ABSTRACT
EFTT (Emotion Focused Therapy for Trauma) is an integrative model that extends and tailors the general theory of emotion focused therapy (EFT) to the area of interpersonal trauma. The treatment model is broadly applicable to complex interpersonal trauma, including recent application with immigrant and refugee victims of torture. However, most clinical work and research has been with men and women dealing with different types of child abuse (emotional, physical, sexual) trauma. EFTT is grounded in current experiential therapy theory and research (e.g., Greenberg & Paivio, 1997; Greenberg, Rice & Elliot, 1993; Paivio & Greenberg, 1995) which, in turn, draws on recent emotion theory and research and developments in affective neuroscience (e.g., Damasio, 1999; Fridja, 1986; LeDoux, 1996). Importantly, EFTT also integrates current knowledge in the areas of attachment and trauma (Briere & Scott, 2006; Herman, 1992; Solomon & Siegel, 2002, van der Kolk, McFarlane, & Weiss, 1996).

Fundamental Assumptions
Experiential therapy. The fundamental assumption underlying all experiential therapies, including EFTT, is that attention to, exploration and symbolization of current subjective experience (feelings and meanings) is a primary source of new information used in construction of meaning (Greenberg, Rice & Elliott, 1993). This is distinct from traditional cognitive-behavioral and psychodynamic approaches that rely on skills training and therapist-provided information and interpretations as the primary sources of new information. Reliance on internal experience as a source of wisdom about one’s own values, priorities, needs, concerns, appraisals, and reactions to others is considered particularly important in self-development and interpersonal functioning.

The capacity to attend to and explore internal experience (thoughts, feelings, memories) also is central to recovery from trauma and resolution of child abuse issues (Briere & Scott, 2006; Herman, 1992; van der Kolk et al., 1996). This is the basis for memory work and exposure-based procedures common to most trauma therapies. However, experiential approaches,
including EFTT, uniquely emphasize the process of exploring and symbolizing internal experience (the experiencing process) and the quality of the exploration process rather than the content. The emphasis is on the narration process rather than the narrative (Paivio & Pascual-Leone, 2007).

Emotion theory. Other assumptions derive from recent emotion theory and research (e.g., Damasio, 1999; Fridja, 1986; Izard, 2002; LeDoux, 1996). Accordingly, emotions are associated with a network of information or multi-modal meaning system (e.g., thoughts, images, feelings, desires, bodily experience, and action tendencies). Once an emotion is activated, the associated information influences current perceptions, motivation, and behavior. Only if an emotion is activated can the associated meaning system be available for exploration and emotional processing, that is, modification through the admission of new information (FoA & Kozak, 1986, Greenberg & Safran 1987). Furthermore, specific emotions are associated with specific areas of brain activation and specific information. The information associated with basic emotions aids in orientation and adaptive functioning. For example, anger aids in self-defence and sadness facilitates acceptance of loss. EFTT particularly emphasizes the experience and expression of previously inhibited adaptive anger and sadness so that information associated with these emotions can be used in emotional processing of trauma material and the construction of new meaning.

Sources of Disturbance Associated with Child Abuse Trauma
The three main inter-related sources of disturbances associated with child abuse are exposure to trauma, negative experiences with attachment figures, and reliance on avoidance as a strategy for coping with overwhelming affect.

Exposure to trauma. Traumatic events are encoded in right brain experiential memory, that is, as feelings, images, bodily sensations, and other sensory experience (van der Kolk et al., 1996). Trauma feelings and memories are activated in response to current stimuli that resemble the trauma and, over time, these responses can generalize to numerous stimuli. Recovery requires activation of the experiential memory system so that information is available for exploration and change (FoA & Kozak, 1986, Greenberg & Safran 1987). Furthermore, processing of trauma memories requires the application of conceptual/linguistic processes to trauma material encoded in the experiential system. Thus recovery from trauma also entails construction of new meaning concerning self, others, and traumatic events. An important distinction has been made between the effects of single traumatic events, such as motor vehicle accidents or natural disaster (simple or Type I trauma), and the effects of prolonged and repeated exposure to actual or threatened violence (complex or Type II trauma) experienced, for example, by victims of political violence and torture, domestic violence, and child abuse trauma. Type I trauma is associated with symptoms of posttraumatic stress disor-
On the other hand, Type II trauma is associated with a more complex array of long-term effects, sometimes called complex PTSD or Disorders of Extreme Stress Not Otherwise Specified (DESNOS; van der Kolk, Pelcovitz, Roth, Mandel, McFarlane, & Herman, 1996). These traumatic experiences are particularly devastating when they occur at the hands of loved ones upon whom one is dependent and when they occur at critical times of development. A constellation of long-term effects of child abuse have been documented (Scoboria et al., 2006). Most notably, these include symptoms of PTSD and other anxiety disorders (Rodriguez, Ryan, Vandec Kemp, & Foy, 1997), as well as depression (Beitchman, Zucker, Hood, & DaCosta, 1992); and affect regulation difficulties, including both under-regulation and over-control (van der Kolk et al., 1996). Cognitive disruptions include enduring perceptions of self as vulnerable or flawed, others as dangerous or untrustworthy, and the world as basically hostile and unsafe (Janoff-Bulman, 1989). These in turn are associated with self-esteem and interpersonal difficulties (Clotire, Scarvalone, & Difede, 1997); and chronic feelings of anger, guilt, powerlessness, and shame (Herman, 1992).

The distinction between simple and complex PTSD has implications for the process of therapy. Evidence based individual therapies for Type I trauma (e.g. Foa, Riggs, Danuc, & Rothbaum, 1993; Shapiro, 1999) typically target episodic memories of a single recent traumatic event. In EFTT and other therapies for child abuse trauma, the targets are blurred memories of distal events, occurring over extended periods, and sometimes involving multiple perpetrators. EFTT typically focuses on resolving issues with attachment figures. These relationships involve complex and ambivalent feelings, and in many instances, there is ongoing interaction with perpetrators and family members. Therapy thus requires a more fluid therapy process.

**Attachment injuries.** People’s core sense of self and expectations of others develop in the context of affectively charged experiences with attachment figures. Secure attachment relationships between children and their parents are crucial in the development of a coherent sense of self, self-confidence, interpersonal trust, and emotion regulation capacities (Sroufe, 1995). Children whose parents respond consistently to their physical and emotional needs eventually develop the capacity to identify and fulfill their own needs. Having parents who empathically mirror their emotions allows children to learn to recognize, label, and describe their own emotional experience. This skill contributes to the ability to connect interpersonally, regulate their own emotional experience, and derive comfort from others.

By contrast, negative and invalidating experiences in the context of early attachment relationships can have a profoundly negative influence on the developing sense of self and perceptions of interpersonal relationships. In abusive and neglectful environments, the child’s feelings and needs for security, autonomy, and love are often ignored, invalidated, or violated. These early experiences with significant others are embedded in memory, act as enduring prototypes, and form the basis of a person’s sense of self and expectations of others (Bowlby, 1988). The
abused child develops a sense of self as powerless, worthless or bad, and others as unreliable, unsupportive, or dangerous, leading to later problems with self-esteem, self-identity, and interpersonal intimacy and trust (Herman, 1992; Liem et al., 1996).

Reliance on avoidance. Finally, in the absence of parental support and appropriate emotional coaching (Gottman, 1997), children learn to rely on avoidance to cope with the powerful feelings generated by abuse and neglect. Chronic experiential avoidance has been associated with difficulties identifying and expressing feelings (alexithymia) which, in turn, has been associated with depression, social anxiety, and poor social support (Taylor, Bagby & Parker, 1997). Difficulties identifying feelings and trusting one’s perceptions and experience (the result of chronic avoidance and parental invalidation) also can make a person more vulnerable to repeated victimization. Chronic inhibition of thoughts and feelings associated with traumatic events also are thought to perpetuate trauma symptoms, interfere with recovery, and contribute to immune system breakdown (FoA, Rigs, & Gershuny, 1995; Pennebaker & Campbell, 2000). Traumatic experiences, attachment injuries, and associated meanings, remain frozen in memory and continue to negatively influence current perceptions of self, others, and reality. Chronically suppressed anger at violation and sadness at loss can have a particularly debilitating effect on self-development and interpersonal relations culminating in disturbances, such as anxiety, depression, a pervasive sense of powerlessness and victimization, and pathological grief.

In sum, child abuse trauma is associated with a constellation of disturbances and affective disruptions are at the core of this constellation. EFTT is exceptionally well-suited to address these difficulties.

Posited Mechanisms of Change
EFTT posits the therapeutic relationship and “emotional processing” of trauma memories as the primary mechanisms of change.

An empathic and collaborative relationship provides a safe context for exploring trauma material. This is a core ingredient of all trauma therapies (Briere & Scott, 2006). As well, this type of therapeutic relationship provides a new learning experience for individuals whose problems stem from experiences of profound lack of empathy and interpersonal control (Herman, 1992). Empathic responsiveness to client’s feelings and needs fosters interpersonal trust, reduces distress, increases awareness and acceptance of feelings and needs that, in turn, enhance interpersonal functioning and self-esteem (Bowlby, 1988). These experiences with the therapist generalize to other relationships.
Emotional processing, the second change mechanism in EFTT, again involves accessing trauma feelings and memories so these are available for exploration and change (Fox, Rothbaum, Riggs, & Murdock, 1991). Through desensitization processes, clients learn to tolerate previously overwhelming experience. More importantly, through exploring and verbally symbolizing distressing experiences with the help of a trusted therapist, clients construct new meaning, that is, a more adaptive view of self, others, and traumatic events. EFTT is similar to traditional CBT for child abuse trauma (e.g., Clotire, Stovall-McClough, Miranda, & Chemtob, 2004) in accessing maladaptive emotional experiences, such as fear and shame, so these are available for modification. However, EFTT is distinct in particularly emphasizing accessing previously inhibited adaptive emotions thought to promote healthy functioning (Damasio, 1999, LeDoux, 1996). For example, appropriate expression of anger at violation promotes assertiveness, self-empowerment, and interpersonal boundary definition. Expression of sadness at loss promotes grieving, acceptance of loss, and accesses self-soothing resources. Thus adaptive anger and sadness help to modify maladaptive fear and shame.

**Distinctive Features of EFTT**

**Empirical support.** There is extensive clinical literature on therapy for child abuse trauma and numerous single studies of different approaches have been published. However, to our knowledge, EFTT is the only systematically evaluated therapy for this client group. The treatment model developed from years of programmatic research on the process and outcome of therapy for resolving interpersonal issues from the past (Greenberg & Foerster, 1996, Paivio & Greenberg, 1995) as well as observing distinctive features of therapy for child abuse trauma. (The empirically-verified model of resolution upon which therapy is based will be presented below.) Research supports the efficacy of EFTT based on this model. For example, results of a study evaluating EFTT (Paivio & Nieuwenhuis, 2001) indicated that therapy (N = 33) brought about statistically significant and clinically meaningful gains in multiple domains and that treatment effects were maintained at six-months follow-up. A recent RCT (Paivio, Chacicioris, Hall, Jarry, & Ralston, 2007) evaluated two versions of EFTT, each employing a different re-experiencing procedure (these will be described in the later section on phases and tasks of therapy). Again, clients in both versions (N = 45) reported large gains in multiple domains that were maintained at one year follow-up. The average pre-post effect size of 1.32 standard deviations far exceeds the standard for effective treatments (.8 standard deviations) recommended by the APA Task Force on the Promotion and Dissemination of Psychological Procedures (1995).

Results from process-outcome research also support the posited mechanisms of change in EFTT. For example, alliance quality improved over the course of therapy and early alliance difficulties associated with severe abuse disappeared by the end of therapy such that these did not interfere with treatment outcome (Paivio & Patterson, 1999). This suggests that therapists
successfully addressed client relationship difficulties. As well, alliance quality contributed to multiple dimensions of client change and emotional engagement with trauma memories during the primary reexperiencing procedure (imaginal confrontation of abusive/neglectful others) additionally contributed to outcome (PAIVIO & PATTERSON, 1999; PAIVIO, HALL, HOLOWAY, JELLIS, & TRAN, 2001). Engagement with trauma material particularly contributed to resolution of issues with specific abusive and neglectful others who were the focus of therapy. Results of recent process-outcome analyses comparing the two version of EFTT (CHAGIGIORGIS & PAIVIO, 2007) similarly support both the therapeutic alliance and emotional engagement with trauma material during re-experiencing procedures as mechanisms of change.

**Modality and applicability.** Most published treatments for child abuse trauma are group approaches for women with histories of sexual abuse (e.g., MORGAN & CUMMINGS, 1999; Saxe & JOHNSON, 1999; ZLOTNICK, SHEA, ROSEN, SIMPSON, MULRENIN, BEGIN, & PERLSTEIN, 1997). However, group modalities are not the treatment of choice for everyone. Survivors go through phases of recovery and require different tools and options depending on the individual and phase (BRIERE, 1992; HERMAN, 1992; Saxe & JOHNSON, 1999). Individual modalities provide opportunities to disclose (perhaps for the first time) and work through painful material in the privacy of a one-on-one relationship with a trusted therapist. As well, the negative effects, described above, are not exclusive to female sexual abuse survivors. Indeed, few differential effects of different types of abuse have been identified (SCOBORIA ET AL., 2006) likely because multiple types of abuse frequently occur in the same family. Thus ecologically valid treatment and research needs to consider the combined effects of different types of abuse (BERNSTEIN & FINK, 1998).

EFTT is one of the few evidence-based (PAIVIO & NIEUWHUIS, 2001) individual therapies for both men and women and for different types of childhood abuse (emotional, physical, sexual). To date, only one other study of therapy for the effects of both physical and sexual abuse could be located (CLOITRE, STOVALL-MCCLOUGH, MIRANDA, & CHEMTOB, 2004). EFTT targets the core affective disturbances that are common across different types of child abuse. At the beginning of therapy, clients identify the abuse experiences and relationships with specific abusive/neglectful others they want to focus on in therapy. Protocol is sufficiently flexible to address individual client processes and treatment needs.

Research supports the intended broad applicability of EFTT. Results of a recent clinical trial (PAIVIO ET AL., 2007) indicated no significant differences between men and women or between different abuse focus types in terms of treatment outcome. As well, there was no effect for severity of childhood abuse experiences or for severity of current trauma symptoms.
**Model of resolution.** Most approaches to therapy for child abuse trauma emphasize current symptoms, self-concept, and relationship problems (e.g., Clotire et al., 2004; Herman, 1992). EFTT is distinct in viewing the adult disturbances associated with childhood maltreatment as largely involving unresolved grievances with perpetrators of abuse and neglect. Most often these perpetrators are attachment figures. Clients not only are distressed by current difficulties, but continue to be distressed by powerful unexpressed feelings, unmet needs, and disturbing memories concerning these individuals. From an attachment perspective, they are unable to separate, let go, and move on, until feelings are expressed and processed and past experiences are satisfactorily resolved (Greenberg & Paivio, 1997). This is the primary task of therapy. Importantly, EFTT is the only trauma therapy that is based on an empirically-verified model (Greenberg & Foerster, 1996; Greenberg & Malcolm, 2002) of the process of resolving these grievances using a specific Gestalt-derived intervention. During this procedure, clients imaginarily confront (IC) abusive/neglectful others in an empty chair and express previously constricted thoughts, feelings, and needs directly to these imagined others. Steps in the process that discriminated clients who resolved these issues from those who did not included expression of adaptive emotion (anger and sadness), entitlement to unmet needs, and changed perceptions of self and others (Greenberg & Foerster, 1996; Greenberg & Malcolm, 2002). Specifically, clients shifted to a stance of increased self-empowerment and self-esteem and increased understanding and/or holding the other accountable for harm. Steps specified in this model function as session-by-session goals to guide the process of therapy. Before and after each session, the therapist evaluates the client’s stage in the resolution process and establishes goals for each session based on this evaluation. Evaluation of the degree of resolution includes assessment of the associated processes, that is, level of emotional arousal, depth of experiencing, perceptions of self and significant others (degree of differentiation), and narrative quality (coherence). Therapist operations during IC have been delineated (Greenberg et al., 1993; Paivio et al., 1997) as follows: Promote psychological contact with the imagined other, evoke episodic memories associated with abuse, promote expression of feelings, explore and help clients overcome blocks to experiencing, differentiate feelings (e.g., anger, sadness) and associated meanings, promote expression of entitlement to unmet needs (e.g., protection, love, justice), explore shifting perceptions of self and imagined others. The therapist also maintains a balance between following client moment-by-moment experience and directing the process.

**Phases and Tasks of Therapy**

EFTT is a semi-structured, manualized treatment (Paivio, 2002; Paivio & Pascual-Leone, 2007). Therapy typically consists of 16-20 weekly one-hour sessions although the exact length of therapy is collaboratively determined and based on individual client processes and treatment needs. Clients typically are screened for suitability for short-term, trauma-focused therapy.
Suitable clients typically are moderately distressed with moderate impairments in functioning and have at least minimum affect regulation capacities. For clients with severe affect regulation and personality difficulties, therapy is likely to be a more complex and long-term. In particular, more time may be required to establish safety and trust, develop effective emotion regulation capacities, and/or reduce maladaptive avoidance, including dissociation and self-harm behaviours.

For example, reducing maladaptive behaviours such as cutting or alcohol abuse, involves increasing awareness of triggers, contracting with clients to stop the behaviour and possibly finding other resources for support (e.g., Alcoholics Anonymous) in conjunction with EFTT. It also could be helpful to draw on emotion regulation and behavioral change strategies from other approaches (e.g., Linehan, 1993; Najavits, 2002). However, EFTT primarily relies on therapist soothing responses and accessing vulnerable emotions and associated self-comforting or soothing resources to help reduce client distress. As well, there is considerable support for the view that deficits in emotion awareness and expression (alexithymia) contribute to maladaptive behaviors, such as alcohol abuse and self-injury (Paivio & McCulloch, 2004; Van der Kolk et al., 1996). Thus the emphasis on increasing emotion awareness and expression capacities in EFTT can help to reduce these behaviors.

For clients who are resistant or reluctant to engage in imaginary dialogues, all interventions described below can be carried out exclusively in interaction with the therapist. It is the intervention principles that are important, not the specific techniques. The typical sequence of therapy sessions can be conceptualized as having four phases.

**Phase One: Cultivating the Alliance**

The first three sessions of therapy are devoted to cultivating a secure attachment bond, developing an understanding of the processes that generate disturbance, and collaborating on the goals of therapy and how these will be achieved. Therapists encourage disclosure and description of traumatic experiences but these are not explored in depth and emotion intensification is avoided. The primary intervention used in the first phase of therapy is empathic responding. Empathic attunement to client feelings and needs guides effective intervention in all therapies, however, experiential approaches particularly emphasize empathic responding. Paivio & Laurent (2001) outline how empathic responding functions to increase awareness of emotional experience, help modulate the intensity and frequency of emotional experience, and enhance appropriate expression skills. Empathic responses that reflect the client’s processes and feelings help direct the client’s attention to their internal experience. Empathic responses implicitly teach accurate labelling and description of emotional experience. Many individuals with a history of child abuse lack these skills (alexithymia). Developing the ability to identify emotions allows the client to further explore and symbolize the meaning of emotional experience, thus contributing to self-understanding and self-control.
Empathic responses that communicate acceptance and understanding also can reduce client arousal and distress. This helps clients to allow painful and threatening experience so it available for exploration and change. On the other hand, evocative empathic responses can activate inhibited or suppressed emotional experience and memories, thus making them available for further exploration. Evocative empathic responses are personal, specific, and connotative. (Rice, 1974).

Empathic responses also can teach adaptive expression skills. Therapist responses model appropriate expression of emotion, emotional authenticity, openness to experience, and compassion. In empathically responding, therapists allow themselves to be touched by the clients’ pain without being overwhelmed by it, thus demonstrating effective emotion regulation. Therapist understanding and responsiveness are gradually internalized by the client, strengthening their capacity for self-soothing, self-support, and self-acceptance. This increases their capacity to manage intense emotion.

Establishing a secure attachment bond is the foundation of alliance formation. During initial sessions, clients are asked about their presenting problem, current symptoms and functioning, as well as their mental health, interpersonal, and trauma history. Many clients initially are fearful of disclosing details of abuse. Safety and trust can be fostered by validating distrust and fear of disclosure (“Of course, you don’t know me from Adam, trust will take time.” “The things you’ve been though are way off the radar for most people. Of course you want to be very choosy about who you share this with.”). Providing information about therapy processes and roles also will help to reduce anxiety (“We are not going to hammer away at your traumatic experiences session after session. I am interested in you as a whole person. You are in the driver’s seat; we will explore both past and present concerns, whatever is most important to you at the time. My job is to ensure your safety and, at the same time, to support and encourage your growth. Of course that will mean helping you get in touch with painful stuff so you can work it through, here, in this safe environment, and at a pace you can handle.”). Safety and trust primarily are fostered by communicating genuine compassion for past and current suffering and struggle to cope (“It’s terrible that a child should be exposed to such ugliness. I feel bad that you had to go through all that, especially alone. I don’t want you to be alone with this stuff anymore.”), and through empathically responding to current feelings (fear, helplessness, isolation, confusion, anger, betrayal) and needs (safety, comfort, control, justice). This will foster further disclosure and begin to reduce isolation. During initial interviews therapists also are attuned and respond to client’s past and present coping strategies. Empathic responses that highlight internal resources, strengths, resilience, and accomplishments (independence, patience, intelligence, education, employment) help to strengthen self-confidence and build self-esteem.

Developing a collaborative understanding of the underlying determinant of disturbance and setting mutual goals emerge in the course of exploring the client’s concerns. These are subject to ongoing discussion and modification over the course of therapy. Themes for exploration dur-
ing initial sessions include clients hopes for and fears about therapy, their understanding of the immediate and long term impact of childhood trauma, reasons for the current activation of symptoms, as well as the triggers for and functions of maladaptive feelings and behaviours. Maladaptive fear, avoidance, and shame (sense of self as vulnerable to abandonment, worthless, or dirty; lack of confidence, interpersonal difficulties, chronic anger, difficulties coping with feelings and memories) are validated as learned responses to trauma and abuse. Maladaptive behaviours, such as self injury or drinking, are validated as efforts to cope with, numb out, escape from painful feelings and memories. At the same time, therapist responses highlight and reinforce the client’s desire to learn more adaptive strategies and to improve their life. Responding to client concerns about maladaptive feelings and behaviour and their desire for justice, to feel better about themselves, or to be better parents, for example, establish broad goals for therapy and can help to motivate change.

**Phase Two: Reducing Blocks to Resolution**

During initial sessions, clients also are asked to identify the abuse experiences and abusive/neglectful others they wish to focus on in therapy. In the standard version of EFTT, the second phase of therapy typically begins with the introduction of the imaginal confrontation (IC) procedure. Clients are encouraged to imagine perpetrators of abuse and neglect in an empty chair and attend to and express previously constricted thoughts, feelings, and needs directly to this imagined other (“What happens to you on the inside as you imagine him/her there? … Tell him/her.”). This quickly evokes core emotional processes, including fear, avoidance, and shame, making them available for exploration and change. Standing up to imagined perpetrators, rather than telling a therapist, can be particularly empowering but this requires considerable ego strength and the capacity for healthy emotional experience and expression. In EFTT, fear, avoidance, and self-blame are considered maladaptive processes that interfere with the experience and expression of adaptive emotion (anger and sadness) and, in turn, with resolving issues with perpetrators and attachment figures. Therefore the middle phase of therapy generally focuses on increasing ego strength and the secondary task of reducing these blocks.

In introducing the IC procedure, it is essential to monitor the client’s capacity to regulate their emotions and to manage trauma material and the procedure. The therapist provides a brief rationale, guidance, reassurance, and support throughout the process, and can switch to exploring issues in interaction with the therapist if needed, for example, at signs of excessive constriction, panic, or dissociation. Clinical judgement will determine whether to initially confront more or less threatening others. Clients often are less afraid of a neglectful mother but collapse into fear and powerlessness imagining the perpetrator of abuse. The guiding principle is to avoid retraumatization. Interventions direct attention to clients responses and difficulties as they imagine the other (“Somehow you collapse, it’s hard to stand up to him even in imagination”), and the implicit view of self as a powerless victim and the other as huge and dangerous (“He
still has the power to shut you down, even in here."). At deflections from IC, the therapist and client collaborate on the goal of reducing fear and clearly expressing legitimate feelings and meanings about the abuse (“We want you to say what you need to say, speak your truth, no holding back, not as practice for confronting in real life, but for yourself, so you become clear and strong, then you can decide what to do in real life.

In EFTT, fear, avoidance, and shame are understood as either primary or secondary maladaptive emotions. Primary maladaptive fear and shame represent the activation of a core sense of self as worthless and insecure. Clients feel vulnerable to rejection or abandonment and view themselves as powerless victims. GREENBERG & PAIVIO (1997) have referred to this as the “weak/bad” sense of self. Secondary feelings of fear and shame are generated by maladaptive thought processes and beliefs or a sequence of feelings and beliefs. The distinction between primary and secondary emotion informs appropriate intervention. At markers of their activation in therapy, a variety of techniques are used in conjunction with IC to explore and reduce these blocks. These include experiential focusing, memory work, and gestalt-derived two-chair dialogues. Clearly delineated intervention principles and guidelines for conducting these techniques have been presented in earlier manuscripts on EFT (e.g., GREENBERG ET AL., 1993) and related therapies (e.g., GENDLIN, 1997).

Promoting experiencing. The capacity to attend to and explore current subjective experience is fundamental to productive participation in all aspects of therapy so that deficits in this area need to be addressed. We rarely use experiential focusing as a structured procedure but rather use the principles of focusing and promoting experiencing outlined by GENDLIN (1997). These include slowing down the process through the use of relaxation and silence, directing client attention to bodily experience, and allowing words to emerge from that experience rather than describing it from an observer perspective. As well, a number of therapist responses can be used to help deepen experiencing (e.g., “Say more about that, help me understand what it’s like for you.” “What’s the worst part of it for you?”) (KLEIN, MATTHIEU-COUGHLAN, & KIESLER, 1986).

Two-chair enactments. Two chair dialogues can be used to reduce self-critical and self-interuptive processes, and fear generated by catastrophic expectations. For example, the process for the client who continually berates himself for not disclosing molestation at the time can be understood as a conflict between the critic (“It’s your own fault, you should have said something to Mom”) and the recipient of the criticism, that is, the experiencing self that feels guilty and ashamed for not disclosing. The goals are to heighten awareness of specific criticisms, as well as client agency in producing guilt and shame, and to access alternate healthy resources to counteract maladaptive beliefs (e.g., “I was so young and completely alone and terrified of being blamed and rejected”). This can access understanding and compassion for self to counter self-criticism.
Similar principles apply to chair work with catastrophic expectations (e.g., “I know it’s crazy but sometimes I’m afraid they’re going to find me, I imagine him outside my window looking in, or waiting outside my door”). Again, interventions are intended to heighten the client’s awareness of core maladaptive processes and agency in contributing to their fear (“Come over here, what do you say to make yourself feel afraid?”), and to access challenges or alternate self-soothing resources to counteract fear (“He is old and sick and can’t hurt you, can’t force you to do anything you don’t want to do, you are not a helpless child anymore …”).

Continuing to promote resolution of interpersonal grievances involves periodically switching from a two-chair dialogue between parts of the self to confronting imagined threatening others. This is done at markers of the emergence of healthy resources (e.g., “It’s not true what he said, I was not a bad kid, I tried my hardest to please”) and can be simply a few assertive statements directed at the imagined other. It is essential to elicit the client’s experience of confronting the other as a barometer of change and to empathically respond to and possibly explore that experience (“Still nervous, somehow still not quite comfortable saying those things. What’s that about, what goes on for you on the inside?”).

**Memory work.** Memory work often is more effective than two chair work in cases of complex PTSD that involve a primary maladaptive sense of self as worthless or insecure. Strengthening this weak/bad sense of self can be accomplished by evoking and exploring episodic memories of times when this sense of self was formed. For example, the client above can be encouraged to remember himself at the time of the abuse and how vulnerable, afraid, and trapped he felt. Principles of intervention involve balancing attention to external details of the event (e.g., the sound of perpetrator’s loud voice or critical tone) in order to evoke an emotional response, with attention to that internal response (feelings of fear or shame). Here again, the change process in shifting maladaptive fear and shame involves accessing associated maladaptive beliefs (“I’m such a loser”, “Who could love me”) and needs (to feel good about self, receive comfort and support), then to access some alternate healthy response to counteract beliefs and bad feelings. Sometimes these emerge spontaneously as a healthy rebellion against bad feelings. For example, for one client, accessing memories of sexual abuse and “feeling dirty,” shifted to feelings of anger at the perpetrator for stealing her innocence that, in turn, shifted to soothing her imagined self as an innocent child. Alternately, accessing healthy resources can be initiated by the therapist (“What does she need, little Tanya, if you were there as your adult self, how would you help her, what could you do or say?”). In either case, it is important to switch to the interpersonal resolution process and to confront imagined perpetrators at the emergence of healthy assertion.
Phase Three: Resolution of Issues with Perpetrators

The catalyst for resolving traumatic attachment injuries is the uninhibited experience and expression of adaptive emotions and associated meanings. In the latter phase of therapy, avoidance and self-blame are gradually reduced and clients are more and more able to clearly express feelings (adaptive anger and sadness) and needs to imagined others in the empty chair and move toward resolution. Although it can be particularly empowering for clients to enact standing up to perpetrators of abuse, this type of imaginal confrontation can be stressful for a variety of reasons (e.g., performance anxiety, emotion dysregulation, need to maintain contact with the therapist). Results of one study indicated that 35% of clients were unwilling or unable to participate in IC after its introduction in session four (Paivio et al., 2001). Thus the IC intervention is used judiciously throughout therapy according to individual client processes and treatment needs. Clients make decisions about how and how often they feel able to explore trauma material. Results of a recent study (Paivio et al., 2001) indicated that, on average, five sessions (range 2 to 15) in a 20 session therapy contained substantial IC work. However, results also indicated that both the quality of engagement and frequency of client participation in IC contributed to good outcome (Paivio et al., 2001). Thus therapists need to be active in initiating and encouraging client participation in the procedure. EFTT specifies underlying intervention principles and provides a hierarchy of alternative strategies for facilitating emotional engagement with individuals who find IC difficult. For example, confront a less threatening other first, only periodically confront an imagined other and initiate confrontation at markers of assertive expression, imagine that the other can hear but avoid using the chair, explore exclusively in interaction with the therapist.

The alternate Empathic Exploration (EE) procedure was developed for clients who declined participation in IC. The EE protocol is identical to IC described above in terms of the model of resolution and intervention principles. However, clients are encouraged to vividly imagine abusive/neglectful others and traumatic events in their “minds eye” and express their thoughts and feelings to the therapist, rather than engage in a dialogue with an imagined other. EE was comparable to IC in terms of efficacy (Paivio et al., 2007) but is thought to be a less stressful and evocative intervention alternative. Recent analyses of therapy sessions indicating lower levels of emotional arousal in EE and a lower drop out rate (7%) compared to IC (20%) support this view.

Regardless of the technique, resolution is guided by the model (Greenberg & Foerster, 1996) and characterized by reduced negative feelings, letting go of unmet needs, and changed perceptions of self and abusive and neglectful others. Interventions help clients shift to a stance of increased self-empowerment and self-esteem. This includes assertive expression of anger (and sadness) about childhood experiences and the effects these have had on them (“How dare you manipulate and corrupt innocent children for your own sick needs, and do it in the name of God! I was an innocent little kid and you destroyed that”), a sense of entitlement to
unmet needs ("I deserve love and security, I refuse to have this dominate my life anymore"), and appropriately holding abusive and neglectful others accountable for harm ("I know she had her own limitations but it was not right to turn a blind eye to what was going on," or "What he did was criminal, he deserve to be punished.").

During this procedure, arousal levels initially are high, emotional intensity then falls as meaning is accessed and explored. Interventions encourage the client to articulate the full impact of the abuse on her and, like a victim impact statement, hold the perpetrator accountable for harm. It also is critical to elicit the imagined perpetrator’s response to client confrontation. This captures the client's view of the other’s capacity for understanding, empathy, and remorse. The goal is for clients to arrive at a more differentiated perspective of attachment figures and perpetrators, so they are seen as more life-size, less powerful, either sick and pathetic and incapable of understanding, or possibly repentant. The IC procedure can be combined with EE ("How do you imagine your father would react [in his heart] if he know how you really felt—defensive, remorseful, blaming and angry? Or if he knew the impact on you?"). Enacting or imagining the other also can elicit client empathic resources. This can be particularly important in healing attachment relationships, for example, coming to understand that one or both of her parents also were victims or had limited resources.

Many clients are better able to express sadness and grieve losses once their anger has been expressed and their grievances validated. In promoting anger expression therapist responses help shift the client from rejecting anger, such as, “You disgust me you pervert!” (PASCUAL-LEONE, 2006), to more assertive stance. The features of healthy adaptive anger expression associated with resolution are as follows: Anger is directed outward at offender for specific wrongs rather than directed at the self; anger is differentiated from other emotions such as sadness or fear, anger is assertively expressed using "I" language rather than hurling insults, arousal level is appropriate to the situation, and there is some exploration of meaning (PAIVIO & CARRIERE, 2006).

Once clients feel stronger, full expression of anger can shift to acknowledging pain and grieving losses. Clients feel strong enough to allow the pain of rejection and accept the fact that they were neglected or not loved and let go of efforts to get these met from attachment figures. Because it is inappropriate for clients to be vulnerable in front of threatening others, allowing pain and grieving losses takes place in interaction with the therapist, an imagined compassionate other (perhaps a remorseful attachment figure), or the imagined self as a child. Evocative empathic responses are used to promote sadness experience and expression at appropriate markers, such as eyes welling up in tears ("Yes, this is what just kills you, so many things you missed out on, let it come, put words to those tears."). It can be particularly powerful for clients to imagine themselves as a child. This can elicit compassion for self and self-soothing responses (Th. Imagine little Tanya here [move empty chair closer] as a frightened confused little girl. What do you want to say to her, want her to know. Cl. You were innocent, you deserved love and protection, I’m gonna take care of you from now on. ).
Phase Four: Consolidation and Termination.
The final phase of EFTT involves integration of therapy experiences and termination. Clients engage in a final dialogue with imagined others in order to consolidate current perspectives and changes. They are explicitly asked to attend to their internal experience while confronting the other and to compare their current experience to memories of what it was like at the beginning of therapy. Therapists support the emergence of adaptive resources that promote reorganization, a self-validating stance, and creation of new meaning. Termination also involves processing client’s experience of therapy (difficulties, successes, helpful aspects). Therapists offer feedback in terms of process observations (“I was aware of how hard it was for you to open up at first and yet you persisted”). Discussions also will focus on and support client’s plans and goals for the future. It can be useful to gradually phase out therapy sessions and it is essential to ensure that clients have adequate supports outside of therapy before sessions are completely terminated.

Summary
This paper outlined the fundamental assumptions underlying EFT applied to child abuse trauma, the posited mechanisms of change, and the distinguishing features of this model compared to other approaches. These include empirical support for both efficacy and the posited mechanisms of change, individual modality and broad applicability to men and women and different types of abuse, focus on accessing healthy adaptive emotion, and empirically verified model specifying steps in the process of resolution. This model forms the basis and guides the process of therapy. We then described the phases of therapy and provided clinical examples to illustrate key intervention principles and techniques. Phases include establishing a safe and collaborative therapeutic alliance, overcoming blocks to emotional experience and expression, resolving issues with perpetrators, and termination. Intervention principles and techniques include empathic responding to client feelings and needs, reducing avoidance and self-blame through the use of experiential focusing, two-chair enactments, and memory work; resolving interpersonal grievances through the use of imaginal confrontation of perpetrators or empathic exploration of trauma issues in interaction with the therapist.

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