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# Nurturing Connections in the Aftermath of Childhood Trauma: A Randomized Controlled Trial of Emotionally Focused Couple Therapy for Female Survivors of Childhood Abuse

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Emotionally focused therapy (EFT) for couples is an empirically supported treatment for relationship distress (Johnson and Greenberg *Journal of Consulting and Clinical Psychology* 1985a;53:175–184; Johnson, *The practice of emotionally focused marital therapy: Creating connection.* New York: Brunner-Routledge, 2004). Despite strong evidence of a link between experiences of childhood abuse and problems in intimate relationships during adulthood (Paradis and Boucher, *Journal of Aggression, Maltreatment & Trauma* 2010;19:138–158; Walker *et al*., *Journal of Family Violence* 2009; 24:397–406), there have not yet been any controlled trials of the efficacy of EFT for adult survivors of childhood abuse. In light of evidence of the effectiveness of individual EFT in the treatment of the sequelae of complex trauma (Paivio and Pascual-Leone, *Emotion-focused therapy for complex trauma: An integrative approach.* Washington, DC: American Psychological Association, 2010), we conducted the first randomized controlled trial of EFT for couples in which the female partner had a history of intrafamilial childhood abuse. Our primary hypothesis was that couples treated with EFT would experience a significant reduction in relationship distress. To test this hypothesis, 24 couples in Toronto, Ontario, Canada (mean relationship length = 14 years), were randomly assigned to either a treatment group (24 sessions of EFT) or a control group (waiting list). Analyses of covariance with treatment condition as the fixed factor and baseline scores on the Dyadic Adjustment Scale (Spanier, *Journal of Marriage and the Family* 1976;38:15–28) as the covariate yielded a statistically significant effect of treatment group on relationship distress. Hierarchical regression analyses unveiled the particular circumstances under which EFT appeared to be effective. These results attest to the effectiveness of EFT for relational distress in trauma survivors and are discussed in light of the relevant clinical literature.

*Keywords:* emotionally focused couple therapy, EFT for couples, childhood abuse, treatment of relationship distress, trauma survivors



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Historically, researchers have paid greater attention to the intrapsychic effects of childhood abuse than to the interpersonal ones. As a result, the intrapsychic effects of childhood abuse have been well documented. Some of these include posttraumatic stress responses, dissociation, suicidal ideation, flashbacks, emotional avoidance, emotion dysregulation, and negative self-image (Briere, 1992). However, in recent decades, researchers have become increasingly interested in delineating the interpersonal sequelae of childhood abuse. These include insecure attachment, mistrust of others, concerns about abandonment, avoidance of intimacy, fear of closeness and vulnerability, sexualization of relationships, fear of betrayal, hypervigilance to potential harm by their partner, revictimization, and viewing themselves as undeserving of love (Classen, Field, Koopman, Nevill-Manning, & Spiegel, 2001). Although these interpersonal responses may be protective during childhood, later in life, they tend to impede the survivor's capacity to form close relationships, particularly relationships with romantic partners.

## The Relation Between Childhood Abuse and Couple Relationships in Adulthood

Research into this phenomenon suggests a strong link between abuse during childhood on the one hand and difficulty establishing and maintaining emotionally satisfying relationships during adulthood on the other. The evidence from recent studies suggests that people who suffer physical, emotional, or sexual abuse during childhood are more likely to experience distress in their relationships as adults than are people who do not suffer such abuse as children. For example, a survey by Paradis and Boucher (2010) found that those who reported emotional, physical, or sexual abuse and emotional or physical neglect by their caregivers as children were more likely to report significant problems in their couple relationships (e.g., emotional distance, difficulty asserting themselves and their needs) as adults. Similarly, Watson and Halford (2010) found that those who reported having endured sexual abuse perpetrated by friends, family members, or strangers as children were significantly more likely to report dissatisfaction with their couple relationships and to separate from or to divorce their husbands than women who did not experience any abuse.

In a large prospective study, Colman and Widom (2004) found that those who had been identified in official court records as having been sexually abused, physically abused, or neglected by caregivers during childhood reported higher rates of separation and divorce 25 years later than did matched controls. In addition, women in their sample expressed greater dissatisfaction with their couple relationships and exhibited significantly more incidents of sexual infidelity than did women in the control group who were not abused as children. These results parallel those generated in a twin study, in which women who had endured sexual abuse during childhood were more likely to divorce later in life than were their twins who had not been abused (Nelson et al., 2002). All these recent studies show a firm association between abuse during childhood and problems maintaining emotionally and sexually satisfying couple relationships as adults, especially among women (Rumstein-McKean & Hunsley, 2001).

## Childhood Abuse and Married Couples: Prevalence and Pathways of Influence

Given the potential for a profound negative impact on relational functioning in adulthood, the prevalence of a history of childhood abuse in intimate relationships is particularly alarming. Whisman (2006) reported that approximately one fifth of married women have experienced either sexual or physical childhood abuse (Whisman, 2006). This high rate of childhood abuse in married women and the association between abuse and relationship distress highlight the importance of understanding more about this phenomenon. A history of childhood abuse seems to create dual obstacles to forming close relationships in adulthood (Whiffen & Oliver, 2004): increased intrapsychic distress and impairment in the capacity for intimacy. As Kapeleris and Paivio (2011) have pointed out, " . . . childhood maltreatment sets up a cycle of painful interpersonal distance and insecurity" (p. 619).

Difficulty regulating the intense and sometimes intrusive emotional states related to past abuse also appears to play an important role in the diminished relationship quality that adult survivors of abuse tend to report (Kapeleris &

Paivio, 2011; Walker, Holman, & Busby, 2009). In addition, adults who experience abuse or neglect as children tend to display biased perceptions of others as harsh or demanding and to have an elevated need for comfort and reassurance, depending on the type of abuse that they endured as children (Drapeau & Perry, 2004). It is plausible that this kind of mistrust of other people and a heightened need for comfort might hinder the establishment of strong emotional ties to significant others.

## Emotionally Focused Therapy for Adult Survivors of Abuse

Despite this well-established link between childhood abuse among women and impaired functioning in intimate relationships in adulthood, there have been to date no controlled trials of empirically supported couple-based interventions for the treatment of childhood abuse survivors in distressed relationships.

### Individual Emotionally Focused Therapy for Trauma Survivors

In the individual therapy literature, there is evidence of the efficacy of emotionally focused therapy (EFT) for survivors of childhood abuse. Paivio and colleagues have found that process-experiential interventions with a focus on client affect can be effective at alleviating symptoms of complex trauma–related such abuse (Paivio & Nieuwenhuis, 2001; Paivio & Pascual-Leone, 2010). Individual EFT involves helping clients symbolize and work through their emotional responses to traumatic events through empathic evocative responding on the part of the therapist, and through a focus on creating safe interpersonal connections (Holowaty & Paivio, 2012). Specifically, Paivio and colleagues discovered in a number of separate investigations that clients who participated in individual EFT for trauma symptoms demonstrated significantly greater improvement than did clients in a waitlist control group (Paivio & Nieuwenhuis, 2001), that "imaginal confrontation" (i.e., Gestalt-based empty-chair work) of perpetrators of abuse was related to improvement in trauma symptoms among adult survivors of child abuse (Paivio, Hall, Holowaty, Jellis, & Tran, 2001), and that, similar to the results of process research into EFT for couples (see Greenman & Johnson, in press, for a review), clients rated events during therapy that involved more intense emotional experiencing as more helpful than those that involved less intense emotional experiencing (Holowaty & Paivio, 2012). All this suggests that the emotion-focused approach to the treatment of trauma and its interpersonal consequences is promising.

### Couple EFT for Trauma Survivors

Johnson (2002) suggests that couple therapy, and EFT in particular, might be useful for trauma survivors because EFT for couples, with its empirically derived steps and stages, is geared primarily toward the establishment and maintenance of strong and secure emotional bonds between partners, which is crucial to relationship satisfaction. As mentioned previously, however, the capacity to create and cultivate such ties seems to be impaired among survivors of childhood abuse (DiLillo & Long, 1999; Johnson, 2002), which might explain their low levels of relationship satisfaction.

## Empirical Support for EFT for Couples

There is extensive empirical support for EFT in physically and psychologically healthy individuals. The efficacy of EFT has been demonstrated by controlled trials (Denton, Burleson, Clark, Rodriguez, & Hobbs, 2000; Goldman & Greenberg, 1992; James, 1991; Johnson & Greenberg, 1985a), and two studies in which subjects served as their own controls (Johnson & Greenberg, 1985b; Johnson & Talitman, 1997). A meta-analysis of EFT outcome research (Johnson, Hunsley, Greenberg, & Schindler, 1999) revealed a mean effect size of 1.3 across studies reviewed, which is considerable in psychotherapy research. The effects of EFT also appear to be stable over time (Cloutier, Manion, Gordon Walker, & Johnson, 2002; Halchuk, Makinen, & Johnson, 2010). For these reasons, EFT is considered to be an evidence-based treatment for couple distress (Snyder, Castellani, & Whisman, 2006). There is also evidence of EFT's effectiveness for the treatment of couples in which one or both partners suffer from mental or physical illness (Cloutier et al., 2002; Couture-Lalande, Greenman, Naaman, & Johnson, 2007; Dessaulles, Johnson, & Denton, 2003; Gordon Walker, Johnson, Man-

ion, & Cloutier, 1996). However, to our knowledge, there have been to date no randomized controlled trials of the efficacy of EFT or of any other approach to couple therapy for relationship distress in which the female partner has been the victim of severe childhood abuse. There has been one study of the effects of cognitive–behavioral couple therapy on posttraumatic stress disorder and relationship satisfaction in combat veterans (Monson et al., 2011), but the only published study of the effects of couple therapy on the relationships of women experiencing symptoms of posttraumatic stress related to childhood sexual abuse (MacIntosh & Johnson, 2008) is a qualitative one with no control group.

### Goals of the Present Study and Hypotheses

The primary goal of the present study was to examine the impact of EFT on relationship distress in couples in which the female partner had a history of childhood abuse. We chose to focus on couples in which the female partner was a survivor of childhood abuse because of the striking prevalence of a history of abuse among women in married couples (Whisman, 2006). We decided to exclude couples in which both partners had a history of childhood abuse in keeping with our treatment model in which one partner assists the other in the recovery process. In addition, the inclusion of male partners with a history of childhood abuse might have confounded the findings. We predicted that men and women who participated in EFT for couples would exhibit significantly greater reductions in their relationship distress than would couples in the control group, and that these changes would be clinically and statistically significant.

Because the primary aim of this study was to determine whether EFT for couples would be effective at reducing relationship distress in men and women engaged in relationships in which the female partner had suffered from childhood abuse, we did not exclude couples in which the women had undergone substantial, and in some cases intensive, psychotherapy for their symptoms of abuse. We were also interested in whether our couple intervention might be related to a reduction in trauma symptoms, similar to Monson and colleagues' (2011) findings for combat veterans. A secondary hypothesis was therefore that female survivors of childhood abuse who received EFT would exhibit significantly greater reductions in trauma symptoms than would those in the control group.

## Method

### Participants

Thirty-two distressed couples in which the female partners had a history of childhood abuse (physical or sexual) enrolled in the study. Participants were recruited from the Trauma Therapy Program (a tertiary treatment program for survivors of childhood abuse) and from the Women's Mental Health Program at the Women's College Hospital in Toronto, Ontario, Canada. Only couples in a heterosexual relationship of at least 2 years or longer, and who were experiencing clinically significant marital distress (as measured by a score of $\leq$33 on the Dyadic Satisfaction subscale of the Dyadic Adjustment Scale (DAS) that was administered verbally during the telephone screening interview), were included in the study. Couples in which male partners had a history of childhood sexual or physical abuse were excluded. Exclusion criteria for both partners included the presence of any physical violence or abuse in the relationship in the 6 months before the study, current substance dependence, active suicidal ideation or psychotic symptoms, and legal separation. A total of 12 couples ($N = 24$) assigned to the treatment group and 10 couples ($N = 20$) assigned to the control group completed the study.

The mean age for the entire sample was 43 years; ages ranged from 22 to 65 years. The average relationship length was 14 years, with relationships ranging from 2 to 40 years. Eighty-five percent of participants had completed some college, and just more than 50% indicated that they had completed at least a bachelor's degree. Sixty percent of participants were employed full-time, 16% were employed part-time, and 24% were not employed. Approximately two thirds of the couples reported a household income of >$60,000, whereas approximately one third reported a household income of >$100,000. Eighty-six percent of participants were white, 6% were black, 2% were East Asian, and 6% identified themselves as "other" on the demographic questionnaire. Al-

most all female participants had engaged in previous psychiatric treatment: 81% reported receiving some psychotherapy; the mode was 50 sessions. Fifty-six percent of them had taken psychiatric medications.

The pretreatment mean DAS score, which was measured during the initial intake visit 1 week before commencing treatment/waitlist, was 92.5 (standard deviation [*SD*] = 16.56), which indicates that, on average, couples enrolled in the study were experiencing marital distress. A score of ≤97 is 1 *SD* below the mean of a large sample of married couples (Spanier, 1976), and is generally accepted as the cutoff score for the presence of marital distress. Scores <87 on the DAS are considered to signify significant relationship problems, and scores of ≤70 are typical of divorcing couples. There were no significant differences between the treatment and the control groups with respect to demographic variables such as age, length of relationship, and number of children.

### Self-Report Measures

**Childhood Trauma Questionnaire.** The Childhood Trauma Questionnaire—Short Form (CTQ; Bernstein & Fink, 1998) is a retrospective 28-item self-report questionnaire that measures the severity of five types of childhood maltreatment, including physical, sexual, and emotional abuse, as well as physical and emotional neglect. The CTQ also includes a three-item Minimization/Denial Scale for detecting false-negative trauma reports. Each subscale is measured in five items on a 5-point Likert scale from 1 (never true) to 5 (very often true). Scores for each subscale range from 5 to 25. The CTQ has good internal consistency; concurrent, convergent, discriminant, and criterion validity; and good sensitivity and specificity (Bernstein & Fink, 1998; Bernstein et al., 2003). Cutoff scores for each subscale have been established to define different levels of maltreatment/abuse.

**Childhood Maltreatment Interview Schedule.** The Childhood Maltreatment Interview Schedule—Short Form (CMIS-SF; Briere, 1992) is a retrospective self-report questionnaire that measures three types of childhood maltreatment, including psychological abuse, physical abuse, and sexual abuse. The CMIS-SF assesses duration of abuse, number of incidents, the relationship of the perpetrator to the victim, and the specific form of the abuse. Because the CMIS-SF is primarily designed to describe various aspects of maltreatment, items are not summed to form subscales (except for psychological abuse). Therefore, there are few data regarding the reliability or validity of the scale; however, Briere and Runtz (1990) report good internal consistency for physical abuse.

**Dyadic Adjustment Scale.** The DAS (Spanier, 1976) is a commonly used 32-item scale designed to assess marital adjustment and satisfaction. Total scores range from 0 to 151, with lower scores representing lower levels of marital adjustment and satisfaction. Spanier (1976) reports good internal consistency ($\alpha$ = .96). Test–retest reliability for the scale is also good ($\alpha$ = .87; Carey, Spector, Lantinga, & Krauss, 1993). Predictive and convergent validity has also been demonstrated. In the present study, internal consistency was adequate (pretherapy $\alpha$ = .74, posttherapy $\alpha$ = .95).

**Trauma Symptom Inventory.** The Trauma Symptom Inventory (TSI; Briere, 1995) is a 100-item test of posttraumatic stress and other symptoms of traumatic events. The TSI measures the frequency of posttraumatic stress disorder symptoms over the past 6 months, in addition to the intra- and interpersonal difficulties associated with chronic psychological trauma. The TSI contains three validity scales and 10 clinical scales that include Anxious Arousal, Depression, Anger/Irritability, Intrusive Experiences, Defensive Avoidance, Dissociation, Sexual Concerns, Dysfunctional Sexual Behavior, Impaired Self-Reference, and Tension Reduction Behavior. The 10 clinical scales of the TSI have good internal consistency (mean alpha coefficients >.84 across various samples) and adequate convergent, predictive, and incremental validity (Briere, 1995). Higher scores are indicative of greater symptomatology.

**Dissociative Experiences Scale.** The Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986) is a 28-item self-report questionnaire designed to identify patients with dissociative psychopathology and to quantify dissociative experiences. The scale measures a broad range of dissociative experiences, including disturbances in memory, identity, and cognition and feelings of derealization, depersonalization, and absorption. Higher scores are indicative of higher levels of dissociative symptoms. The test has demonstrated adequate reliability and validity (Frischholz et al., 1992; Carlson & Putnam,

1993). In the present study, the internal consistency was good (pretherapy $\alpha = .94$, posttherapy $\alpha = .93$).

**Couple Therapeutic Alliance Scale.** The Couple Therapeutic Alliance Scale (CTAS; Pinsof & Catherall, 1986) is a 29-item self-report questionnaire that measures the perception of the therapeutic alliance for each member of a couple participating in couple therapy. Higher scores on the CTAS are indicative of higher degrees of therapeutic alliance on a 7-point scale, with 7 indicating "completely agree" with the therapist on tasks, objectives, and methods. Predictive validity for the CTAS has also been demonstrated (Johnson & Talitman, 1997). Internal consistency was high ($\alpha = .96$).

## Procedure

Participants were recruited from Women's College Hospital using fliers and brochures posted in the Women's Mental Health Program, clinician referrals, and a mass mailing to all former patients of the Trauma Therapy Program. Eighty-one women interested in the study contacted the research office and were informed about the study. Fifty-one of these women completed the screening questions, along with the DAS Dyadic Satisfaction subscale items, to determine whether they met the inclusion/exclusion criteria. A total of 32 of these women and their relationship partners were then enrolled into the study.

Of the 81 women who were interested in the study, 49 were not enrolled in the study. Thirty of the women who had called about the study either did not complete a screening interview because they were lost to follow-up (i.e., they were not reachable after several contact attempts had been made) or they no longer wished to participate once they learned more about the study (e.g., possibility of waitlist control group). Nineteen women were screened but did not enroll in the study. Ten of these women did not meet with inclusion criteria: five had husbands with a history of childhood abuse, two were separated, one was in a relationship in which physical violence had occurred in the past 6 months, one was in a relationship of $<2$ years' duration, and one another indicated that she was not willing to be assigned to the control group. The remaining nine women did meet the inclusion criteria after telephone screening but did not enroll in the study because they either did not attend their initial assessment (six women) or because their husbands purportedly did not want to participate in the study (three women).

After successful telephone screening, couples attended an initial intake conducted by the principal investigator, during which they were given more details about the study and signed informed consent forms. Thirty-two couples in total were enrolled in the study. Of the 16 couples assigned to the treatment group, 4 left or were removed from the study during the clinical assessment phase of the treatment process.[1] At the same visit couples completed the DAS and the CTQ (male and female participants), along with the TSI, DES, and CMIS-SF (female participants only). After this visit, couples were randomly assigned to either the treatment group or to the waitlist control group.

Couples in the treatment group were assigned to a therapist and began therapy within the week. Therapy consisted of 22 couple sessions and 2 individual sessions (that occurred in week 3 after the first 2 couple sessions), for a total of 24 sessions. Each session was 75 min in length. All therapy sessions were audiotaped. At visit 3, all couples completed the CTAS. One week after their final therapy session, all couples in the treatment group completed the posttherapy questionnaires. Women completed the DAS, TSI, and DES, whereas men completed only the DAS. All 12 couples in the treatment group completed the study (that is, they attended 22 EFT couple therapy sessions, and 1 individual session each and then returned to complete the poststudy questionnaires).

Couples in the waitlist control group were contacted 24 weeks after they had completed the prestudy questionnaires and invited to return to complete the poststudy questionnaires. Of the 16 couples in the waitlist control group, 10

[1] One woman was diagnosed with a serious medical condition immediately after starting therapy and decided to postpone couple therapy while undergoing chemotherapy. One woman began actively abusing cocaine before starting therapy and did not attend her first scheduled therapy session and was removed from the study. Another male participant withdrew from the study after he disclosed an affair to the therapist in his individual session. The fourth couple attended two sessions but were deemed unable to benefit from couple therapy and referred for individual psychotherapy instead.

completed the study (that is, they returned after 24 weeks on the waitlist to complete the post-study questionnaires). Couples in the control group who completed the study were offered treatment.

### Treatment and Monitoring of Implementation

Five therapists participated in the study. Four of them were masters-level mental health therapists in the Trauma Therapy Program (WCH), and all of them had at least 4 years of experience treating individuals with a history of childhood abuse. The fifth therapist was the principal investigator, who assigned couples to therapists according to a match between therapist and client availabilities (i.e., couples who needed evening appointments were matched to therapists with evening openings).

Before the study, all four therapists received 5 months of weekly training in EFT that consisted of engaging in role-plays, viewing training videos, and completing required readings, which included the EFT treatment manual (Johnson, 2004) and the volume entitled *Emotionally Focused Couple Therapy With Trauma Survivors* (Johnson, 2002). During the study, group supervision was given once a week by the principal investigator, who is an experienced EFT therapist. In addition, a random selection of approximately 25% to 30% of all taped therapy sessions was sent to a senior EFT trainer (Alison Lee, Ph.D.) at the Ottawa Couple and Family Institute.

**Implementation check.** To verify that therapists adhered to the EFT manual, there were three therapy implementation checks. First, a random selection of approximately 25% to 30% of taped therapy sessions (from all five study therapists) were audited by the senior trainer at the Ottawa Couple and Family Institute, who deemed that adherence was adequate. In addition, the trainer recorded her verbal feedback about therapist interventions onto the tapes that were then audited by study therapists. Second, segments of the therapy sessions were played during weekly group supervision to ensure proper implementation of the treatment, and feedback was provided as required by the principal investigator. Third, two independent raters, using a checklist of EFT and non-EFT interventions, coded therapists' statements in 10-min audiotaped segments taken from sessions that were randomly selected from the early, early middle, late middle, and end stages of therapy with each couple. In total, 657 therapist statements were coded. Of these, 588 (89.5%) were coded as EFT adherent, 42 (6.4%) were coded as trauma-based interventions consistent with EFT, and only 27 (4.1%) were coded as nonadherent statements. Interrater reliability (Cohen's kappa) based on 486 observations (74%) was .88. We also conducted analysis of covariance (ANCOVA) and post hoc analyses to test for potential therapist effects.

**Data analyses.** To test the primary and secondary hypotheses, we conducted ANCOVAs with treatment condition as the fixed factor and each individual participant's baseline scores on the outcome measures as covariates. Next, to determine the circumstances under which EFT would be an effective treatment for couple distress, we conducted hierarchical regressions with treatment condition entered in the first step and the variables related to trauma and the therapeutic alliance in the second step. We conducted separate regression analyses for each predictor (CTQ subscales, CMIS-SF subscales, etc.; please see below). Relationship distress, as measured by the DAS, was the dependent variable for the hierarchical regressions. Finally, we were also interested in the clinical significance of our results. We, therefore, calculated Cohen's *d* for treatment effect size, along with nonparametric tests of change on the DAS pre- and posttreatment. It is important to note that we analyzed *individuals'* DAS scores as outcomes in all cases, as we were interested in each participant's subjective experience.

## Results

### Severity of Childhood Abuse and Neglect

Mean scores on the CTQ and the CMIS-SF were calculated to determine the nature and severity of female participants' history of childhood abuse. Mean scores on the CTQ were in the "severe" range on the emotional and sexual abuse subscales and in the "moderate to severe" range on the physical abuse subscale. Almost all the women in our sample experienced sexual abuse (92%), whereas two thirds experienced

physical abuse (65%). Furthermore, almost two thirds (60%) of women experienced all three types of abuse (sexual, physical, and emotional), whereas another third (32%) experienced at least two types of abuse. Participants' responses on the CMIS-SF revealed that the mean ages at which the first incident of childhood abuse occurred were 6 years for physical abuse, 5 years for emotional abuse, and 7 years for sexual abuse. In addition to abuse, women suffered physical and emotional neglect during childhood, with CMIS-SF scores in the "moderate to severe" range.

Women revealed on the CMIS-SF that they had experienced repeated incidents of physical and sexual abuse during childhood ($M = 81$ and $M = 50$ occurrences, respectively), which were often perpetrated by a family member. All women who experienced physical or emotional abuse reported that family members were responsible for at least some of the incidents, whereas approximately two thirds of the women who experienced sexual abuse indicated that family members perpetrated at least some of the abuse. Hence, the childhood abuse that women in the study suffered was not only predominantly severe, but it was also highly interpersonal in nature.

## Therapeutic Alliance

Therapeutic alliance was examined at session 3. The mean score on the CTAS was indicative of high levels of mutual collaboration on the tasks and goals of treatment ($M = 5.98$; maximum score, 7). Therapeutic alliance was also a significant predictor of relationship satisfaction at the end of the study ($\beta = .57$, $t(42) = 2.72$, $p < .02$), and it explained a significant portion of the variance in posttreatment DAS scores ($R^2 = .33$, $F(1, 15) = 7.42$, $p < .02$).

## EFT and Relationship Satisfaction

To test our main hypothesis that couples in the EFT treatment group would demonstrate significant reductions in relationship distress whereas couples in the control group would not, we conducted ANCOVAs. Table 1 contains the pre- and posttreatment means and *SD*s on the DAS for all participants. The main effect of treatment condition was significant ($F(1, 38) = 4.73$, $p < .04$). Because a major focus of the study was on the relationship quality of female survivors of childhood abuse, we also conducted an ANCOVA on female participants' posttreatment DAS scores. The result ($F(1, 17) = 4.70$, $p < .05$) was nearly identical. These results indicate that posttreatment DAS scores in the treatment group were significantly higher than were posttreatment DAS scores in the control group, even after removing the statistical effect of respondents' initial pretreatment levels of relationship satisfaction. The treatment effect size was medium ($d = 0.62$) across the entire sample and large ($d = 1.00$) for female participants.

Table 1
*Mean Dyadic Adjustment by Treatment Condition and Time Point*

| | Time point | | | |
|---|---|---|---|---|
| | Pretreatment | | Posttreatment | |
| Treatment condition | *M* | *SD* | *M* | *SD* |
| EFT group | 95.95[a] | 13.29 | 104.81[b] | 15.15 |
| Control group | 89.05[a] | 16.82 | 88.32[a] | 25.54 |

*Note.* DAS = Dyadic Adjustment Scale; EFT = emotionally focused therapy.
[a] DAS score in the "Mildly Atypical: Indicates Significant Problem" range. [b] DAS score in the "Average: Typical Score—no concern" range.

Next, we conducted two hierarchical regressions with treatment group entered in the first step and the variables related to trauma and the therapeutic alliance in the second step. We only went ahead with regression analyses for those predictor variables that were significantly correlated with relationship satisfaction before treatment. Of the different independent variables measured, an increase since age 18 years in female clients' understanding of the abuse they endured as children (an item on the CMIS-SF) was related to lower relationship satisfaction at the beginning of the study (as measured by pretreatment DAS scores; $r = -.45$, $p < .03$), as were higher scores on the Anger/Irritability (A/I) and Depression (D) subscales of the TSI ($r = -.54$, $p = .007$ and $r = -.59$, $p = .003$, respectively).

ANCOVAs and planned contrasts with the Bonferroni correction revealed no significant differences on treatment outcomes among four of the five therapists participating in the study; there was, however, a significant difference between the outcomes of therapist 1 and therapist 3 ($F(4, 16) = 3.66$, $p = .03$). It

is important to note that the *N*s in these analyses were small ($N = 4$ for four of the five therapists and $N = 8$ for the other therapist).

Treatment condition alone predicted increases in posttreatment DAS scores in separate hierarchical regression equations with the "understanding of abuse" item from the CMIS-SF ($\beta = .49$, $t(42) = 2.05$, $p = .05$) entered at step 2 in one equation and the two TSI subscales ($\beta = .46$, $t(42) = 2.33$, $p = .03$) entered as predictors at step 2 in the other. Treatment condition also explained a significant portion of the variance in DAS posttreatment scores in each regression equation ($R^2 = .22$, $F(1, 19) = 5.42$, $p = .03$). This indicates that when we controlled for treatment condition, the relation between the CMIS-SF item and the DAS disappeared, as did the relation between the two TSI subscales and the DAS.

We also conducted nonparametric tests to determine the clinical relevance of our results. According to Jacobson and Truax (1991), an improvement of 10 points or more on the DAS is considered clinically significant. In our sample, a statistically significant proportion of participants who participated in EFT displayed this clinically relevant improvement on the DAS from pretest to posttest ($\chi^2(1) = 18.00$, $p < .001$). However, no participants in the control group exhibited clinically significant changes on the DAS. Finally, 70% of the treatment group was classified as "recovered" (i.e., posttest DAS scores were ≥97r, the nondistressed range; Spanier, 1976) at the end of therapy, which means that they were no longer experiencing relationship distress.

### EFT and Trauma Symptoms

To test our secondary hypothesis, that female survivors of childhood abuse who participated in EFT would exhibit significant reductions in trauma symptoms, we conducted a series of ANCOVAs with female participants' posttreatment scores on the 10 TSI subscales and on the DES as outcome variables, treatment condition (EFT vs. waitlist) as the fixed factor, and participants' baseline scores on the TSI and DES as covariates. The results of these analyses were not significant.

## Discussion

The primary aim of this study was to examine the effectiveness of EFT for couples in which the female partner was a survivor of childhood abuse. As predicted, couples who participated in 24 sessions of EFT demonstrated significant increases in their relationship satisfaction over time, whereas couples who did not participate in EFT exhibited no such change. Furthermore, after 24 sessions of EFT, the treatment group's marital distress decreased, on average, from the "distressed" range to the "average" range, which indicates a clinically significant improvement in marital functioning that was also statistically significant (Jacobson & Truax, 1991; Spanier, 1976). These findings are all noteworthy for the reasons outlined below.

First and most importantly, these results suggest that EFT can be an effective treatment for one of the most prevalent and troublesome consequences of childhood abuse: distressed couple relationships in adulthood. The medium effect size overall, as well as the large effect size for the target population of women, lends further credence to this notion. This reduction in relationship distress (see Figure 1) is particularly striking given that the childhood abuse experienced by women in the study was not only severe, but was also in most cases perpetrated by a family member. One of the hallmarks of this type of complex trauma is difficulty establishing and maintaining emotional connections to others, owing to fears of closeness as a source of threat (Herman, 1992). The reduction in relationship distress that women and men who participated in EFT for couples experienced is evidence that they might have been able to overcome some of their fears of connecting with their spouses on a meaningful level. EFT thus appears to have helped women and their partners overcome some of the negative effects of childhood abuse on their adult relationships. In light of these findings, clinicians who treat female survivors of childhood abuse might now look to EFT for couples as a viable option for helping their clients reconnect with significant others, which is the third and final crucial step toward full recovery from trauma (Herman, 1992).

We were also able to determine some of the conditions under which EFT for couples seemed to be particularly effective in our sam-

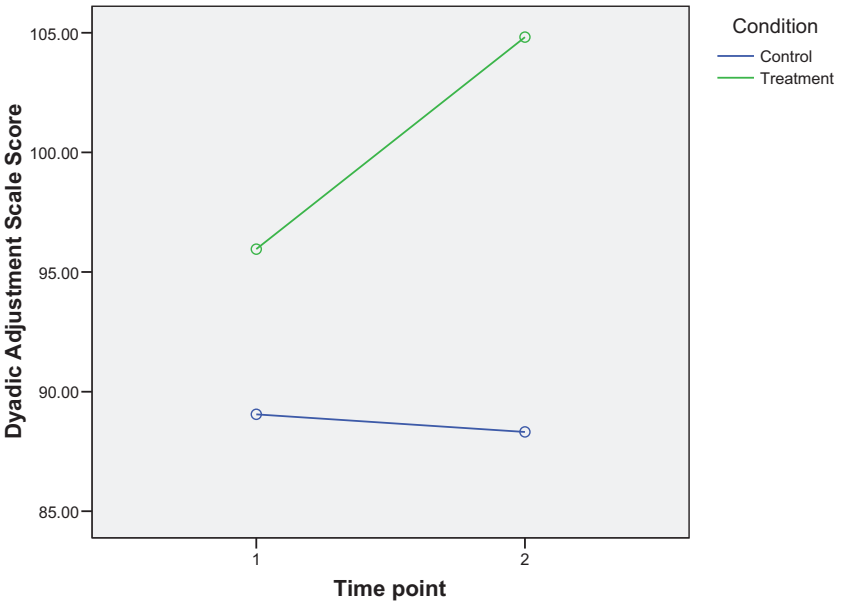


*Figure 1.* Mean dyadic adjustment scores as a function of treatment condition and time point.

ple of couples in which the female partner had suffered childhood abuse. For example, we found at the beginning of the study that when female participants reported significant changes in their understanding of their abuse since age 18 years (as measured by the CMIS-SF), both they and their partners were less satisfied with the couple relationship. At the conclusion of therapy, however, this item from the CMIS-SF was no longer predictive of men and women's relationship satisfaction. Similarly, two TSI subscales (Depression and Anger/Irritability) predicted lower relationship satisfaction at the beginning of the study, but by the end of therapy, these aspects of the trauma experience no longer appeared to be affecting either partner's level of relationship satisfaction. These findings suggest that EFT for couples might be particularly helpful (1) when women in distressed relationships experience changes in how they understand their abuse during adulthood and (2) when they display symptoms of depression and anger/irritability related to the abuse.

This study also makes an important contribution to the scientific literature because it is the first controlled trial of EFT for couples in which the female partner had endured childhood abuse. Our findings with this population are consistent with those of previous EFT research that support the efficacy of this intervention (Denton et al., 2000; Halchuk et al., 2010; Johnson et al., 1999). The high levels of therapeutic alliance in the present study and low study dropout rates are also consistent with those found in the literature on EFT; the dropout rate is typically approximately 5% or lower in EFT outcome research (Johnson & Talitman, 1997). They highlight the strength of the EFT model in engaging couples in the treatment process.

Our secondary hypothesis, that women who participated in EFT for couples would experience a reduction in trauma symptoms, was not supported. There are several possible explanations for this. First, our sample size was small, which appears to have limited the statistical power of the study. Post hoc power analyses of the TSI and DES results revealed that beta (the probalility of type II errors) levels were well above the standard .20 for all of the trauma-related outcome variables, despite small to medium effect sizes on the majority of the TSI subscales (range: $d = .17$ to $d = .86$) and an appreciable, although small, effect size on the DES ($d = .39$).

Another explanation is that the treatment might have been effective at reducing relationship distress not by targeting trauma symptoms per se, but rather by helping partners to create a secure emotional bond that facilitated their ability to manage trauma symptoms in the relationship. Finally, participants were recruited from a tertiary treatment center that specializes in the treatment of trauma. For this reason, many of them had already received individual trauma-focused therapy before the study. We included them because their relationships were the focus of this investigation. However, it is possible that untreated women with a history of childhood abuse and marital distress would experience a reduction in trauma symptoms after marital therapy.

## Limits and Considerations

The findings of this study should be interpreted in light of its limitations. First, the treatment group was only compared with a waitlist control group, rather than with an intervention control group. More information on the differential effects of EFT for couples and other evidence-based marital therapies is necessary. In addition, no longitudinal data were obtained to determine whether the treatment effects lasted after termination of therapy. Next, our exclusion criteria (i.e., at least a 2-year relationship, no physical violence, not legally separated, and absence of psychosis and alcohol dependence) limit the generalizability of our findings. Finally, the generalizability of our findings is further reduced by our decision to focus on treating only couples in which the female (and not the male partners) had a history of childhood abuse.

Despite these limitations, the present study not only contributes to the EFT literature, but it also provides evidence of the effectiveness of a couple-based treatment for women with comorbid relationship distress and a history of childhood abuse. Our findings suggest that EFT for couples might be a treatment of choice for women and men working through relationship problems in the specter of the female partner's childhood victimization. Perhaps a combination of couple-focused EFT and individual EFT would be optimal for women with a history of childhood abuse, in light of our findings in this study and those of Paivio and colleagues, which provide evidence for the efficacy of individual EFT with adult survivors of complex trauma (e.g., Paivio & Nieuwenhuis, 2001; Paivio & Pascual-Leone, 2010). Among other things, principal aims of both individual and couple approaches to EFT are to help clients identify, articulate, and effectively act on primary socioaffective needs in relationships. It would therefore indeed be interesting to discover through future research how some combination of individual and couple EFT might benefit adult survivors of childhood abuse.

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