* 191-200. doi: 10.1007/s10615-010-0300-7

Siegel, D. J. (1999). *The developing mind: Toward a neurobiology of interpersonal experience*. New York, NY: Guilford Press.

Sing, M. (1994). *Validation of measure of session outcome in the resolution of unfinished business.* Unpublished doctoral dissertation, York University, Toronto, Canada.

Spielberger, C. D. (1983). *Manual for the state-trait anxiety inventory* (Form Y; Self-evaluation questionnaire). Palo Alto, CA: Consulting Psychologists Press.

Spielberger, C. D. (1988). Anger Expression Scale. In M. Herson & A. S. Bellack (Eds.), *Dictionary of behavioral assessment techniques* (pp. 446-448). New York, NY: Pergamon Press.

Spielberger, C. D. (1991). *State-trait anger expression inventory* (Rev. research ed., professional manual). Odessa, FL: Psychological Assessment Resources.

Spielberger, C. D., Gorsuch, R. L., & Lushene, R. E. (1970). *Manual for the state-trait anxiety inventory.* Palo Alto, CA: Consulting Psychologists Press.

Spielberger, C. D., Gorsuch, R. L., Lushene, R. D., Vagg, P. R., & Jacobs, G. A. (1983). *Manual for the state-trait anxiety inventory.* Palo Alto, CA: Consulting Psychologist Press.

Spitzer, R. L., Williams, J. B., Gibbon, M., & First, M. B. (1994). *Structured clinical interview for DSM-IV-Patient edition.* New York: New York State Psychiatric Institute, Biometrics Research Department.

Stolorow, R., & Atwood, G. (1979). *Faces in a cloud: Subjectivity in personality theory.* New York, NY: Aronson.

Sullivan, H. S. (1963). *The interpersonal theory of psychiatry.* New York, NY: Norton.

Terr, L. C. (1991). Childhood traumas: An outline and overview. *American Journal of Psychiatry, 148,* 10-20.

Thoma, N. C., & Cecero, J. J. (2009). Is integrative use of techniques in psychotherapy the exception or the rule? Results of a national survey of doctoral-level practitioners. *Psychotherapy Theory, Research, Practice, Training, 46,* 405-417. doi:10.1037/a0017900

Tracey, T. J., & Kokotovic, A. M. (1998). Factors structure of the working alliance inventory. *Psychological Assessment, 10,* 207-210. doi: 10.1037/1040-3590.1.3.207

van der Kolk, B. A. (2005). Developmental trauma disorder: Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals, 35,* 401-408.

van der Kolk, B. A., McFarlane, A. C., & Weisaeth, L. (1996). *Traumatic stress: The effects of overwhelming experience on mind, body, and society.* New York, NY: Guilford.

van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress, 18,* 389-399. doi: 0.1002/jts.20047

Vitriol, V. G., Ballesteros, S. T. Florenzano, R. U., Weil, K. P., & Benadof, D. F. (2009). Evaluation of an outpatient intervention for women with severe depression and a history of childhood trauma. *Psychiatric Services, 60* (7), 936-942. doi: 10.1176/appi.ps.60.7.936

Wachtel, P. W. (2010). Psychotherapy integration and integrative psychotherapy: Process of product? *Journal of Psychotherapy Integration, 4,* 406-416. doi: 10.1037/a0022032

Wallin, D. J. (2007). *Attachment in psychotherapy*. New York, NY: Guilford Press.

Weathers, F. W., Keane, T. M., & Davidson, J. R. T. (2001). Clinician administered PTSD scale: A review of the first ten years of research. *Depression and Anxiety, 13,* 132-156. doi: 10.1002/da.1029

Weissman, E., & Bothell, S. (1976). Assessment of patient social adjustment by patient self-report. *Archives of General Psychiatry, 33,* 1111-1115. doi:10.1001/archpsyc.1976.01770090101010

Westen, D. (1995). Social cognition and object relations scale: Q-Sort for projective stories (SCORS-Q). Unpublished manuscript, Cambridge Hospital and Harvard Medical School, Cambridge, MA.

Winnicott, D. W. (1960). The theory of the parent-infant relationship. *International Journal of Psychoanalysis, 41,* 585-595.

Winnicott, D. W. (1965). *The maturational process and the facilitating environment.* New York, NY: International Universities Press.

Young, M. B. (1988). Understanding identity disruption and intimacy: One aspect of posttraumatic stress. *Contemporary Family Therapy, 10,* 30-43. doi: 10.1007/ BF00922431

VITA

NAME:

Jacob Russell Confer

EDUCATION:

Rosemead School of Psychology Clinical Psychology	PsyD (Cand.)	
Rosemead School of Psychology Clinical Psychology	MA	2010
Biola University Major: Psychology, Minor: Biblical Studies	BA	2008

INTERNSHIP:

Hamm Memorial Psychiatric Clinic St. Paul, MN	2012 - 2013

PRACTICA:

Patton State Psychiatric Hospital Clerkship Program	2011 - 2012
Biola Counseling Center Outpatient Program	2010 - 2011
La Habra School District	2009 - 2010
Biola Counseling Center Practicum Consortium	2009 - 2010

EMPLOYMENT:

Biola Counseling Center Psychotherapist	2011 - 2012