Resolving Attachment Injuries in Couples Using Emotionally Focused Therapy: A Process Study

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ABSTRACT

The current study identified attachment injuries in couples and developed a preliminary model for the resolution of attachment injuries using Emotionally Focused Therapy (EFT). An attachment injury occurred when one partner betrayed or broke the trust of the other in a specific incident and that incident became a clinically recurring theme or stuck-point of task resolution. Couples with attachment injuries were identified by an expert clinician and the researcher. Subjects were couples with moderate to mild distress. The attachment injuries were resolved using EFT, an empirically validated approach to couples therapy. The model (N = 3) was developed using task analysis. Audiotaped segments of "best sessions" of marker events were reviewed by raters to determine change events throughout the therapy process. A rational, conceptual map of expected change was compared to an empirically developed map. The marker events emerged at the assessment, de-escalation, and resolution phases of treatment. Pre- and post-tests measured overall resolution of the attachment injury and process measures identified in-session changes. The results of this study yield a proposed theoretical model of change for couples who sustain an attachment injury.

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Chapter I

Introduction

When couples enter therapy, partners have often experienced considerable emotional distress. They report feeling absorbed in negativity toward their partner and trapped in limited ways of relating to one another. The person they used to turn to for comfort and support no longer seems available. Some may react to their distress through blame and criticism, others through distance and withdrawal. Research has indicated that distressed couples report lower levels of adjustment and satisfaction (Collins & Read, 1994; Simpson, 1990), lower levels of intimacy and trust, and higher levels of defensiveness, hypervigilance, and fear of abandonment than non distressed couples (Hazan & Shaver, 1987).

Lower levels of intimacy, trust, and relationship satisfaction often indicate insecure attachment bonds (Hazan & Shaver, 1987). Couples with insecure attachment bonds tend to interact through defensive emotional patterns and block accessibility, trust, and responsiveness (Johnson, 1996). These couples are susceptible to attachment alarms, manifested through behaviors such as protest and hostility, and feelings of despair and detachment (Bowlby, 1969). Secure attachment bonds, on the other hand, have been characterized by emotional affiliation, trust, and accessibility. The secure relationship bond serves as a safe base and buffer against distress (Johnson, 1996).

From a systems perspective, pinpointing a cause of distress and the dissolution of an attachment bond ignores the complexity and context of the relationship. From a client's point of view, however, significant events can occur which punctuate desultory attachment bond insecurities. Johnson (1996) proposed that distress and attachment insecurities can frequently be traced to a specific incident when one partner feels a strong sense of betrayal by the actions of the other. In therapy, this incident stands as a nodal transition in the couple's relationship: the injurious event becomes a recurring theme, representing a wound in the attachment bond and marking patterns of mistrust and distress.

Guided by Emotionally Focused Therapy (EFT), attachment theory, and clinical experience of the developers of EFT, this study tested the utility of attachment injuries as a concept and developed a preliminary model for the resolution of attachment injuries in mildly to moderately distressed couples using EFT as the treatment. The model was developed by task analysis. A conceptual map of expected change processes were refined by an empirically developed map. The results of this study validated the hypothesized concept of attachment injuries and yielded a proposed resolution model of change for couples who sustain an attachment injury.

Attachment Injury

An attachment injury is a newly developed concept in the marriage and family therapy, counseling, and psychology literatures. The concept stems from the theoretical underpinnings

of child and adult attachment theory (e. g., Ainsworth, 1960; 1990; Bartholomew & Horowitz, 1991; Bowlby, 1969; 1973; 1980; West & Sheldon, 1988), Emotionally Focused Marital Therapy (e. g., Johnson & Greenberg, 1985a), and expert recommendation from clinical experience (Susan Johnson, Personal Communication, June 1998).

EFT theory maintains that a secure attachment bond in couples is fostered by emotional accessibility and responsiveness (Johnson, 1996). Accessibility implies being available for emotional and physical contact when the other partner is in distress. Responsiveness refers to the willingness to respond to the needs and desires of the other. When one partner is inaccessible or unresponsive to the psychophysical needs of the other, an insecure attachment can ensue (Johnson & Whiffen, 1999). Based on EFT theory, an attachment injury is characterized as a betrayal that contributes to insecure attachment bonds and that is continually used, whether implicitly or explicitly, as a standard for the dependability of the other. The loss of trust, and the accompanying insecure attachment, are hypothesized to lead to negative interactional cycles between the couple that may escalate into severe marital distress (Johnson, 1996).

Definition of attachment injury. An attachment injury occurs when one partner does or says something to the other partner that "damages the nature of the attachment bond" (Johnson, 1996). The damaging incident can be as grave as an extramarital affair or as seemingly minor as being left out of a photograph at a family gathering (Susan Johnson, Personal Communication, June 1998). The actual incident of an attachment injury is not necessarily the cause of the disruption of the relationship bond. Some partners may have endured insecure attachment bonds over time and the incident serves as a symbolic marker of the insecure attachment state. Others may have a secure bond and the incident prompts the beginning of relationship distress.

Johnson (1996) defined an attachment injury as:

> [an] attachment betrayal or crime, that is, traumatic incidents that have damaged the nature of the attachment and actively influence the way the relationship is defined in the present . . . For example, a small current incident where one partner is disappointed may become an enormous issue because it evokes a key incident in the past, where one partner experienced traumatic abandonment, rejection, or betrayal at the hands of the other . . . As the emotions underlying interactional positions are processed, these incidents come alive in the session. (p. 103)

Johnson and Whiffen (1999) further defined attachment injuries and the resulting interactional patterns:

> These injuries may appear insubstantial to an outside observer or they may be obvious betrayals of trust, such as an affair. They often occurred at particularly critical

> moments of need when a person was particularly vulnerable. These events may become a touchstone, an incident that, for them, defines the security of the relationship. The anxious partner will bring the incident up again and again in an attempt to get closure. This becomes aversive for the spouse who withdraws from the discussion. (p. 28)

The attachment injury event serves as an alarm, a warning system that sends the message that the other cannot be trusted to provide security and comfort. The injured partner experiences a decrease in the level of trust in his/her partner and may decide implicitly not to reach out to their partner for security and comfort. Johnson (1996) wrote that highly distressed couples and couples who describe an attachment injury often speak in life-or-death terms and metaphors such as, "You let me drown," or "You didn't care that I crashed and burned after that argument."

Clients who report attachment injuries may enter therapy and talk about the attachment injury incident in the assessment stages of therapy having well-formulated meanings ascribed to the event (Johnson, 1996). Some clients may report the incident as a traumatic flashback; others may report an incident as symbolic of the dissolution of the bond. Other clients who report attachment injuries may enter therapy and have little memory of the incident until after initial presenting problems have been discussed, until a safe therapy alliance has been created, or until the injured's defensiveness has abated enough so the incident appears in more clarity (Johnson, Personal Communication, July 1998).

As identified by the researcher, the therapists providing treatment, and clients who entered the Ottawa Civic Hospital (Ontario, Canada) for couples therapy, an attachment injury for purposes of this study occurred when one partner betrays or broke the trust of the other in a specific incident and that incident became a clinically recurring theme and stuck-point of task resolution. The injurious event weakened the attachment bond and then promoted negative interactional cycles, leading to relationship distress.

Emotionally Focused Therapy

EFT (Johnson & Greenberg, 1985a) is a short-term structured approach to couples and family therapy. EFT is one of few family therapy models that has provided replicable procedures, has stipulated specific interventions, and has tested the effectiveness of the interventions. EFT has been empirically tested on numerous presenting problems, most notably marital distress, and has shown to create stronger attachment bonds and higher levels of trust and intimacy in couples (Johnson, 1997; Johnson, Hunsley, Greenberg, & Schindler, 1998). EFT has shown that partners sustain long-term change (Johnson, Hunsley, Greenberg, & Schindler, 1998). Overall, EFT has shown to have large effect sizes (1.3). An effect size of 1.3 suggests that the average couple treated with EFT reports more marital satisfaction, trust and affiliation than 90% of untreated control group couples (Johnson, Hunsley, Greenberg, & Schindler, 1998). The primary goals of EFT are: (a) to expand and reorganize key emotional

responses; (b) to create a shift in partners' interactional positions and; (c) to foster the creation of a secure emotional bond between partners.

EFT theory postulates that emotions serve to organize experiences of self and responses to others. When the attachment bond is threatened, powerful emotional signals shape behavioral responses. For example, the perceived inaccessibility of the other can create powerful negative emotional and interactional cycles and distress (Johnson, 1996). Marital distress tends to create absorbing states of negative affect that limit the range of other behaviors. Partners with insecure bonds tend not to have the behavioral flexibility as those with secure attachment bonds (Johnson & Whiffen, 1999). Insecure bonds tend to be played out in negative interactional patterns such as pursuing and avoidant behaviors which "create an interaction pattern that actually exacerbates each partner's insecurity and precludes safe emotional engagement" (Johnson, 1996, p. 24).

The proposed conceptual resolution model for attachment injuries for this study followed the empirically validated treatment process of EFT. The three phases of EFT treatment are: cycle de-escalation, re-engagement and interactional shifts, and the consolidation and integration of change (Johnson & Greenberg, 1985a).

Attachment Theory

EFT draws from principles of child-parent and adult attachment theories. Attachment theory (Bowlby, 1969) generally connects neurophysiological and social phenomena and emphasizes the interactions that center around the development of affiliative bonds between child and parent and between partners in adult relationships. The crux of adult attachment is the individual's capacity for concern, trust, and accessibility.

Adult attachment theory was developed as an offspring of child-parent attachment. Sperling and Berman (1994) defined adult attachment as:

> The stable tendency of an individual to make substantial efforts to seek and maintain proximity to and contact with one or a few specific individuals who provide the subjective potential for physical and/or psychological safety and security. This stable tendency is regulated by internal working models of attachment, which are cognitive-affective-motivational schemata built from the individual's experience in his or her interpersonal world. (p. 8)

The above definition has served as the model for classifying adult-love relationships into various attachment styles. The broadest categorizations are secure and insecure attachment styles.

Overview of Methodology: Task Analysis

The task analysis protocol was followed in this study. Task analysis, a discovery-oriented or rational-empirical research method, identifies, describes and analyzes the processes of change within a given clinical context (Greenberg, 1984; 1986; Greenberg & Newman, 1996). Task analysis can be used for several research purposes: to identify major clinical in-session change events; to build models of therapy; to refine models of therapy; and to predict complex therapy outcomes from in-session change processes (Greenberg & Newman, 1996).

There are two phases of the task analysis strategy: the rational-empirical phase and the verification of the rational model of change. In the rational-empirical phase, the clients' moment-to-moment successful performances are identified as they resolve a meaningful clinical task (Greenberg, 1984; Pascual-Leone, 1976). The researcher describes the sequences of events from the assessment marker event such as an attachment injury to the resolution event. The goal is to develop a conceptual model of the interactions of resolved or "successful" performances. The verification phase consists of comparing groups of resolution and non resolution performances to ascertain whether components of the model discriminate at a statistically significant level between successful and unsuccessful performances. This study included only the rational-empirical phase and not the verification phase.

The eight steps of the rational-empirical phase of task analysis are (Greenberg, Heatherington, & Friedlander, 1996):

1. The explication of the implicit map of experts of the process.
2. The selection and description of a task.
3. The specification of the task environment.
4. The evaluation of the potency of the task environment.
5. The rational task analysis.
6. The empirical task analysis.
7. The construction of the rational-empirical model.

The first step begins with an expert clinician who has an explicit theory or model of therapy. The clinician has an implicit map of some important event that has not been empirically tested. The event should be based on the clinician's theory or model of therapy, and the clinician's clinical experience. The clinician's map identifies an event or client performance to be studied and guides the investigation of change (Greenberg, 1986). In the second step, the researcher selects a task to be investigated and delineates a detailed description of the task event and the behavioral components of the client marker. The researcher then develops a strategy for identifying the markers' occurrence or non occurrence (Greenberg, Heatherington, & Friedlander, 1996).

The third and fourth steps involve descriptions of change events of client performance that follow a "when-then" format such as *when* clients show a negative blame-withdraw cycle,

then the therapist can begin to explore the clients' primary affect cycles (Greenberg, 1986). The client performance patterns are markers of change. The marker, the therapist's intervention, the resulting client process and the resolution performance make up the change event. According to Greenberg (1986), the event is worthy of study when it occurs across clients over time. Self-report questionnaires can obtain the verification of the potency of the event (an optional step) to determine if the client thought that the task resolution had occurred.

The purpose of the fifth step is for the researcher to map out a framework or rational model for understanding client performances and how the task can be ideally resolved. The researcher diagrams a flowchart that spells out and hypothetically predicts the possibilities of the performance. The investigator proposes how the tasks will be measured and how the behavioral tasks can be identified and rated. Examples of measures used in task analysis research are the Experiencing Scale (Klein, Mathieu, Kiesler, & Gendlin, 1969), the Structural Analysis of Social Behavior (Benjamin, 1974), and the Emotional Arousal Scale (Daldrup, Beutler, Engle, & Greenberg, 1988).

The sixth step involves studying clinical performances which involve successful resolution in moderately to mildly distressed clients (Greenberg, 1986). The researcher observes client performances to identify and describe the sequences of events from the marker to the resolution. Process measures and/or statistical tests should be used to verify that event patterns are actually taking place in different points of the marker-resolution process.

In the seventh step, the empirical model is compared to the rational model in order to construct a more specific performance model. Quantitative and qualitative methods can be used to explicate differences between the models.

After the confirmed working model has been identified, the researcher, typically in further studies, can perform repetitive testing of the model (verification) by comparing, through hypothesis testing, resolution versus non resolution performances and, in addition, relating outcome to process through long-term outcome studies. This last verification step was not researched in this study.

Research Questions

The research questions for this study were as follows:

1) How did clients describe the attachment injury?

2) What were the results of the pre-test scores for couples?

3) What were the post-test scores and did the scores result in "successful" resolvers according to the measures' norms?

4) What were the results of the Structural Analysis of Social Behavior (Benjamin, 1975) and Experiencing Scale (Klein, Mathieu, Kiesler, & Gendlin, 1969) process measure scores within each marker or phase of resolution?

5) How did clients describe the attachment injury after the resolution phase of treatment?

6) In what ways did the event pathways of the proposed rational model of attachment injury resolution differ from those of the empirical model?

Rationale and Summary of The Study

This study tested the utility of the hypothesized concept of attachment injuries in couples and developed a preliminary model for the resolution of attachment injuries using Emotionally Focused Therapy. This study served several functions. First, there were no references to attachment injuries other than Johnson's (1996; 1998) conceptualization. This study may further solidify Johnson's (1996) conceptualization through clients' points of view. Second, there were no empirical studies in the literature on attachment injuries. This study attempted to build a preliminary model of how attachment injuries can be resolved clinically. Third, EFT has shown a high effect size for couples with general distress, but has not addressed couples who relapse to initial distress levels during treatment or who terminate treatment as non resolvers. Forth, this study may contribute to the programmatic efforts of EFT.

For this study attachment injuries were validated by the client, an expert clinician and the researcher. Couples were given assessment measures to ascertain the nature and extent of the injury. "Successful" couples with moderate to mild distress were used to develop the model. "Successful" couples were identified by: (a) passing the screening; (b) having an identifiable attachment injury; (c) completing EFT treatment and; (d) showing improvements to "normal" ranges on pre- and post-test measures. Also, pre- and post-tests measured overall resolution of the attachment injury and process measures will identified in-session changes.

The model (N = 3) of resolution was developed by task analysis. Audiotaped segments of "best sessions" of marker events were reviewed by the researcher and a rater to determine change events throughout the therapy process. The proposed marker events emerged at the assessment, de-escalation, and resolution phases. A rational map of change pathways of expected change was compared to an empirically developed map of change pathways.

The Attachment Injury Resolution Model

The following is a preliminary model that outlines the process of an attachment injury resolution (See Table 1 for Preliminary Empirical Model of Attachment Injury Resolution Process):

Table 1
Preliminary Empirical Model of Attachment Injury Resolution Process

Marker		Resolution
Attachment Injury	De-Escalation	Re-Engagement/ Softening
(Partner A) Blames and is hostile	(Partner A) Differentiates affect	(Partner A) Discloses and expresses needs; Is less hostile and has more trust
(Partner B) Withdraws, defends, denies, or minimizes	(Partner B) Less defensive	(Partner B) More engaged and empathic; Responds and is accessible

The first phase marks the attachment injury to be studied. This marker should occur in the assessment phase or the first two steps of the EFT model. The markers are statements of an incident of betrayal or rejection from *partner A* (e.g., of an affair, not being emotionally available, or other events having priority over the spouse). The injured *partner A* accuses and blames in a hostile manner, while the other *partner B* withdraws and takes a defensive stance. Second, in the de-escalation phase, *partner A* begins to articulate the significance of the injury, differentiates affect (e.g., hostility and hurt), and relates underlying feelings such as hurt and fear to the past and present cycle in the relationship. *Partner B* becomes less defensive and more responsive. However, the couple continues to interact in the similar rigid interaction cycles as in the first phase.

Third, in the re-engagement phase, *partner A* continues to differentiate affect, expresses vulnerability, and describes the attachment meanings in terms of safety and trust. *Partner B* becomes more engaged, listens and acknowledges the other partner's pain, and accepts responsibility for his/her part in the attachment injury. Fourth, the resolution phase, *partner A* softens (i.e., becomes less hostile and more trusting) and expresses the need for comfort, safety, and reassurance. *Partner B* responds to the needs of *partner A*, is accessible, and offers comfort.

CHAPTER II

Review of Literature

Introduction

In an effort to describe the underpinnings of the hypothesized attachment injury concept and model of resolution, the following reviews the literature on child-parent and adult-adult attachment theory, the programmatic efforts of emotionally focused therapy, and the construction of process research and task analysis. The purpose of this attachment review is not to cover comprehensively the development of attachment, but to describe attachment theory and the various influences of attachment theory, particularly adult attachment, on the theoretical foundations and clinical applications of EFT.

The first part of the chapter traces the roots of attachment theory as conceptualized by Bowlby (1969) and its subsequent development pertaining to child-parent bonds. The first part also includes links of child-parent attachment to characteristics of adult attachment. The second part of the chapter reviews the theoretical and clinical course of emotionally focused therapy, including process and outcome studies, and its relation to adult attachment theory. The third part explores process research and the justification for the use of task analysis for this study.

Attachment Theory

In the past twenty years, there has been an abundance of publications in the child-parent attachment literatures. Attachment theory began as a theoretical framework for describing the significance of child-parent bonding. Bowlby (1969) proposed that attachment bonds are not only a universal human phenomenon, but also a mammalian phenomenon. Attachment bonds connect biological and social phenomena and emphasize the interactions that center around the development of affiliative and affectional bonds between child and parent. Campbell and Taylor (1980) described attachment as a long-term emotional tie. The most common conceptualization of attachment theory is the individual's capacity for concern and trust, particularly in distress. Attachment behaviors have been described as not merely a reaction to separation but a natural response to any distress or uncertainty (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969). In the child-parent bond, strong affiliation and trust (or the lack thereof) are built as primary caregivers recognize and attend to the developmental physical and emotional needs of the child.

In his three-volume description of attachment, separation, and loss (1969; 1973; 1980), Bowlby's developed his theory from his observations of infants who were separated from their primary caregivers. He explored how infants become emotionally attached to their primary caregivers and how separation from these caregivers created a context of distress. He

discovered that the infants who were separated from their parents went through predictable behavioral stages from distress to protest to despair to detachment. He hypothesized that child attachment behaviors had a biological and evolutionary function of achieving proximity to caregivers under potential or actual threats of harm (Bowlby, 1969). Thus, attachment behaviors are thought to be crucial for survival.

Attachment styles. The research of child-parent attachment has generally involved the following goals (Weiss & Sheldon-Keller, 1994): (a) the identification of parental behaviors that activate child attachment behaviors (e.g., Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969/1980); (b) the investigation of infant attachment behaviors into early childhood (e. g., Lamb, 1985; Main, Kaplan, & Cassidy, 1985) and; (c) the correlation of attachment patterns with psychological well-being (e. g., Cohn, 1990; Matas, Arend, & Sfoufe, 1978).

The bulk of research has examined how the interaction behaviors of mothers and infants vary in relation to the security of the attachment bond and the classification of attachment styles in child- parent interactions (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1988; Main & Solomon, 1990). Ainsworth and colleagues (1978) classified attachment styles through the Strange Situation procedure, where the child's parent was temporarily replaced by a stranger and then reunited with the mother. Three attachment styles were identified through this procedure: secure, anxious-ambivalent, and anxious-avoidant.

A secure emotional bond has been described as an emotional bond formed between an infant and one or more adults such that the infant will: (a) approach them especially in periods of distress; (b) show no fear of them, particularly during the stage when strangers evoke anxiety; (c) be highly receptive to being cared for by them and; (d) display anxiety if separated from them (Reber, 1985; Shaver, Hazan, & Bradshaw, 1980). The secure child feels assured that the parent will be responsive, comforting, and protective, allowing the child to meet developmental needs (Ainsworth, Blehar, Waters, & Wall, 1978).

A child with an anxious-ambivalent attachment style has been characterized as being reluctant to get close to others. The child shows uncertainty as to the availability and protection of the parent. Behavioral manifestations of anxious-ambivalent children include being clingy, greatly distressed by separation, and often fearful of their environments (Ainsworth, Blehar, Waters, & Wall, 1978). The parent has been described as being inconsistently emotionally available.

The anxious-avoidant attachment style has been characterized by the child having little confidence that the parent will be emotionally available and caring. These children tend to develop an overly self-reliant internal model of self, hide dependency needs and withdraw from others (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1988).

In observational studies of parent-child interactions, Main and Solomon (1990) proposed a fourth parent-child style, a disorganized/ disoriented attachment. The authors reported that these children seemed confused when presented with tasks under separation and were engaged in "incomplete or undirected movements or expression" (Main & Solomon, 1990, p. 122). These children were often victims of abuse/neglect (Crittendon, 1988; Main & Solomon, 1990).

The origins of attachment. Many studies have speculated on the etiology of attachment. In a review of literature, Colin (1996) stated that some authors treated attachment as an innate potential while others viewed it as patterns of behavior, making no assumptions about genetic foundations. Bowlby (1969) assumed that humans have an innate attachment instinct for bonding that serves as an alarm system for threats of harm. Bowlby (1969) also assumed that behavioral manifestations are learned and malleable.

Attachment behavior is Bowlby's term for the behavior of an infant in relation to attachment figures. The essential feature of this behavior is that the infant will seek out the adult and behave so as to maintain close contact through distress with responses such as clinging, crying, protesting, and withdrawal. Bowlby (1969; 1973) postulated that infants construct an internal working model of self and others through their attachments to significant others.

Ainsworth et al. (1978) examined the effects of attachment and children's cognitive advances and showed that the children depended less on physical proximity to the caregiver because they had developed secure internal working models of the attachment figure and were aware that parental distance did not imply inaccessibility and absence of protection. The development of internal working models allowed for the child to explore new environments without being in constant proximity to the caregiver. Ainsworth et al. (1978) termed this internal model the "secure base phenomenon."

Attachment theorists have conjectured that attachment is of vital importance throughout the life-span and that even though attachment behaviors or behavioral styles are relatively stable over time, they can change due to other attachment figures or environmental circumstances (Bowlby, 1969; Cicchetti, Cummings, Greenberg & Marvin, 1990; Main, Kaplan, & Cassidy, 1985). Bowlby (1969) also postulated that the internal models guide a person's primary relationship behaviors throughout life. Ainsworth (1985) stated that attachment patterns are stable throughout life, but are not fixed personality characteristics.

Adult Attachment

A majority of the theoretical and clinical research on attachment theory has focused on child-parent bonds. Since the mid-1980s, the foundational work of Bowlby and Ainsworth has been extended to adult-adult attachment and the classification of adult attachment styles (e. g., Hazan & Shafer, 1987, Kobak & Hazan, 1991; Shafer, Hazan, & Bradshaw, 1990; Simpson & Rholes, 1998; Sperling & Berman, 1994; Weiss & Sheldon-Keller, 1994).

Bowlby (1979) stated that attachment extends from "the cradle to the grave" and that "there is nothing intrinsically childish or pathological about it" (pp. 127/131). He described adult caregiving as the need of human beings to form and maintain emotional bonds with a few specific others. He discussed the sense of emergency one feels when separated with primary partners particularly while under distress. Ainsworth (1990) defined adult attachment as an affectual bond that is long-enduring with a seemingly irreplaceable other. Sperling and Berman (1994) departed from Bowlby's caregiving label for adults to the label of adult attachment bonds. They defined adult attachment as the tendency of one to seek and maintain proximity to those who provide physical and/or psychological safety and security.

Adult attachment research. Early research on child-parent attachment dealt with normative responses to a child's separation from his/her attachment figure. The seminal work of adult attachment dealt with observing reactions to the disruption of the attachment bond in traumatic events such as in cases of separation (Weiss, 1975) and the death of a spouse (Glick, Weiss, & Parkes, 1974; Parkes, 1972). Reactions to adult bond disruption followed similar processes to that of child-parent separation: protest, despair, and detachment/reintegration (Sperling & Berman, 1994).

Theoretical connections have been made from child-parent attachment to adult-adult attachment. Weiss (1982) posited that the behaviors that meet child-parent features are also found in adult attachments. The central defining features of child attachment are: proximity-seeking, secure base, and separation protest. Weiss (1982) described three characteristics that differentiate adult from child-parent attachment. First, in adults, attachment relationships are between peers rather than care receiver and caregiver. Second, attachment in adults is not as susceptible to being overwhelmed by other behavioral systems and life contexts. Adults have cognitive and behavioral strategies to cope with distressful situations. Third, attachment in adults typically includes a sexual relationship.

Researchers have studied attachment distress in phase-of-life nodal events such as the transition from high school to college (Kenny, 1987; Sperling & Berman, 1994). Findings were that students maintained attachment to their parental attachment figures and that the quality of attachment corresponded with their adjustment and emotional distress to college. Other studies have looked at changes and continuities throughout the life cycle (e. g., Levitt, Weber, & Clark, 1986) and have shown that a secure child attachment style promoted secure adult behaviors to parents, spouses, and friends despite life transitional stresses.

Extensive research has focused on the correlation of attachment styles and DSM-IV mood and personality disorders (Florsheim, Henry, Benjamin, 1996). Sperling and Berman (1994) reviewed the literature describing how insecure attachment can contribute to susceptibility to depression, anxiety, and greater degrees of interpersonal conflict. They described studies showing how the sensitivity of attachment or how quickly one gets involved in relationships can be correlated to dependent and borderline personality disorders.

Sperling and Berman (1994) classified general topics covered in adult attachment such as the activation of attachment behaviors. They reported that couples differ in the degree and frequency of responses to distress and how the activation of attachment behaviors tends to be less in secure couples. The authors reviewed studies on how frustration tolerance and the reliance of defensive behaviors tend to be higher in insecure styles. Sperling and Berman (1994) applied systems theory to attachment, maintaining that disturbances in the dyadic relationship "account for differences in attachment style" (p. 9), whether secure or insecure, and for differences in emotional and behavioral adjustment.

Adult Attachment Styles. Research in adult attachment has involved classifying individual differences in attachment style. Perhaps a limitation in adult attachment theoretical development, most theorists have suggested that there is one secure style and various insecure styles. Adult attachment styles have generally referred to one's behavioral responses to perceived and actual distress, and to the separation and reunion to attachment figures (Sperling & Berman, 1994).

There has been no agreement on the overall classification of adult attachment styles. Some styles have overlapping characteristics. In general, a secure adult to adult attachment style is characterized by internal working models in which the person has a positive view of self and others, has high levels of intimacy, and has high levels of trust and perception of the availability and responsiveness of others in both relationship and external distress (Ainsworth, 1985; Bartholomew & Horowitz, 1991).

A secure adult attachment style has been correlated to adjustment and satisfaction in adult relationships (Collins & Read, 1990; Simpson, 1990), having a wider range of responses to conflict (Simpson, Rholes, & Phillips, 1996), seeking and giving support (Simpson, Roles, & Nelligan, 1992), and having higher levels of intimacy and trust and lower levels of hypervigilance, jealousy, and fear of abandonment (Hazan & Shaver, 1987). Also, attempts are being made to correlate secure attachment to the quality of physical health (Colin, 1996).

Approximately nine "insecure" styles have been identified in adult-adult attachment. The styles used primarily for research purposes have been secure, preoccupied, dismissive, and fearful-avoidant. A preoccupied person has a negative view of self and a positive view of others and tends to need the acceptance of others for self-acceptance and self-definition (Bartholomew & Horowitz, 1991). A dismissive person has a positive view of self and a negative view of others (Bartholomew & Horowitz, 1991; Main & Goldwyn, 1985) and tends

to avoid emotional closeness and vulnerability (Bartholomew & Horowitz, 1991). A fearful-avoidant person has a negative view of self and others, and tends to avoid emotional

involvement with others. A fearful-avoidant person also expects betrayal, rejection, and criticism (Bartholomew & Horowitz, 1991).

Other styles have been identified such as compulsive self-reliant (Bowlby, 1977; West & Sheldon, 1988), compulsive caregiving (Bowlby, 1977; West & Sheldon, 1988), compulsive care-seeking (West & Sheldon, 1988), and angry withdrawn (West & Sheldon, 1988). (See Table 2 for Classification of Adult Attachment)

Table 2
Classification of Adult Attachment

Attachment Type	Description		
	View of Self	View of Others	Relationships
Secure	positive	positive	high intimacy and autonomy
Preoccupied	negative	positive	self-acceptance from valued others
Dismissive	positive	negative	protects self by avoiding closeness; independent and invulnerable
Fearful-avoidant	negative	negative	expects betrayal, rejection and criticism; protects self by avoiding closeness

Adult Attachment As Applied to Emotionally Focused Therapy

Few empirical studies have focused on the psychotherapeutic restructuring of insecure attachment behaviors except in the theory and clinical applications of EFT. Adult attachment theory is central to EFT theory. The goal of EFT from an adult attachment point of view is to foster the creation of a secure bond and reduce attachment insecurities (Johnson, 1996). Attachment in EFT concerns itself not so much with naturalistic explanations of attachment

styles in the daily routine of people's live, but with how attachment styles manifest themselves when couples in distress make sense of their relationship bond in a therapeutic context.

Attachment theory posits that seeking and maintaining an emotional bond in primary relationships is a survival force and a dependency need. Some sources characterize this dependency in insecure styles as pathological (Bowlby, 1980; Colin, 1996). From the EFT perspective, attachment dependency is an innate characteristic throughout life and the cornerstone of healthy relationships. Johnson (1996) stated that the power of this affect is associated with a "wired in" evolutionary survival system. EFT's use of attachment depathologizes attachment needs, such as dependency, which are seen as healthy and adaptive (Johnson, 1996; Jordan, Kaplan, Miller, Stiver, & Surrey, 1991). Johnson and Whiffen (1999) also stated that attachment styles are not necessarily fixed or characterlogical, but represent influence tendencies under stress. One may have a secure style in day-to-day mildly stressful situations but exhibit an avoidant style in distress.

EFT theory maintains that the emotional experience of self and responses to others make up interactional patterns that can be classified into attachment styles, or more generally put, into either secure or insecure attachment styles. EFT has empirically shown that couples can access the primary emotions said to be crucial for fostering more secure affectional bonds (Johnson, 1996). Secure attachments help partners regulate negative emotional experiences such as experiences of sadness, loss, anger, fear and shame (Johnson, 1996).

When one's security is threatened, affect organizes cognitive and behavioral responses into predictable sequences, parallel to Bowlby's theoretical mapping, of protest and anger to clinging and seeking to depression and despair (Johnson & Whiffen, 1999). Negative attachment styles such as anxious, avoidant fearful, and avoidant dismissing (Bartholomew & Horowitz, 1991) sustain an insecure, threatened bond. Insecure bond behaviors are played out in reactions such as fight, flight, or freeze, and "predictable behavioral sequences" such as protest, anger, clinging, depression, and despair specifically (Bowlby, 1969).

Secure attachment can create a secure base (Ainsworth, 1978; Bowlby, 1988) or a safe haven (Johnson, 1996), which acts as a buffer to stress and helps partners respond to new contexts and developmental needs. In a secure attachment style, the person has a positive view of self and others, and a moderate to high level of intimacy and autonomy (Bartholomew & Horowitz, 1991).

The main clinical issues concerning attachment are the degree of connection and disconnection, and the degree of separateness and closeness. Johnson (1996) stated: "[t]herapy focuses upon the deprivation, loss of trust and connection, isolation, and attachment fears of the partner, and the ways in which their interaction patterns maintain the distress" (p. 21). In therapy, attachment issues are manifested when partners show their capacity to express fear and hurt and for providing comfort, trust, and acceptance.

Emotionally Focused Therapy

EFT then focused on improving partners' affectional bonds. Numerous studies have shown the efficacy of behavioral marital therapy (Gurman, Kniskern, & Pinsof, 1986). There has been an absence of empirical research, however, of non behavioral models and dynamically-oriented approaches in the couples and family literature (Johnson & Greenberg, 1985a) until the development of Emotionally Focused Therapy (EFT) in the early -1980s (Johnson & Greenberg, 1985b).

The EFT programmatic effort has addressed crucial questions facing the field of couples therapy (Johnson, Hunsley, Greenberg, Schindler, 1998). Targets of intervention of marital distress had not been pinpointed or under empirical investigation. There had been no clear empirical models of marital change other than behavioral approaches. A definition of adult love and attachment in adult relationships and appropriate interventions to address these issues clinically had been underdeveloped (Johnson & Whiffen, 1999; Roberts, 1992). Finally, most interventions targeted behavioral or cognitive change (Gurman, Kniskern, & Pinsof, 1986) and the role of affect had been virtually ignored as an agent of change and as a contributor to marital distress (Greenberg & Johnson, 1986a). EFT began to provide answers to the above concerns.

The development of the EFT model has been practice-driven (Johnson, Hunsley, Greenberg, & Schindler, 1998) and is based on task analysis (Johnson & Greenberg, 1985a). EFT is empirically validated and has been further developed through process research (Greenberg & Foerster, 1996; Greenberg, Ford, Alden, & Johnson, 1993; Paivio & Greenberg, 1995; Johnson & Greenberg, 1987a; Johnson & Greenberg, 1988), outcome research (Dandeneau & Johnson, 1994; Goldman, 1987b; Goldman & Greenberg, 1992; Greenberg & Johnson, 1986a; Greenberg & Johnson, 1986b; James, 1991; Johnson & Greenberg, 1985b; Johnson & Greenberg, 1987; Gordon-Walker, Johnson, Manion, & Cloutier, 1996; MacPhee, Johnson, & Van Der Veer, 1995), process to outcome studies (Johnson & Greenberg, 1988; Greenberg & Webster,1982), case studies on incest survivors (Johnson, 1989), and predictive studies (Johnson & Talitman, 1997). Recent investigations have been on the use of EFT with couples dealing with trauma (Johnson & Williams-Keeler, 1998), adapting EFT to attachment styles (Johnson & Whiffen, 1999) and studying the resolution of attachment injuries.

EFT: The Theoretical Composition

The roots of EFT lie in the integration of gestalt/experiential therapy, systemic family therapy approaches, and attachment theory (Bowlby, 1969). Gestalt/experiential therapy, developed by Perls (e.g., Perls, 1973; Perls, Hefferline, & Goodman, 1951), emphasizes the role of affect both intrapsychically and interpersonally. By focusing on affect in the here-and now, clients remove patterns of unresolved conflict and are more able to be spontaneous and create new experiences (Perls, 1973). Systemic family therapy focuses on the role of

communication sequences and identifies redundant interactional patterns in the "maintenance of problem states" (Sluzki, 1978). EFT identifies rigid negative interactional patterns to gauge the amount of control and closeness in the relationship bond. Attachment theory (Bowlby, 1969) connects neurophysiological and social phenomena and emphasizes the interactions that center around the development of affiliative bonds between parent and child and between partners in adult relationships. The crux of attachment is the individual's capacity for concern, trust, and accessibility.

EFT process of change. The process of change in EFT occurs when "the emotional responses underlying interactional positions are experienced and reprocessed so as to create a change in such positions in the direction of increased accessibility and responsiveness" (Johnson & Greenberg, 1988, p. 176). The reprocessing of emotional interactional patterns enables couples to create new experiences of self which then enable the partner to respond in different ways.

EFT postulates that if a partner has a weak attachment from their upbringing or resulting from present relationships, he/she will conceal the "primary emotions" such as vulnerability, fear and the need for attachment with "secondary emotions" such as defensiveness, coerciveness, blaming or needing to withdraw. Patterns of secondary emotion, according to EFT theory, lead to negative interactional patterns, identified by such cycles as distance-pursue or blame-withdraw (Johnson & Greenberg, 1994). The cementing of these interactional patterns, particularly under distress, impedes the integration of such primary emotions into patterns of relating such as sharing and positively coping. The cementing of negative patterns also fosters defensive processing such as the shifting of hurt into critical anger. EFT theory maintains that the accessibility of primary affect crucial for the maintenance of healthy attachment bonds, a sense of security and connection, the creation of new experiences, and the growth and maintenance of intimacy.

Gottman (1979) has shown that the primary reasons for distress in relationships are negative affect, negative content patterns such as criticism and blame (secondary emotions), and over-repetitive interaction patterns. EFT theory makes a distinction between secondary and primary emotion and successfully alters negative emotional and over-repetitive interaction patterns.

Goals of EFT. The goals of EFT are to change negative affect intrapsychically and interpersonally, to help the partners access primary emotions, revitalize the emotional bond, and change the relationship event and negative interaction patterns (Johnson & Greenberg, 1987). Distressed partners are said to have "insecure bonds" in which "healthy attachment needs are unable to be met due to rigid interaction patterns that block emotional engagement" (Johnson & Greenberg, 1987a, p. 553). EFT attempts to access and reprocess the emotional responses underlying couples' interactional positions. New emotional responses can assist in the growth of safety and trust, crucial for secure attachment. EFT typically re-engages the withdrawn partner and "softens" the attacking partner so that he/she can show vulnerability,

yearning and fear. This clears the way for "the ultimate goal of EFT--healing the attachment bond" (Johnson, 1997, p. 41).

The Nine Steps of EFT

The EFT procedure involves nine steps which can be carried out in ten to fifteen sessions (Johnson & Greenberg, 1987). The following is the usual course of EFT treatment:

1. Delineating conflict issues in the core struggle. The focus is on content presenting problems and on instrumental and secondary intrapsychic affect. Instrumental and secondary affect refers to defensive emotional reactions such as blaming, denying, or minimizing conflict. The therapist assesses how these issues reflect core problems in the areas such as separateness/connectedness. The therapist also contracts for change.
2. Identifying the negative secondary interaction cycles such as pursue-withdraw or attack-defend. Both individual's content presenting problems are made relational through the negative interaction cycles.
3. Accessing the unacknowledged feelings underlying interaction positions. The therapist begins to identify and validate the primary emotional responses, such as fear, trust, and longings for connection, the content presenting problem, and the secondary emotions.
4. Reframing the problem in terms of underlying feelings, attachment needs, and negative cycles. The content level of problems is relabeled in light of primary emotions.
5. Promoting identification with disowned needs and aspects of self and integrating these needs into relationship interactions. A primary emotion cycle is identified and reinforced through relational patterns.
6. Promoting acceptance of the partner's experience and new interaction patterns. The therapist attempts to build safety and trust in partners and to accept difference from past relational patterns and difference between partners' perspectives.
7. Facilitating the expression of individual needs and wants to restructure the relational interaction and to create emotional engagement.
8. Facilitating the emergence of new solutions to problematic interactions and issues. The therapist encourages the reconstruction of relational content patterns based on primary affect.
9. Consolidating new positions. The therapist reinforces new patterns.

The above protocol will be the treatment for this study. Steps 1-4 identify the presenting problem and are the de-escalation phase; steps 5-9 are the re-engagement and resolution phases. The steps of change parallel the preliminary model of change proposed for the resolution of attachment injuries.

The Development of EFT

EFT has a sound theoretical and empirical history. The model is based on task analysis (the study of change processes) and combines both intrapsychic and relational

perspectives, (i.e., a systems-based model that also includes the perspective of the individual's history and unique contribution to the relationship). The model was first tested through comparative methodology to show efficacy; next, the researchers set out to stipulate the nature of change through process research; and finally, researchers tested change variables through predictive research to show which variables work best with what clinical problem and populations.

Theoretical development. The first step in the development of EFT involved Greenberg and Safran's (1984; 1984b) and Greenberg and Johnson's (1986) preliminary exploration of the role of affect in the context of therapeutic change. The researchers attempted theoretically to integrate affect, cognition and behavior. The authors argued that there is a complex "interdependence of cognition and affect" (Greenberg & Safran, 1984a, p. 577) and that the profound influence of affect has been ignored in the development of clinical models. The authors argued that many clinical problems "involve a breakdown in the emotional synthesis process" (Greenberg & Safran, 1984, p. 579). Greenberg and Korman (1993) wrote that the reconstruction of emotional experience and emotionally focused interventions were needed for different emotional problems (Greenberg & Korman, 1993).

The development of the model. Johnson and Greenberg (1985a) used process research, or task analysis, to develop the EFT model. The authors used Greenberg and Safran's (1984) theory of the role of affect, systemic communication theories (Sluzki, 1978), and attachment theory (Bowlby, 1969) to help identify clinical events. Theory and clinical empirical description in the steps of change were bridged to develop the model. The researchers isolated "key episodes" in therapy to identify significant change processes. An initial intensive task analysis of change processes in Emotionally Focused Couples Therapy (Johnson & Greenberg, 1988) suggested that high levels of experiencing (i.e., high emotional involvement), and affiliative interpersonal responses (i.e., high acceptance and low hostility) were essential elements in resolving marital conflicts. The study also noted the value of analyzing qualities of experiencing and the quality of interactions in therapy.

The authors produced a manual to be followed for clinical and/or research use. The same nine steps of EFT were used throughout the programmatic effort (Johnson & Greenberg, 1985a). The authors postulated that the model fosters intimacy and facilitates conflict resolution. In addition, the authors purported that emotional responses such as love, trust, and respect are not "teachable" but "may be evoked in a process of mutual emotional expression" (Greenberg & Johnson, 1985a, p. 3).

Outcome studies. Outcome studies were implemented in the first years of EFT to show its efficacy compared to other types of marital interventions. In experimental outcome studies (e.g., Goldman & Greenberg, 1992; Greenberg & Johnson, 1986a; Greenberg & Johnson, 1986b), researchers compared the effectiveness of EFT to a cognitive-behavioral intervention; to interventions that focused on teaching problem-solving skills; and to an experiential intervention that focused on the emotional experience underlying interaction

patterns. The results showed that all treatment groups demonstrated significant gains over untreated controls and that EFT was as effective as other treatments.

Relating process to outcome. Research was needed to show how change occurs in therapy (Gurman, Kniskern, & Pinsof, 1986). Through outcome studies, EFT had shown empirical validation but the issues of how outcome related to the processes of EFT remained (Johnson and Greenberg, 1988). The focus of EFT research then began to focus on process issues such as client performance and response rates in the manifestation of negative interaction cycles. Researchers used the Experiencing Scale (Klein, Mathieu, Kiesler, & Gendlin, 1969) to measure intrapsychic change processes and the Structural Analysis of Social Behavior (Benjamin, 1974) to measure interpersonal change processes. The aforementioned scales had been previously validated in linking process events in therapy to successful outcomes (Greenberg & Webster, 1982).

In the process to outcome studies (Greenberg & Webster, 1982; Johnson & Greenberg, 1988) the occurrence of particular change events arising from the theoretical principles of EFT correlated to the process events and higher levels of experiencing and more autonomous and affiliative interactions characterized “best sessions.”

A series of studies conducted by Greenberg and Korman (1993) demonstrated a number of interactional patterns that seem to be more prevalent among improved couples than among unimproved couples. They noted that unimproved couples showed more hostile, controlling behaviors (i.e., "accuses and blames other") at the beginning of therapy and moved to being more supportive, affirming and understanding after several sessions. There were also more affiliative and depth of experiencing statements in peak sessions than in poor sessions.

Overall, these studies demonstrated that intrapsychic experience is deepened, and that interactions become more affiliative, over the course of treatment. The expression of underlying feelings and needs leads couples to change from negative interactional patterns to being more accessible and responsive to each other.

Recent studies. More recent studies have confirmed the efficacy of EFT of distressed couples with partners suffering from depression (Desaulles, 1991) and chronic illness (Gordon-Walker, Johnson, Manion, & Cloutier, 1996). Another study focused on the theoretical development of EFT as applied to post-traumatic stress disorder (Johnson & Williams-Keeler, 1998).

Methodological Issues in Process Research

Process research has entered its fifth decade of development. Process research addresses specific events that take place in-session, observing variables such as therapist behaviors, client behaviors, and interactions between therapist and client during treatment (Hill, 1991). Intents and methods of study until recently, however, have remained

underdeveloped. A goal of process research has been to consolidate methodological information on process research so that current and future investigators have a methodological base from which to proceed (Greenberg & Pinsof, 1986). Attempts have been made to stimulate research of the process of psychotherapy, particularly in couples and family therapy, to explain how psychotherapy produces change (Greenberg, 1986; Greenberg, Ford, Alden, & Johnson, 1993; Greenberg & Newman, 1996; Greenberg & Pinsof, 1986; Hogue, Liddle, & Rowe, 1996; Jacobson & Addis, 1993; Johnson & Greenberg, 1988).

In a recent review of process research, authors reported that treatment adherence to process procedures has been congruent with the methods, goals, and theoretical framework that guide process research. Targets of study have become more specific, and more reliable and valid measures have been developed and implemented (Hogue, Liddle, & Rowe, 1996). Methods of process research have become more standardized over the past few years and more specific protocols have been developed.

Efforts have been made to classify the dimensions of process measures such as direct versus indirect measurement, perspective, focus, aspects of process, use of classical or pragmatic coding schemes, types of scaling, and theoretical perspective (Hill, 1990; Russell & Stiles, 1979). The above dimensions also help the researcher make sure that guidelines are compatible with the chosen methodology.

Task analysis. One major development of process research is that the process of psychotherapy can be studied in smaller in-session units and post-session outcomes can be linked to specific client-therapist interactions (Greenberg & Rhodes, 1994). In addition, focus has been extended to how process research can better serve the practicing clinician, how clinician and researcher can form partnerships to "preserve the richness and complexity of the psychotherapeutic process as it unfolds over time" (Greenberg & Rhodes, 1994, p. 217).

Task analysis and the events-based approach (Greenberg, 1986) have been developed to study change events that work within the theoretical framework and operational level of the clinician and to study the specific therapist-client interactions that fit coherently within the researcher's theory of change. A number of researchers from diverse therapeutic orientations are using task analysis to study change processes (Clark, 1996; Friedlander, Heatherington, Johnson & Skowron, 1994; Greenberg & Foerster, 1996; Greenberg, Ford, Alden & Johnson, 1993; Greenberg & Webster, 1982; Paivio & Greenberg, 1995; Safran & Muran, 1996).

Task analysis is a discovery-oriented research or rational-empirical method (Greenberg, 1986) which identifies, describes and analyzes the processes of change within a given clinical context (Greenberg, 1984; 1986; Greenberg & Newman, 1996). As in this study, task analysis can be used for several research purposes: to identify major clinical in-session change events; to build models of therapy; and to refine models of therapy. After in-session change events are identified and preliminary models are built, task analysis can be used to predict complex therapy outcomes from in-session change processes (Greenberg &

Newman, 1996). Future studies will use the findings of this study to link processes to outcomes.

Greenberg (1986) argued that context-sensitive process research needs to be developed and that variables such as speech act, episode, and relationship need to be examined in the context in which they occur and that the context of one process project does not necessarily have the same meaning under different theoretical premises. "To explain processes of change, it will be important to measure three types of outcomes--immediate, intermediate, and final--and three levels of process--speech act, episode, and relationship (Greenberg, 1986, p. 4). This approach would result in the use of a battery of process instruments to measure process patterns in context and to relate these to outcome.

The study of the processes of change brings up the issue of how events are identified and then measured. Task analysis delineates seamless therapy interactions into frameworks of units such as content, speech acts, episodes, and relationship levels (Greenberg, 1986). Rice and Greenberg (1984) suggested bracketing specific events or episodes as targets of study: the client problem marker, the therapist operation, the client performance, and the immediate in-session outcome. Episodes can be identified by markers or by a set of statements that indicate a particular problem or event is imminent and amenable for intervention. The therapist operation, described in an operation manual, is a set of interventions that promotes problem resolution (Greenberg, 1986). Client performance is how the client responds to the therapist operation which typically ends in some form of in-session outcome.

Task analysis has studied three types of changes over the course of therapy: immediate outcomes, intermediate outcomes, and ultimate outcomes (Pinsof, 1981). An immediate outcome is the change event that takes place in the session that results from specific therapeutic markers, interventions, or the overall interaction. Immediate outcomes are then related to intermediate changes. Intermediate changes are change markers (or target attitudes or behaviors) identified through observations of several client episodes by session outcome measures. The markers or targets are observed over time for validation and to be linked to the process of ultimate outcomes.

A series of studies conducted by Greenberg and colleagues (1993) demonstrated a number of interactional patterns that seem to be more prevalent among improved couples than among unimproved couples. They noted that couples showed more hostile, controlling behaviors (i.e., "accuses and blames other") at the beginning of therapy, and moved to being more supportive, affirming and understanding after several sessions. Researchers also found that there more affiliative and depth of emotional experiencing statements in peak sessions than in poor sessions. Overall, these studies demonstrated that intrapsychic experience is deepened, and that interactions become more affiliative, over the course of treatment. The expression of underlying feelings and needs leads couples to change from negative interactional patterns to being more accessible and responsive to each other.

Summary

EFT theory and clinical practice (Johnson, 1996), supported by child and adult attachment theories have aided in the conceptualization of attachment injuries. EFT has clearly demonstrated the effectiveness of moderating distress and creating more secure attachment bond through validated replicable interventions. Recent studies in EFT have developed the model beyond the focus of general distress to more specific presenting problems as depression, eating disorders, and sexual dysfunction. Similarly, attachment injuries is a new concept designed to expand EFT's application to specific presenting problems. In this study, task analysis (Johnson & Greenberg, 1988; Greenberg et al., 1993), and retrospective studies (Greenberg et al., 1988) were used in the construction of a preliminary model of resolution performances in couples with attachment injuries (see Table 1). The results of this study will validate the hypothesized concept of attachment injuries and will yield a theoretical resolution model of change for couples who sustain an attachment injury.

CHAPTER III

Methodology

Overview of the Research Design

The purpose of this study was to investigate the hypothesized concept of attachment injuries in couples and to develop a preliminary model for the resolution of attachment injuries using Emotionally Focused Therapy. For this study, the definition of an attachment injury was when one partner betrayed or broke the trust of the other in a specific incident and that incident became a clinically recurring theme or stuck point of task resolution. The attachment injuries were identified by Dr. Susan Johnson, an expert clinician, and the researcher. Unstructured pre- and post-treatment interviews of the couple were conducted to ascertain the nature and extent of the injury. This study suggests that attachment injuries may be present for some couples, and they theoretically can follow the process of resolution identified in this study.

The model was developed by task analysis and proposed to correspond to the following pathway markers: presenting problem, de-escalation, and re-engagement and softening/resolution. Based on task analysis protocol for this stage of model development (Greenberg, 1986), three "successful" couples with moderate to mild distress were used to develop the model. "Successful" couples (a) passed the screening criteria; (b) had an identifiable attachment injury; (c) completed EFT treatment; (d) and showed normal range scores on pre- and post-test measures.

The empirical map was developed as follows: Pre- and post-tests measured overall resolution of the attachment injury and process measures identified in-session changes. The pre- and post-measures were the Dyadic Adjustment Scale (DAS) (Spanier, 1976), Relationship Trust Scale (RTS) (Holmes, Boon, & Adams, 1990), Revised Adult Attachment Scale (RAAS) (Collins, 1996), and the Attachment Injury Measure (AIM). Audiotaped segments of "best sessions" were rated by a doctoral level student and the researcher to determine change events throughout the therapy process. "Best sessions" were rated using the Structural Analysis of Social Behavior (SASB) (Benjamin, 1975), and Experiencing Scale (ES) (Klein, Mathieu, Kiesler, & Gendlin, 1969).

At the resolution session the researcher interviewed couples based on pre-assessment AIM responses to identify change events from the clients' point of view. The Target Complaints Discomfort Box Scale (TCDBS) (Battle, Imber, Hoehn-Saric, Stone, Nash, & Frank, 1966) and Post-Session Resolution Questionnaire (PSRQ) (Orlinsky & Howard, 1986) were used to measure the successful resolution of the attachment injury. A rational map of expected change (See Table 1) was compared to the empirically developed map. (See Table 3 for data measures and procedures)

Research Questions

The research questions for this study were as follows:

1) How did clients describe the attachment injury?
2) What were the results of the pre-test scores for couples?
3) What were the post-test scores and did the scores result in "successful" resolvers according to the measures' norms?
4) What were the results of the Structural Analysis of Social Behavior (Benjamin, 1975) and Experiencing Scale (Klein, Mathieu, Kiesler, & Gendlin, 1969) process measure scores within each marker or phase of resolution?
5) How did clients describe the attachment injury after the resolution phase of treatment?
6) In what ways did the event pathways of the proposed rational model of attachment injury resolution differ from those of the empirical model?

The Resolution of Adult Attachment Injuries Using Task Analysis: The Discovery Phase

The first and second steps of the rational-empirical phase of task analysis (Greenberg & Foerster, 1996; Greenberg, Heatherington, & Friedlander, 1996) for this study involved an expert's identification of the concept and clinical process of an attachment injury, and the selection and description of how attachment injuries were to be investigated. For this protocol, an "expert" in a particular model or theory identifies a concept of clinical interest, and draws a preliminary rational mapping of how the processes may unfold.

Emotionally Focused Couples Therapy is an empirically based form of couples therapy (Johnson & Greenberg, 1987). EFT is based in attachment theory (Bowlby, 1969) and a comprehensive theory and research on emotions and emotional process (Johnson & Greenberg, 1994). One premise of EFT is that emotion signals a partner's availability and responsiveness, and the extent of the security and trust of the attachment bond. Another premise is of EFT is that a secure attachment bond is critical to emotional well-being (Johnson, 1996).

A primary goal of EFT is to create security and connection in the attachment bond and to re-engage couples from rigid negative "secondary" emotional cycles to "primary" emotional cycles. The "primary" emotional patterns create the safe emotional engagement necessary for secure bonding. The typical clinical process of EFT in the resolution of conflict involves identifying the presenting problem and negative emotional cycles; the de-escalation of cycles such as blame/withdraw; and the re-engagement, resolution and softening events identified by higher levels of trust, accessibility, and responsiveness.

Guided by EFT, attachment theory, and clinical experience of the developers of EFT, this study tested the utility of attachment injuries as a concept and the resolution of attachment

injuries using EFT as the treatment. Attachment injuries have not been identified in the literature (Literature Review). An attachment injury was hypothetically defined as clients who entered therapy and became stuck on one significant episode in the relationship that marked a disruption in the level of trust, security, responsiveness and accessibility of partners (Johnson, Personal Communication, 1998).

The attachment injury marker for purposes of this study was an incident that came up in therapy as the emblematic problem event that lead to a sense of betrayal of the attachment bond, which later organized and promoted negative interactional cycles that later lead to relationship distress (Johnson, 1996). The injury became a recurring theme of topical discussion and stood as the obstacle to the couple's capacity to become re-engaged and increase the level of trust, security, responsiveness and accessibility.

The third and fourth steps are the evaluation of the potency of the task environment and the rational task analysis. This study compared a rational model of attachment resolution to an empirical model of task resolution. The attachment injury was identified through self-report of clients and the verification of Dr. Susan Johnson and the researcher. The identification of attachment injuries was based on clinical experience (Johnson, Personal Communication, 1998) and the rational model (See Figure 1) was based on validated EFT process markers and a hypothetical map (Johnson, Personal Communication, 1998).

The fifth step involved the empirical task analysis and the construction of the rational-empirical model. The following were the markers of the rational model: First, clients have been clinically observed to describe a betrayal or attachment injury marked by *partner A* expressing blame and hostility and by *partner B* withdrawing, defending, or minimizing. Second, clients de-escalate conflict marked by *partner A* differentiating affect and *partner B* becoming less defensive. Third, clients re-engage emotionally and resolve the target complaint marked by *partner A* disclosing and expressing needs, becoming less hostile, and achieving higher levels of trust and *partner B* becoming more engaged, empathic, responsive and accessible. (See Table 1)

The sixth step, the empirical task analysis and the construction of the rational-empirical model, involve data collection of the specified task, mapping the empirical results based on the data, and comparing the rational and empirical models. For this study, the empirical task analysis and model construction were performed by the procedures described below:

Sample Description and Sample Selection Procedures

This study used data collected from three "successful" couples who entered therapy at the Marriage and Family Therapy Clinic at the Ottawa Hospital - Civic Campus in Ontario, Canada. The clinic team members, supervised by Susan Johnson, were family therapists, psychologists and social workers who had been trained in EFT. The clinic members served as

therapists and the reflecting team during the assessment session. The hospital clinic typically gets one to two referrals (couples) per week from family therapists, psychologists and psychiatrists in the Ottawa area; or couples themselves contact the clinic for therapy.

When clients make an appointment at the Marriage and Family Therapy Clinic, they are informed that the clinic is for training purposes and that they can be subject to being viewed by a therapy team, being video or audiotaped, and possibly being part of a research project. All couples are asked to come into the clinic for an assessment session which is viewed by team members behind a one-way mirror. Sessions after the assessment are not viewed by the team. Before the first session, couples typically fill out various assessment measures, although not all specific to this study, such as demographics questionnaires, trust and attachment questionnaires, and the Dyadic Adjustment Scale. At the end of the session, couples are assigned to a team therapist or co-therapists.

For this research, couples were screened for attachment injuries by the researcher and the team during the assessment session. If one partner recalled an instance of an attachment betrayal or rejection in the relationship associated with the current problem, or if a partner gave a strong indication that an injury had occurred, the couple was asked if they wanted to participate in a project which studies how clients, in therapy, attempt to resolve past conflicts.

The DAS was scored before the assessment session in order to identify prospective couples. To be included in the study, the mean couple score on the DAS had to be between 75 and 97 (which indicates mild to moderate distress). If a couple's mean score was less than 75, they were not considered for the study, even if they report an attachment injury.

For purposes of this study, couples met the following criteria in the initial screening:

1) Both partners consented to participate in the study and both were expected to attend the therapy sessions conjointly.

2) The couple, whether married or in a committed relationship, lived together for a minimum of one year. Minors were not included.

3) Neither partner had reported problems related to drugs nor alcohol. The sample did not include participants who reportedly used drugs recreationally or participants who took more than five drinks per week. To ensure that clients accurately reported how much alcohol they consumed and whether or not they used recreational drugs, clients were verbally asked to confirm that the information they had provided was valid and that by signing the consent form, they reported information as accurately as possible.

4) The couple was not included in the sample if either had received any psychiatric treatment or medication in the past year, received any form of psychological or psychiatric treatment, or had participated in any form of psychological or psychiatric treatment in the duration of the study.

5) Neither partner could have a reported history of physical nor sexual abuse.

6) Finally, partners were asked to recall an instance of betrayal or rejection in the relationship associated with the current problem.

Couples were informed that the study had been approved by the Institutional Review Board for Research Involving Human Subjects of Virginia Tech and the Ottawa Hospital - Civic Campus, that the study was conducted by therapists experienced in working with couples, and that therapy was supervised by a registered psychologist in the province of Ontario, Canada.

Couples who met the inclusion criteria were informed that participation in the study involved both partners participating in therapy for a total of about fifteen counseling sessions of approximately one hour duration on a weekly basis. Couples were informed that their participation in this study was voluntary and that they could withdraw from the project at any time without jeopardizing access to further counseling. Referrals were provided in case of early termination.

The researcher met with clients immediately after the team assessment session. They were given more information about their responsibilities in the study, asked to read and sign a consent form, and were assured of confidentiality before completing the questionnaires. Couples were also notified that sessions would be audiotaped and informed that all tapes would be securely filed.

Both partners were asked to fill out additional questionnaires after the intake session to determine their participation in this study. They completed the Revised Adult Attachment Scale (RAAS), Relationship Trust Scale (RTS), the Attachment Injury Measure (AIM), and a demographics questionnaire. Couples were given the AIM for a self-report description of the attachment injury and a problem-severity rating of the injury on a scale of one to seven. (See Appendix C for all self-report measures)

The number of expected subjects was six to ensure the intensive study of three "successful" couples. The minimum number accepted for scrutiny was three in the event that all successfully resolve the attachment injury. Therapists for this research included EFT team members and the researcher. Couples who did not meet the inclusion criteria were treated by the team, but not for purposes of this study, or were asked if he/she would like to be referred elsewhere for treatment. (See Appendix A for a referral list)

Data Collection Procedures

Pre- and post-treatment assessment measures. Couples who met the inclusion criteria after the intake session completed the DAS, RTS, RAAS, AIM and a demographic questionnaire. The researcher used the couple's improvements on the DAS, RTS, and RAAS pre- and post-treatment measures, as well as the mutual confirmation of the couple and the therapist, to substantiate the "successful" resolution of the attachment injury.

The demographics questionnaire was used for general information regarding length of the relationship, the couples' income, education level, and occupational status.

The DAS was used to screen potential participants and as a post-treatment "success" measure. To be included in this study, each couple's mean total scale score must be less than 98 but not less than 75. Couples were expected to score at least above an average score of 98 to be considered "successful." The DAS cut off for distressed couples is 98 and the mean total score of happily married couples is 114.8. (Spanier, 1976).

The RTS was used to measure the amount of trust gained through treatment. The RTS's range of scores is from 30 to 210. Couples were expected to score above 150 (normal range trust of partner) to be considered "successful."

The RAAS was used to measure the amount of change is the participants' perception of attachment style. A change in attachment style was not a criterion for whether treatment had been successful or the resolution of attachment injury. Changes in the degree of styles were expected such as high "Preoccupied Style" scores at pre-treatment would be low "Preoccupied Style" or in any range of "Secure Style."

The Attachment Injury Measure (AIM) is a self-report measure constructed by the researcher. The researcher asked the couple to describe the attachment injury in detail. The client who sustained the injury rated the injury on scale of 1 to 7 from "Not a Problem" to "Extremely Severe Problem." "Successful"couples were expected to score from "Moderate Problem" to "Not a Problem" at the end of treatment.

Post-treatment unstructured interviews were conducted based on each participant's pre-treatment written responses on the AIM. The post-treatment interviews were intended to get participants' validation that the attachment injury had been satisfactorily resolved. The use of attachment language (Johnson, 1996) was also analyzed, as such language is typical of "successful" treatment in EFT.

At the termination session, both partners were asked to complete the Post-Session Resolution Questionnaire (PSRQ) and the Target Complaints Discomfort Box Scale (TCDBS). The PSRQ measures the amount of in-session change perceived by the couple. The scores range from 5 to 33 where low scores indicate little change and higher scores indicate greater change. Couples were expected to score at least 20 or above to be considered "successful." The TCDBS measures whether clients experience continued discomfort in light of the initial presenting problem. The scores of the target issue range from "Couldn't be Worse" to "Not at All." "Successful" couples were expected to score from "A Little" to "Not at All."

In-session process measures. To determine the de-escalation, re-engagement, and resolution sessions, couples were seen weekly for approximately fifteen weeks or until they resolved their attachment injury. The session in which the re-engagement and softening occurred was considered the resolution session for this study.

The identification of de-escalation, re-engagement, and resolution sessions was a two-step procedure (i.e., identification of essential steps by therapists and identification of resolvers by raters). The first step, therapist identification, required each therapist to identify potential de-escalation, re-engagement, and resolution sessions. Following each session the therapist made a record of any resolution components that occurred in the session.

At the end of treatment, therapists were asked to review the taped sessions marked as having the most advanced component of de-escalation, re-engagement, and resolution and indicate the best example of that component for each couple. These components were used as a midpoint for a ten minute segment (i.e., five minutes prior to the identified component, the de-escalation, re-engagement, and resolution component itself, followed by another five minutes of tape).

The second step was rater coding of the "best session" examples. In this step, taped segments were presented to two raters, a doctoral student trained in EFT and the researcher. The raters received sufficient training on the process measures to code the de-escalation, re-engagement, and resolution segments. The units for the ratings were statements from the couples, and were rated using the SASB and the ES. (See rater criteria below in Rater Selection and Training).

Using the above process measures, couples were considered "successful" if the resolution session contained a re-engagement/softening event along with positive scores on the pre- and post-test measures. Based on intensive task analysis (e.g., Johnson & Greenberg, 1987) the following criteria were the hypothesized process measure scores for identifying the components of the model of the resolution of attachment injuries:

A) De-escalation

1. On the SASB, statements from Partner A were expected to be rated as 1-6 (belittling and blaming), 1-7 (attacking and rejecting), or 2-1 (asserting and separating). Statements from Partner B were expected to be rated as 2-6 (sulking and appeasing), 2-7 (protesting and withdrawing), or 1-1 (freeing and forgetting).
2. On the ES, statements from both partners were expected to be rated as a level 3.

B) Re-engagement

1. On the SASB, statements from Partner A (injured) were expected to be rated as 2-2 (expressing and disclosing of needs). Statements from Partner B (violator) were expected to be rated as 1-2 (affirming and understanding).
2. On the ES, statements from both partners were expected to be rated as a level 4.

C) Softening/Resolution

1. Sequential responses from both partners were expected to be rated as falling in Quadrant I or IV on the SASB (autonomous/affiliation).

2. Sequential responses from both partners were expected to be a level 4 rating (description of feelings and personal experiences) on the ES, with at least one of these responses reaching a peak of 5 or 6.

The softening criteria were met in order for a couple to be considered a resolver. Cohen's Kappa (Cohen, 1960) yields a coefficient of agreement for nominal scales and was used to determine the extent of agreement between the raters.

Description of Pre- and Post-Treatment Instruments

Instruments were chosen based on their use in previous EFT studies. The following self-report instruments were selected on the basis of their theoretical relevance to EFT and because of their ability to predict outcome in distressed couples (Johnson & Talitman, 1997).

The Dyadic Adjustment Scale (DAS). The DAS (Spanier, 1976) is a 32-item self-report rating scale designed to measure the quality of adjustment between married or cohabiting couples. The scale yields a total adjustment score, as well as scores on four subscales: Consensus, Satisfaction, Cohesion, and Affectional Expression. The DAS was used in this study to select mild to moderately distressed couples, and to ensure that resolving attachment injuries in these couples actually made a difference in their marital relationship.

There is evidence that the DAS is a valid and reliable measure of dyadic adjustment. Internal consistency has been determined for each of the subscales and for the total measure using Cronbach's Coefficient Alpha (Cronbach, 1960). Reliability coefficients ranged from .73 to .94 for the subscales, and .96 for the total dyadic adjustment scale. Content validity was determined by evaluating the pertinence of each item to contemporary relationships, its consistency with nominal definitions of adjustment and the components, and its careful wording with the fixed choice responses.

Criterion-related validity was established by assessing the difference of each item with the external criterion of marital status (divorce vs. married couples). On the total scale score, divorced and married couples differed significantly ($p < .001$). Construct validity was established through factor analysis and by correlating this scale with the Locke-Wallace Marital Adjustment Scale, which was one of the most frequently used scales. Correlations were .86 for married and .89 for divorced respondents.

The DAS is scored by summing the scores of each fixed response. The scale score has a theoretical range of 0-150. High scores are indicative of less distress and better adjustment.

The mean total scale scores were 114.8 for happily married couples and 70.7 for divorced couples. The distress cut off point of 98 has been set at one standard deviation below the mean for the married samples. Any couple scoring below 98 will be considered distressed. The average of the individual couple's scores yields the couple's mean total score. (See Appendix C for a copy of this scale)

Relationship Trust Scale (RTS). The RTS (Holmes, Boon, & Adams, 1990) is a 30-item self-report inventory. It was specifically designed to assess interpersonal trust in married or cohabiting couples. This scale consists of five subscales: Responsiveness of Partner (8 items), Dependability/Reliability (6 items), Faith in Partner's Caring (6 items), Conflict Efficacy (5 items), and Dependency Concerns (5 items). The scale is a reconstruction of the Rempel, Holmes, and Adams (1985) Trust Scale in order to render it more compatible with recent empirical findings and theoretical speculation regarding issues of insecurity and interpersonal trust in marriage (Holmes et al., 1990), attachment styles (Collins & Reed, 1994), and emotion (Gottman & Levenson, 1986).

Reliability for this scale was established for each of the component subscales, as well as for the total scale using Cronbach's Coefficient Alpha (Cronbach, 1960). The standardized reliabilities for the above subscales were .89, .83, .84, .84, and . 83 respectively. Reliability for the entire scale was .89. Test-retest reliability over a three-year period was approximately .72.

Construct validity was obtained by assessing the relationship between this scale and other measures designed to assess individuals' comfort level at being close to their partner, and believing in the availability and responsiveness of their partner. This sample consisted of 70 married couples and the results showed a strong relationship between scores on the trust scale and the couples' experiences in their relationship. This revised scale also has demonstrated discriminant validity by contrasts with measures of self-disclosure, ambivalence, and anger, for both partners.

To obtain a score for this scale, individuals are asked to respond to the 30 items on a 7-point scale ranging from strongly disagree (1) to strongly agree (7). The theoretical range of scores is 30-210. Subscales are summed to provide an overall score. High scores are indicative of a stronger presence of trust between partners. A couple's mean score is obtained by averaging the sum of each partner's score. (See Appendix C for a copy of this scale)

The Revised Adult Attachment Scale (1996). The RAAS (Collins, 1996) is a 18-item self-report inventory. The RAAS was designed to measure the amount of closeness, dependability and fear of abandonment in intimate adult relationships. The scale contains three subscales composed of six items. The three subscales are Close, Depend and Anxiety. The Close scale measures the extent to which a person is comfortable with closeness and intimacy. The Depend scale measures the extent to which a person feels he/she can depend on others to be available when needed. The Anxiety subscale measures the extent to which a

person is worried about being abandoned or unloved. The revised scale is similar to the 18-item Adult Attachment Scale (Collins & Read, 1990) which also measured the amount of closeness, dependability and fear of abandonment in intimate adult relationships.

Reliability for this scale was established for each of the component subscales, as well as for the total scale using Cronbach's Coefficient Alpha (Cronbach, 1960). The standardized reliabilities for the above subscales were .75, .72, and .69 respectively. Reliability for the entire scale was .89. Test-retest reliability over a three year period was approximately .72. Reliability also was established through Factor Analysis. Construct validity was obtained by comparing the RAAS with the Rosenberg Self Esteem Scale (Rosenberg, 1965), the Texas Social Behaviour Inventory (Helmreich & Stapp, 1974), the Personal Attributes Questionnaire (Spence & Helmreich, 1978), the Opener Scale (Miller, Berg, & Archer, 1983), the Rotter Trust Scale (Rotter, 1969), the Philosophies of Human Nature (Wrightsman, 1964), and the Love Attitudes Scale (Hendrick & Hendrick, 1986). From each scale, the RAAS differed at $p < .05$ according to a Scheffe test.

Individuals are asked to respond to the 18-items on a 5-point scale ranging from Not At All characteristic of Me (1) to Very Characteristic of Me (5). The 6-item subscales are individually summed. The range of scores is 6-30 for each subscale. A midpoint split is used to determine closeness, dependability and anxiety scores. For example, a secure person should score above the midpoint score of around 18 on the close and depend dimensions, and below the midpoint score of around 18 on the anxiety dimension. Individuals who score at the midpoint will be scored as no definable attachment style or as mixed styles. Secure attachment styles will score high of closeness and dependability and low anxiety items; Preoccupied attachment styles will score high on anxiety and closeness and low on dependability; Fearful attachment styles will score high on anxiety and low on closeness and dependability subscales; and Dismissing attachment styles will score low on closeness, dependability and anxiety subscales. (See Appendix C for a copy of this scale)

Attachment Injury Measure. The Attachment Injury Measure (AIM) is a self- report measure written by the researcher. The AIM asks the couple to describe the attachment injury in detail. The AIM also asks couples to rate the injury on a severity scale of 1 to 7 or "Not at All Severe" to "Extremely Severe." "Successful" resolvers were expected to report "Moderately" to "Extremely Severe" at the beginning of treatment and report below "Moderately Severe" after treatment. (See Appendix C)

Description of Other Session Outcome Instruments

The following self-report measures were selected on the basis of their ability to identify post-session change in individuals and couples (e.g., Greenberg & Webster 1982; Paivio & Greenberg, 1995).

Post-Session Resolution Questionnaire (PSRQ). The PSRQ is designed to measure the amount of in-session change perceived by the couple. The questionnaire, which is adapted

from the Orlinsky and Howard (1975; 1986) Therapy Session Report Questionnaire, consists of three 5-point session evaluation scales and a 7-point scale evaluating how resolved the couples feel they are in relation to the issues that brought them into therapy. The questionnaire has only face validity but has been used in previous studies successfully to identify best sessions (Greenberg & Foerster, 1996; Greenberg, Ford, Alden, & Johnson, 1993).

The first scale asks the couple to identify whether the issue dealt with in the session was related to the issue identified at the beginning of therapy. The remaining two five-point Likert scales and the seven-point scale are grouped together to derive a single PSRQ change score. High scores are indicative of no change and low scores are indicative of much change. (See Appendix C)

Target Complaints Discomfort Box Scale (TCDBS). The TCDBS (Battle, Imber, Hoehn-Saric, Stone, Nash, & Frank, 1966) is a rating scale consisting of a single column divided into thirteen boxes. The words "Not at All" are written beside the bottom box; "A Little" beside the fourth box; "Quite a Bit" beside the seventh box; "Very Much" beside the tenth box, and "Couldn't be Worse" beside the top (thirteenth) box. This scale has shown satisfactory pre-post session reliability (Battle et al., 1966). (See Appendix C)

Description of Process Measurement/Instrumentation

These measures were selected on the basis of their utility to describe in-session changes (e.g., Greenberg & Foerster 1996; Johnson & Greenberg, 1988).

The Structural Analysis of Social Behavior (SASB). The SASB (Benjamin, 1974: 1977) is a coding system designed to analyze and rate interpersonal processes. This method of analysis is based on a circumplex model of social interactions and is comprised of three two-dimensional grids. The first grid depicts communications in which the speaker focuses on the other person. The second grid describes communications in which the speaker focuses on self. The third grid, which has an intrapsychic focus, will not be used in this study.

Each grid consists of 36 points, forming eight clusters. Statements are characterized as belonging to one of the 36 points that belong to one of four quadrants on one of two grids. Affiliation (measured by the horizontal axis) intersects with autonomy (measured by the vertical axis) and combinations of these two axes represent a full range of behaviors. In the present study, SASB will be used to measure the changing quality of interaction between the couple.

This system has shown high inter-rater reliability and has been extensively validated. Inter-clinician reliability for difficult material containing multiple and complex messages yielded kappas between .70 and .85. By using trained undergraduates, kappas ranged from .61 to .79. However, by using group consensual judgments (two independent coders followed

by two additional coders and then group consensus) kappa coefficients ranged from .80 to .84 with a mean of .81 for process codes.

The Experiencing Scale (ES). The ES (Klein, Mathieu, Kiesler, & Gendlin, 1969), is a 7-point rating scale that measures in-session level of experiencing and is very sensitive to changes in the couple's involvement in therapy. Moving up the scale, there is a gradual progression from superficial, interpersonal self-references to simple, limited, or externalized self-references, to a synthesis of newly emerged feelings and new awareness that leads to problem solving and better self-understanding.

The validity of the scale has been supported by its correlation with client variables such as introspectiveness and cognitive complexity (Klein et al., 1986). The scale has been used to predict client change, especially in client-centered therapy (Orlinsky & Howard, 1986). The scale has been highly reliable in terms of measuring client involvement or "experiencing" in therapy (Greenberg & Foerster, 1996). Interrater reliability coefficients from several studies were in the high .80s and .90s. General descriptions of the seven scale stages and short form descriptors are provided in Appendix B.

Rater Selection and Training. One graduate level doctoral student/therapist from the Ottawa Civic Hospital was selected, along with the researcher, to rate the process data. The two raters had been previously trained in EFT to identify the specific components of the model. The raters received formal training on the process measures. The SASB and ES training consisted of two 2-hour sessions, which involved rating practice segments (10 for each session). At the end of training, inter-rater reliability was to be above .80.

Transcription process. After couples were selected for the study, therapists, trained in EFT, were asked to select sessions that best exemplified the de-escalation and re-engagement events in relation to the attachment injury. Audiotapes of all sessions were reviewed by the researcher. Transcripts of “best sessions” were chosen by both therapists who identified significant change events during sessions and the researcher while reviewing the tapes. Examples of “best sessions” were transcribed and coded by raters. The “best sessions” were used to map the empirical model of change.

Implementation Check. Upon completion of the therapy sessions, an implementation check was used as a guide by the researcher to ensure that the therapy condition was implemented according to EFT practice standards. The focus was on client change processes and not the client-therapist interaction. The checklist of interventions used in previous studies was informally used (Dandeneau & Johnson, 1994; Johnson & Greenberg, 1985a; Johnson & Talitman, 1997). The checklist consists of 16 interventions. Eight interventions are selected from the EFT manual are considered to be EFT interventions. Eight interventions considered to be non-EFT interventions have also been included. Interventions considered to be specific to EFT are 1, 3, 5, 7, 9, 11, 13 and 15 (See Appendix C for a copy of the checklist). The researcher verified that interventions were conducted according to EFT protocol.

Data Analysis Process

For a majority of the pre- and post-tests such as the DAS, RTS, PSRS, and TCDBS, "successful" scores were chosen within normal ranges of non distressed couples according to the tests' "normal" range scores. The RAAS scores were expected to improve from pre-assessment, however, couples were not expected to score in the "Secure" attachment style. "Successful" scores for each couple were combined as an average. The AIM"s "successful" range was a self-report description based on a Likert scale. The pre- and post-tests showed that couples had satisfactorily resolved their presenting issues, the attachment injury in particular.

The in-session measures showed changes within the process of treatment. The in-session SASB and ES scores were coded from "best session" audiotapes chosen by therapists and researcher. The researcher typed transcripts of the "best sessions" and the raters marked them according to SASB and ES codes. Rater reliability was done using Cohen's Kappa (1960) inter-rater reliability procedure.

The descriptions on the pre- and post-AIM interview were grouped thematically. Themes were identified by the type of injury and the injury's effects on trust and intimacy/closeness. The improvement of trust and closeness are goals of EFT treatment and suggest more secure emotional bonds (Johnson, 1996). The post-AIM interviews also were analyzed by participants' use of attachment language such as expressing vulnerabilities, wants, needs, desires for contact (Johnson, 1996).

The empirical model was mapped by either adding or deleting interpersonal cycles and general thematic processes from the rational model, depending on responses in "best sessions." All new details in the empirical model were based on SASB and ES scores.

In summary, "successful" couples were expected to score in "normal" ranges of generally well-adjusted couples. The process measures (SASB and ES) were used to present the ranges of behavioral responses during each "best session" phase. Based on the process scores and the proposed resolution model (See Table 1), the researcher diagramed the pathways of resolution. Any markers of change not included in the empirical model were added to the empirical model.

Table 3
Data Measures and Procedures

	Type of Measure	Pre assessment	Assessment	De-escalation	Resolution	Post-measures
Measure						
Demo-graphics	Self report	Yes	No	No	No	No
DAS	Self report	Yes	No	No	Yes	No
Relationship Trust Scale	Self report	Yes	No	No	Yes	No
Revised Adult Attachment Scale	Self report	Yes	No	No	Yes	No
Attachment Injury Measure	Self report Researcher	Yes	No	No	No	Yes
SASB	Raters	No	Yes	Yes	Yes	No
ES	Raters	No	Yes	Yes	Yes	No
Implemen-tation Checklist	Rater	No	No	No	No	Yes
Post Session Resolution Scale	Self report	No	No	No	Yes	No
Target Complaint Scale	Self report	No	No	No	Yes	No

CHAPTER IV

Results

Purpose and Summary

The purpose of this study was to identify attachment injuries in couples and to develop a preliminary model for the resolution of attachment injuries using Emotionally Focused Therapy. The definition of an attachment injury was when one partner betrayed or broke the trust of the other in a specific incident and that incident became a clinically recurring theme and stuck point of task resolution.

The model (N = 3) was developed using task analysis. Moderate to mildly distressed couples with attachment injuries were identified by the researcher and an expert clinician. The attachment injuries were resolved using EFT. Audiotaped segments of "best sessions" of marker events were reviewed by the researcher and raters to determine change events throughout the therapy process. The marker events were proposed to occur at the de-escalation, re-engagement, and resolution/softening phases of treatment. Pre- and post-tests were used to measure overall resolution of the attachment injury and process measures were used to identify in-session changes. Couples were interviewed at the completion of treatment in order to assess their own perceptions of the attachment injury and their levels of change and closeness.

Sample Description

The three couples for this study were selected from the Marital and Family Therapy Clinic at the Ottawa Hospital Civic-Site. Participants voluntarily entered the clinic for general therapy services and were not solicited to come to the Ottawa Hospital to participate in this study. The participants passed the initial screening requirements: all were married, had pre-treatment DAS scores between 75 and 97, had no history of alcohol or drug abuse, had no history of physical or sexual abuse, and had an identifiable attachment injury based on the theoretical judgment of the MFT clinic team and the researcher.

Six couples were chosen over the course of four months. Three couples were not used for this study because they either discontinued therapy or did not demonstrate a clear example of an attachment injury that was previously conjectured by the team and the researcher. Of the couples in the study, two were assigned to the researcher and a co-therapist, and one couple was assigned to other co-therapists. All therapists were trained in EFT.

The average age for the couples was 37.1 and all had been married for about eight years. The average income was around 95,000 Canadian dollars. All were employed outside the home except one who was entering a graduate program. All were university graduates except one couple who had earned associate degrees. Two couples had two children under

eight years of age. The wife of the third couple had three children 16 years of age and older from a previous marriage. (See Table 4 for Demographics Description)

Table 4
Demographics

	Couple 1 Female/Male	Couple 2 Female/Male	Couple 3 Female/Male
Age	43/43	32/35	36/34
Years together	9	11	7.5
Number of Children	3	2	2
Annual income	110,000	53,000	120,000
Occupation	Accounting depart-ment/ Self-employed: computers	Administrative assistant/Drug store	mother, student/ Software designer
Education	Bachelor's degree/ Bachelor's degree	Associate's degree/ High school	Bachelor's degree/ Bachelor's degree

Research Questions

How did clients describe the attachment injury before treatment?

Attachment Injury Measure scores. The pre-treatment AIM asked how partners rated the severity of the injury. A score of 1 indicated "Not a Problem," and 7 indicated "Extremely Severe Problem." AIM scores for all couples were approximately 5 or "Very Much a Problem" and 6 or "Severe Problem." In Couples 1 and 3, partners reporting the attachment injury had more distressed scores than their partners; Couple 2 reported the same score. (See Table 5 for AIM scores)

Qualitative description of Attachment Injury Measure. The AIM asked participants to report a significant negative event in the relationship. They were also asked to include how the event affected the level of trust and intimacy between them and their partner. (See Table 5 for themes in AIM results and Appendix E for full description)

One partner in all couples reported an attachment injury. The event tended to be a specific incident that marked a change in the injured's perception and emotional issues such as level of trust and level of intimacy in the relationship. Partners reporting the attachment injury were brief in their descriptions, but nonetheless touched upon an event that later became the significant event that interrupted the progress of treatment. Non-attachment injury partners either focused on different "negative events" or reported ongoing problems instead of a specific event that changed interpersonal dynamics.

AIM examples. The female partner in Couple 3 reported a specific event when she was having a miscarriage and her partner refused to come home from work to help her. She remarked that the miscarriage frightened her and she called for comfort. His refusal to come home marked a feeling of distance between them. She wrote:

> About 1 ½ years ago, I had my second miscarriage in 3 months. I called Mike at work to tell him to come home because I was hemorrhaging and was really scared. He refused to come home because he was working late on an important project with a deadline. I begged him to come home, but he refused to come. This situation compounded my distance of Mike being there for me even in a crisis.

Earlier in her AIM statement, the injured partner in Couple 3 reported an attachment injury concerning career plans and her partner's refusal to honor a promise. She remarked that the injury gravely affected her level of trust. She stated:

> I was devastated that he was backing out on a very important promise. I had told him that I would never marry someone who didn't support my goal of being a career woman and mother . . . I went into a deep depression, developed a chronic health condition from the stress, and tried to get professional help without success. I was clinically depressed for over four years. I felt trapped. I was too depressed to leave the relationship, although I felt like leaving many times. My trust in him was completely destroyed along with my self-esteem. I gained over 30 pounds of extra weight and felt terrible. I felt I had no place, or money, or self-esteem to go anywhere or do anything. We started fighting regularly after this event. I also lost a lot of respect for him as a person, and became quite bitter and critical.

The female partner in Couple 2 also reported an incident when she has a miscarriage and her partner did not respond to her emotional needs, thus resulted in a felt decrease of intimacy. She wrote:

> This became glaringly obvious after my miscarriages. He just didn't seem to know what to do. It hurts me that can't show me his feelings. I still trust him but I know that I can't depend on him for emotional support. The miscarriages themselves decreased the level of intimacy between us. . .

Table 5
Summary of Pre-Treatment Attachment Injury Measure

	AIM Score	Negative Event	Effect on Trust	Effect on Intimacy
Couple 1 Female	"Very Serious Problem"	son's ongoing behavior problems	resentment for choosing between son and husband	stress and resentment
Male (AI)	"Severe Problem"	child's ongoing behavior problems	feelings will be stomped on	separation; anger, grief; non- loving
Couple 2 Female (AI)	"Extremely Severe Problem"	miscarriage	still trusts, but undependable	can't get emotional support
Male	"Very Much a Problem"	"her" control issues	belittled by partner	avoid "heated" contact, intimacy
Couple 3 Female (AI)	"Extremely Severe Problem"	partner backs out of promise; miscarriage	trust completely destroyed	doesn't feel supported; bitter and critical
Male	"Very Much a Problem"	puts him and family down	felt emotionally stalked	needs ignored

What were the results of the pre-test scores for couples?

The following scores were from the pre-test measures of the Dyadic Adjustment Scale, Relationship Trust Scale, Revised Adult Attachment Scale, and Attachment Injury Measure. All couples passed initial screening criteria such as appropriate DAS scores and had an identifiable attachment injury. (See Table 6 for pre-test results)

Dyadic Adjustment Scale. The DAS score for divorcing couples is 70; a score of 98 is the distress cut off point (Spanier, 1976). Couples 1 and 2 reported scores just below and above the distress cut off point. Couple 3 reported more distressed and lower adjustment than Couples 1 and 2, but scored above the norm for divorcing couples. All couples generally

reported higher agreement scores on the Consensus sub-scales and lower disagreement scores on Affectional Expression and Cohesion sub-scales.

Table 6
Pre-assessment Measures Results

PRE-	DAS	RTS	RAAS
Couple 1			
Female	93	173	Fearful/ Avoidant
Male	95	167	Fearful/ Avoidant
Average	94	170	
Couple 2			
Female	95	154	Preoccupied
Male	108	166	Dismissing
Average	101.5	160	
Couple 3			
Female	72	136	Preoccupied
Male	80	159	Dismissing
Average	76	147.5	

Relationship Trust Scale. In Couple 1, both scored just above the normal range of trust for couples, indicating an above average trust level. Partner A indicated lower scores on the Responsiveness of Partner and Dependency subscales. Partner B indicated lower scores on the Dependency subscale. In Couple 2, both scored above the normal range of trust for couples, indicating an above average trust level. Partner A scored lower of the Responsiveness of Partner and Faith of Caring subscales, and Partner B scored lower on the Conflict Efficacy subscale. Couple 3 scored just below the normal range, indicating a low moderate trust level. Partner A scored lower on Responsiveness of Partner,

Dependability/Reliability, Faith in Partner's Caring , Conflict Efficacy, and Dependency Concerns; and Partner B scored lower on Dependability/Reliability, Faith in Partner's Caring, Conflict Efficacy, and Dependency Concerns.

Revised Adult Attachment Scale. The RAAS was designed to measure the amount of closeness, dependability and fear of abandonment in intimate adult relationships. The pre-treatment RAAS scores indicated general defensive attachment styles among all couples. Both partners in Couple 1 scored in the moderate Fearful/Avoidant attachment style range. In Couples 2 and 3, Partner A (with the attachment injury) scored in the Preoccupied range and Partner B scored in the Dismissing range.

What were the post-test scores and did the scores result in "successful" resolvers according to the measures' norms?

Pre- and post-tests were used to measure overall resolution of the attachment injury. All couples scored within target "norms" according to each measure and also reported "successful" resolution in the TCDBS. The implementation checklist confirmed that EFT interventions were used throughout treatment.

Dyadic Adjustment Scale. Couples were expected to score at least above a combined score of 98 to be considered "successful." The norm for happily married couples is 114.8 (Spanier, 1976). All couples scored above the "successful" cut off and within close range of 114 or the score of happily married couples. All couples, as in the pre-treatment scores, generally reported higher agreement scores on the Consensus sub-scales and showed fewer disagreement scores on Affectional Expression and Cohesion sub-scales.

Relationship Trust Scale. The RTS was used to measure the amount of trust gained through treatment. Couples were expected to score above 150 (normal range trust of partner) to be considered "successful." Post-treatment average scores on the RTS were approximately 180, compared to pre-treatment scores of approximately 160.

Revised Adult Attachment Scale. The RAAS was used to measure the amount of change is the participants' perception of attachment style. A change in attachment style was not a criterion for whether treatment has been "successful" or the resolution of attachment injury. Changes in "low" scores of attachment styles were expected for to become more moderate. On the pre-treatment RAAS assessment, Couples 1, 2, and 3 scored fearful/avoidant and preoccupied; preoccupied and dismissing; and preoccupied and dismissing, respectively. Post-treatment scores for Couples 1, 2, and 3 were secure and low preoccupied; secure and secure; and low preoccupied and low dismissing, respectively. Dismissing style participants scored higher on Dependency subscales, and preoccupied and fearful/avoidant style participants scored lower on Fear of Abandonment subscales, suggesting "successful" changes in attachment style.

Attachment Injury Measure. Pre-treatment scores for the AIM indicated a range from "Very Much a Problem" to "Severe Problem." The "successful" range for post-treatment was expected to be below 3 or "Moderately Severe." Post-treatment scores for all couples were about 2, indicating "Slight Problem."

Table 7
Results of Post-Treatment Measures

POST-	DAS	RTS	RAAS	AIM	TCDBS	PRSQ
Couple 1						
Female	98	188	Low Preoccupied	"Slight Problem"	4	25
Male	105	182	Secure	"Slight Problem"	4.5	27
Average	101.5	185		"Slight Problem"	4.25	26
Couple 2						
Female	108	182	Secure	"Slight Problem"	4	28
Male	118	191	Secure	"Slight Problem"	4	31
Average	113	186.5		"Slight Problem"	4	29.5
Couple 3						
Female	102	172	Low Preoccupied	"Slight Problem"	4	25
Male	106	180	Low Dismissing	"Slight Problem"	4	28
Average	104	176		"Slight Problem"	4	26.5

Post-treatment AIM interview. The post-treatment interviews extended the participants' validation that the attachment injury was satisfactorily resolved. Partners were interviewed separately and were asked about their written responses on the pre-treatment Attachment Injury Measure. The purpose of the interviews was to get the participants' perspective on the "specific negative event" or attachment injury, and for participants to expand of relationship themes such as trust, intimacy/closeness, and the amount of change since the beginning of treatment.

Target Complaint Discomfort Box Scale. Post-treatment of the TCDBS asks how much does the issue brought into therapy presently "bother" each participant. Scores range from (1) Couldn't be Worse to (5) Not at All. Couples scored approximately 4 or "A Little."

Post Session Resolution Questionnaire. The PSRQ measured the amount of in-session change perceived by the couple. "Successful" scores were expected to be above 20. The average for Couples 1, 2, and 3 was 26, 29.5, and 26.5 respectively.

Implementation Check. The implementation check was used as a guide by the researcher to ensure that the therapy condition was done according to the EFT model. The focus was on client change processes and not the client-therapist interaction. The researcher reviewed all therapy sessions of the three couples on audiotape when choosing the "best sessions" for the process of resolving attachment injuries. An informal check was done to ensure that the therapists were following EFT protocol and that the focus of client change was specific to EFT criteria. All EFT intervention procedures (1, 3, 5, 7, 9, 11, 13 and 15) for the categories of Definition of Problematic Event, Attacking Behavior, Process Focus, Resolution of Problematic Event were used.

What were the results of the Structural Analysis of Social Behavior and Experiencing Scale process measure scores within each marker or phase of resolution?

One graduate level student/therapist from the Ottawa Civic Hospital and the researcher rated the change events in each stage of the therapy process. The two raters were previously trained in EFT and also received training in the SASB. The training consisted of two 2-hour sessions and involved rating practice segments (10 for each session). The interrater reliability for the SASB for the in-session process measures was .89, indicating high inter-rater reliability (Cohen, 1969). The majority of rater disagreements fell within the Cluster codes of specific behaviors such as protesting versus sulking. Raters rarely disagreed on the more general category codes of Focus scores such as Self or Other, or Quadrant scores such as Affiliative, Distant, Hostile or Friendly. The researcher coded the ES for all phases of resolution.

Change events fell within the predicted stages of the resolution process. The first phase emerged in the assessment phase or the first two steps of the EFT model and marked the attachment injury. The markers were statements of an incident of betrayal or rejection

such as responsiveness during a miscarriage or accessibility during a critical discussion concerning family members. Although other issues and event were discussed in this phase, the attachment injury was nonetheless introduced. The injured partner accused and blamed their partner in an angry or critical manner, while the blamed partner withdrew and took a defensive stance.

Couple 1 expressed the following:

Sara: I was mad at him. He was just standing there watching and the baby needed comforting, like he is only five years old and he just stands there. I think, "Do something." I feel mad now thinking about it.

Sam: I was going to. (*Pause*)

Therapist: What happened after that?

Sara: Well he just went into his shell and I was left to clean up the mess off the floor and do all the other stuff too. I'm fed up. I just kind of slap him down . . . I have a short fuse, especially when I have a bad day or a headache. He should just know. It takes a lot for me to get really angry and sometimes I have to get really angry just to get a reaction. Sometimes I feel I have to stay and have a fight so I can get a reaction just so we can communicate about something.

The process measures showed that defensive behaviors such as blaming or withdrawing were highest at the beginning or the Assessment phase.

Codes in the De-escalation phase showed lower levels of anger or pursuing behaviors for partner A, and more engagement and affiliative behaviors for partner B. "Secondary" issues to the attachment injury were discussed in the beginning stages of this phase. Couple 1 expressed:

Sara: I am glad to hear that I am important to you. Sometimes, I just don't know how you feel about me or how you feel about anything. I used to say to him that I was sorry to hurt his feeling (*laughter*) because I thought he only had one.

Sam: Well, I have never been a very expressive person, never talked a lot, but she knows that I do have feelings but I just don't talk a lot about them. I do want to talk more about them, but I just don't want to be criticized.

There was a return to higher anger levels during the de-escalation phase, particularly when the attachment injury was worked through. However, during the attachment injury phase, within the de-escalation phase, partners with the attachment injury showed more differentiated affectual expression, such as a mix of anger statements followed by more

vulnerable expressions of needs and self-disclosure. Their partners became less defensive and more responsive. Although affect expression was more differentiated in this phase than in the Assessment phase, couples continued to interact in the similar rigid interaction cycles.

The following transcript shows the discussion of the attachment injury:

Therapist: What happened after that, after you realized that you had lost the baby?

Sara: I called for Sam to come down and help me. He came down, but was frozen, like he didn't know what to do. I just remember thinking that if I go off the deep end here, at what point will he pick up the phone and call. . . at what point will he come over to comfort me. Well I didn't want him to call anyone. I wanted him to take care of me and I thought . . .

Therapist: Take care of you how?

Sara: To. . . (pause) to hold me and do what people do when somebody dies. To me if somebody I knew died, I would ask if they are ok and say that I am really sorry and if they wanted to talk about it, I would listen and if they started to cry, I would comfort them. You kind of have to say something. Everything just seemed so solid and he didn't seem upset by it.

The Re-engagement/Resolution phase scores showed high affiliation and re-engagement and followed predicted scores, indicating both a resolution of therapy and a resolution of the attachment injury. Partner A continued to differentiate affect, expresses vulnerability, and also described the attachment meanings in terms of safety and trust. Partner B became more engaged, listened more, acknowledged the other partner's pain, and accepted responsibility for his/her part in the attachment injury. During this phase, partner A "softens"and became less hostile and more trusting and expressed the need for comfort, safety, and reassurance. Partner B responded to partner A's pain and offered comfort. The behaviors in this phase redefined the bond as engaged.

The following shows the re-engagement/softening marker in Couple 2:

Sara: I know that. And I appreciate that he does all that he does for me. I know if over the years if I hadn't criticized you so much, you may be more open to me and trust me more.

Sam: I totally trust you.

Sara: I really am seeing you differently. Not for who I want you to be, but who you are. But not that I expect a totally emotional person all the time, but find different ways for us fit together.

SASB and ES scores during marker events. The following shows the range of SASB and ES scores with marker events. All rater codes fell within predicted ranges.

I. Assessment:

1. On the SASB, statements from Partner A (injury partner) were rated as 1-6 (belittling and blaming), 1-7 (attacking and rejecting), or 2-1 (asserting and separating). Statements from Partner B were rated as 2-6 (sulking and appeasing), 2-7 (protesting and withdrawing), or 1-1 (freeing and forgetting). Scores were consistent with predicted ranges of scores.

2. On the ES, statements from both partners on average were rated less than 3.

II. De-escalation:

1. On the SASB, statements from Partner A (injury partner) were rated as 2-2 (expressing and disclosing of needs). Statements from Partner B were rated as 1-2 (affirming and understanding).

2. On the ES, statements from both partners were rated as a level 4.

3. On the SASB during the attachment injury phase, statements from Partner A (injury partner) were rated as 2-2 (expressing and disclosing of needs). Statements from Partner B were rated as 1-2 (affirming and understanding).

4. On the ES, statements from both partners were rated as a level 4.

III. Re-engagement/ Softening/Resolution:

1. Sequential responses from both partners were rated as falling in Quadrant I or IV on the SASB (autonomous/affiliation).

2. Sequential responses from both partners attained a level 4 rating (description of feelings and personal experiences) on the ES, with at least one of these responses reaching a peak of 5 or 6.

How did clients describe the attachment injury after the resolution phase of treatment?

The post-treatment interviews extended the participants' validation that the attachment injury was satisfactorily resolved. Partners were interviewed separately and were asked to read their written responses on the pre-treatment Attachment Injury Measure. The purpose of the interviews was to get the participants' perspective on the "specific negative event" or attachment injury, and themes such as trust, intimacy/closeness, and the amount of change since the beginning of treatment.

The following segments showed participants' views of the attachment injury, change and intimacy after treatment. Segments of attachment significance, as shown through attachment language (Bowlby, 1969, and Johnson, 1996), are provided. The first segment gave the injured and her partner's perspective of the attachment injury event after resolution. Both showed empathy for the other's experience.

> Molly: He was very preoccupied with a major project at work and also I think our emotional baggage got in the way that day. Had we been less distant and less antagonistic towards each other, he would have been there. I know he would have been.
>
> Molly: I am pretty sure that if I had a miscarriage today, he would not react the same way again. I think he learned a hard lesson from that experience. And I am watching him with his mother now in treatment, and he is so there for his mom that I am surprised and frankly jealous (*laughter*).
>
> Mike: Well, I know it was very difficult for her and actually it was very painful for us both. If that were to happen today, undoubtedly I would drop what I was doing and be there. We were so tangled up in conflict then and there had been so many false alarms that I could make that kind of decision then. Now I could not do that.

Another participant expressed that the attachment injury would surface during everyday conversations, and that the injury had been worked through to her satisfaction. She stated:

> Sara: It seemed that every time we had a fight, it was so bizarre, I would always end up bringing up the miscarriage. We would be fighting about where the knives go, for example, and all of a sudden I would say, "You just didn't understand" and "Why didn't you see what this was about?" But it never comes to that now. We dealt with it. I did what I needed to do and it seems like a thing of the past now. It is different. It feels so good to have it behind us. I mean, I will never forget it, but it doesn't have the impact that it used to.

All participants expressed a sense of positive general change in the relationship. One partner stated:

> I thought we were going to separate as a result of it. It feels different now. I mean, we haven't gone through major personality overhauls, but we know we can handle things that used to get us down. And it seems simple now. I stop hiding and talk about it.

As predicted by the resolution phase of EFT, participants described their post-treatment using attachment language. The use of attachment language such as "lonely" and implied access to "primary emotions" and a sense of safety to express them interpersonally for both partners. The partner of an attachment injury participant explained:

> Sam: Yes, just agree with her with whatever. I was very lonely though. It took the manhood out of me. There was a time that I was lonely. I am not a talker and don't show my emotions and I know that is a problem and I am trying to do better. I mean we went through some hard times, especially the miscarriage, and I went through

some hard times. Had I known more about what was happening to her on a deeper level, it would have helped.

Table 8
Summary of Post-Treatment Attachment Injury Interviews

	Attachment Injury	Perception of change	Attachment Significance	Effect on Intimacy
Couple 1 Female	son's ongoing behavior problems	"It got so much better"	"I need to show love"	more talking, coping; "We are allies"
Male (AI)	child's ongoing behavior problems	positive change; "we can handle it"	"I need her help"; "stay in touch"	emotionally "know" each other; opened up
Couple 2 Female (AI)	miscarriage	AI less impact; give space	trust; "I know he cares"; "he's not un-emotional	more encouraging; less reactive
Male	"her" control issues	wider range of possibilities; less controlling	"I was very lonely"	talk more; she listens more
Couple 3 Female (AI)	partner backs out of promise; miscarriage	"He would have been there;" tremendous progress	"We can really be there for each other" accessible, reliable.	more trust; sense of peace, joy; both actor and director
Male	puts him and family down	puts them down less; supportive with family	"It was painful for us" "Being there for her is therapy for me"	give love and receive love; talk more; more trust

Rick: It was severe. And there is no control over a teenager sometimes so I expect problems to come our way. But as I said, we can handle it . . . Or we can handle

> ourselves as a couple. I have come to realize that I need Rhet's help sometimes and can ask her for it and I know not to get in the middle and put her in a place to decide between me and her kids.

All participants expressed positive change in levels of felt and expressed intimacy after treatment.

> Mike: Being there for her is a type of therapy for me. It is a reciprocal process and it I express love and I feel I will get it back. It is a positive sharing. Sometimes coming together has caused so much friction and we are showing the good ingredients now. I really try to show that I care.

> Molly: If you look through the trust scales, you will see the changes in us. In February, I was in a terrible place, and now I feel a sense of empowerment and I take care of me and take care of Mike and the family. I trust Mike, I trust that we will work things through. . .

<u>In what ways did the event pathways of the proposed rational model of attachment injury resolution differ from those of the empirical model?</u>

The rational and empirical models of the resolution of attachment injuries share similar pathways. It was proposed that the markers would be statements of an incident of betrayal or rejection from *partner A*. The injured partner would show hostility, while the other partner would withdraw and take a defensive stance. Second, in the de-escalation phase, *partner A* would begin to articulate the significance of the injury, differentiate affect (e.g., hostility and hurt). *Partner B* would become less defensive and more responsive, but both interacting in similar rigid interaction cycles as in the first phase. Third, in the re-engagement phase, *partner A* would continue to differentiate affect, express vulnerability, and describe the attachment meanings in terms of safety and trust. *Partner B* would become more engaged, acknowledge the other partner's pain and accept responsibility for his/her part in the attachment injury.

The difference in the rational and empirical models lies in where the attachment injury became a significant event in treatment. The rational model proposed that the attachment injury would become a significant, workable theme from the beginning of treatment in the assessment phase and continue as such thematically through the de-escalation and re-engagement phases. The empirical, however, model showed that the attachment injury was indeed brought out as a clinical issue, however, the resolution of the injury did not take place until after de-escalation had taken place. Some couples worked through the injury in under ten sessions after the assessment phase; others worked through other issues for up to fifteen sessions. What couples had in common, in summary, was that the resolution of the attachment injury came after a period of de-escalation and that the resolution of the attachment injury was a prerequisite event before the Resolution/Softening phase.

The empirical model proposes that the attachment injury is not necessarily *the* focus of treatment until the de-escalation phase of treatment. The injury may appear in the assessment phase and become a thematic therapy issue. On the other hand, as shown through participants in the study, the attachment injury can remain an unspoken topic.

The empirical model, as expected, expands the rational model in detail. The following empirical model follows the similar steps as the rational model. The attachment injury marker event was renamed as the Assessment Phase due to variations of topics discussed in treatment.

I. Assessment Phase.

1. Pre-assessment session measures are given. Clients report initial content presenting problem and typically report distress concerning the relationship. *Partner A* shows secondary affect behaviors such as blaming, hostility, critical anger and contempt. *Partner B* shows secondary affect behaviors such as defensiveness, minimizing, withdrawal and avoidance. The attachment injury can be mentioned, but not necessarily becomes the core focus of therapy.

2. Relational cycles are identified. Typical patterns are: pursue/distance, hostility/withdraw, attack/defend, attack/attack and defend/defend.

II. De-escalation Phase.

3. Partners become less defensive. Clients show differentiation of affect and the expression of needs. *Partner A* shows less anger and pursuing behaviors, and expresses vulnerability. *Partner B* becomes more engaged and listens more empathically. Couples vacillate between periods of closeness (re-engagement) and periods of anger and distance, especially if the attachment injury or other significant attachment issues are discussed. Other issues, whether topical, emotional or relational, are worked through. This phase is the bulk of therapy and can last as few as ten to more than twenty sessions. The attachment injury emerges in this phase but at different points in the therapy process depending on the couple.

4. Attachment Injury. *Partner A* expresses the attachment significance of an event that marks a drastic change in the relationship. *Partner A* begins to express vulnerability and articulates lack of trust, accessibility, responsiveness, emotional security, emotional contact and engagement, commitment and belonging. *Partner A* uses attachment language such as "I was devastated and all alone." *Partner B* becomes more engaged, listens more empathically and is less defensive. The attachment injury can be resolved but does not necessarily serve as the re-engagement or softening event. The resolution of the attachment injury precedes the re-engagement phase of therapy.

Table 9
The Empirical Attachment Injury Resolution Model

Phase 1: Assessment		
Presenting problem; Secondary affect; Cycles of pursue/distance or attack/defend	(Partner A: The Injured) Shows blaming, hostile, critical anger and contemptuous behaviors	(Partner B) Defensive, minimizing, withdrawal/avoidance behaviors
Phase 2: De-Escalation		
Differentiation of affect and the expression of needs; Attachment Injury discussed at any point in this phase	(Partner A) Express less anger and more vulnerability; Uses attachment language such as "I am hurt"	(Partner B) Becomes more engaged; Listens more empathically and less defensive
Attachment Injury		
Couples can revert to Phase 1: Secondary affect; Cycles of pursue/distance or attack/defend	(Partner A: The Injured) Shows blaming, hostile, critical anger and expression of needs	(Partner B) Some defensive, minimizing, avoidance behaviors, but more engaged
Phase 3: Re-Engagement/ Resolution/Softening		
Primary Affect: Expression of vulnerability and emotional engagement; Mutual expression of needs; More empathic	(Partner A) More trusts; Discloses and expresses needs; Less hostile; Accepts limitations	(Partner B) Trust the other more; More engaged and empathic; More accessible and responsive

III. Re-engagement and Softening Phase.

5. Couples express vulnerabilities and show emotional engagement. There is an emergence of new relational cycles which serve as the biggest shift in the relationship positions compared to pretest measures. *Partner A* expresses needs and vulnerabilities, trusts the other more, feels that the other can be accessible and responsive, and accepts limitations. *Partner A* is more empathic, less hostile and is able to ask for comfort from the other. *Partner B* also is more engaged and empathic, trusts the other more, and accepts limitations.

Partner B is more accessible and responsive, and feels that the other more approachable. (See Table 5 for The Attachment Injury Empirical Model)

Summary

Attachment injuries, according to Johnson (1996), are relationship events that occur in critical moments of need when a person is vulnerable. The person's sense of trust, closeness, and general satisfaction feels betrayed. The event may seem inconsequential to an outside viewer, and even the person's partner; yet the incident is repeatedly raised without satisfactory closure and it later becomes a stuck point to task resolution clinically. This study identified couples with such injuries and proposed a theoretical/empirical model of resolution.

Couples with attachment injuries were identified by an expert clinician and the researcher. The attachment injuries were resolved using EFT and the model (N = 3) was developed using task analysis. The empirical map was developed as follows: Pre- and post-tests such as the DAS, RTS, RAAS, and AIM measured overall resolution of the attachment injury. All couples scored within proposed ranges and were considered "successful" resolvers according to all pre- and post-measures. Process measures identified in-session changes. All "best sessions" ratings from the SASB and ES fell within predicted ranges. At the resolution session the researcher interviewed couples based on pre-assessment AIM responses to identify change events from the clients' point of view. The TCDBS and PSRQ showed the "successful resolution" of the attachment injury.

A rational, conceptual map of expected change was compared to an empirically developed map. The marker events emerged at the assessment, de-escalation, and resolution phases of treatment. The attachment injury emerged during the de-escalation phase of treatment.

Chapter V

Discussion

Couples often enter therapy under significant emotional distress. They report low levels of marital satisfaction, trust and intimacy. Many feel emotionally defeated and that their attempts at restoring intimacy have fallen short. These couples relate to one another in limited ways, often through defensiveness, reactivity, anger, indifference and rigid attack and defend cycles. The therapist may guide these couples through a long de-escalation process and note improvements in intimacy and satisfaction, and later find that the couple has reverted back to similar rigid cycles, anger and withdrawal as in the initial stages of therapy. The couple feels stuck; the therapist feels stuck.

Johnson (1996) proposed that distress can frequently be traced to a specific incident when one partner experiences a strong sense of betrayal by the actions of their partner. For the couple, this injurious incident represents a wound in the attachment bond and is marked by consuming pain and mistrust. In therapy, this incident becomes a recurring theme, where couples are seemingly stuck in negative interactional cycles and report a loss of trust, dependability, responsiveness and accessibility.

EFT is a form of couples therapy that offers a systematic means for understanding relationship distress. Few family therapy models have been empirically tested. EFT, however, has empirically mapped out replicable procedures, specific interventions, and has tested the effectiveness of interventions on numerous presenting problems, particularly on marital distress (Greenberg & Johnson, 1986a). EFT has been shown to create stronger attachment bonds and higher levels of trust and intimacy in couples (Johnson, Hunsley, Greenberg, & Schindler, 1998).

This study posed several essential questions that have needed examination. First, there are no references to attachment injuries other than Johnson's (1996; 1998) conceptualization. This study may further validate Johnson's (1996) conceptualization through the clients' points of view. Second, there are no empirical studies in the literature on attachment injuries. This study attempted to build a preliminary model of how attachment injuries can be resolved clinically. Third, EFT has shown a high effect size for couples with general distress, but has not addressed couples who relapse to initial distress levels during treatment or who terminate treatment as non resolvers. Additionally, EFT theory does not distinguish between general distress and specific events that hamper resolution. This study offered a refinement in EFT theory through the tested concept of attachment injuries.

This study identified the theoretical construct of attachment injuries in couples and proposed, through task analysis, a preliminary rational/empirical model of resolution of such injuries. Couples with attachment injuries were identified by an expert clinician and the

researcher. Couples described critical "negative events" in a pre-treatment self-report measure. Pre- and post-tests measured overall resolution of the attachment injury. At termination, all couples scored within the "successful" range in the Dyadic Adjustment Scale, Relationship Trust Scale, Revised Adult Attachment Scale, Attachment Injury Measure Post Session Resolution Questionnaire, and Target Complaints Discomfort Box Scale. Process measures identified in-session changes. All couples scored within "successful" ranges in "best sessions" in the Structural Analysis of Social Behavior and Experiencing Scale measures. Lastly, couples were interviewed at post-treatment and described a clear impact by the focus on EFT and attachment injuries as shown by their improved empathy, the use of "primary affect" and attachment language, and reports of positive change and higher marital satisfaction.

A rational, conceptual map of expected change was compared to an empirically developed map. The data showed significant overlap between rational/empirical models, with one compelling exception. The rational model mapped the attachment injury as the first marker event in treatment. The empirical model, however, showed that the attachment injury was not necessarily the first maker or presenting problem in treatment, and the resolution of the attachment injury came after several sessions within the de-escalation phase and was a necessary step that precipitated the re-engagement/resolution phase.

Attachment needs are activated when there is a real or potential threat, danger, loss, or uncertainty (Bowlby, 1969). The hypothesis of this study was that a relationship event such as feeling betrayed at a specific time of need could activate innate attachment reactions and damage the attachment bond. The injured's sense of trust and the other's accessibility and responsiveness, all vital to secure emotional bonds, seemed lost. These events theoretically solidified more rigid emotional positions such as pursue/withdraw or attack/defend. The attachment injury event became a touchstone for future relationship interactions and stuck points in treatment.

The concept of attachment injury helps clinicians identify specific events in relationships that may have prompted an enormous change in partners' perceptions and emotional positions towards one another. The clinician may recognize the injury by the amount of charged affect around the issue and, if put into relational cycles and into relational context of needs and vulnerabilities, the couple may avert such stuck points. The results of this study have yielded a proposed theoretical model of change for couples who sustain an attachment injury and adds to the validation of the theoretical concept of attachment injuries.

Attachment Injury as a Useful Clinical Concept

Differentiating clinical issues. This study showed that the attachment injuries can provide a useful clinical tool for differentiating between general distress and specific critical events. Most couples experience distress in varying degrees, but not all couples experience

injurious events which unravel the emotional bonds that connect them. In therapy, some couples resolve their distress without undue complications. Other couples, however, despite their efforts, can show improvements but repeatedly fall back into the same anger, criticism, and withdrawal as in the first sessions. Perhaps some of these "relapse" clinical events are due to attachment injuries.

As shown in this study, couples did not move into the re-engagement phase of treatment until after the injury had been addressed and placed within a relational attachment context. Couples tended to show markers of re-engagement and resolution only after the attachment injury had been addressed in depth. All couples reported "successful" DAS, RTS, PSRQ, TCDBS scores and verbal confirmation in post-treatment interviews a few sessions after the attachment injury resolution. In-session measures confirmed that after couples had de-escalated, their relational patterns became more rigid during the attachment injury phase, and marked the beginning of the re-engagement phase.

This study presented a way to identify attachment injuries in treatment. Not every critical relationship event is an attachment injury. Two couples can go through roughly the same experience with the same interactions, and one has few resulting problems and the other suffers significant relationship damage. This study showed, through self-report measures, that couples who had attachment injuries were particularly emotionally vulnerable at the time of the injury. The event, in other words, could be the "straw that broke the camel's back." Clinically, there are many types of attachment injuries in terms of content. The process, however, was similar. Couples' relationship satisfaction and trust was low. Attachment styles suggested high preoccupation or withdrawal. Couples reported that similar events had happened repeatedly in the time that preceded the injury. In treatment, the attachment injury was a clinical theme which the couple had attempted to work through, but later came up again with similar emotional charge, according to the SASB process measure.

Identifying attachment injuries. Pinpointing an attachment injury at times may be difficult. Some couples specifically identified the attachment injury in the assessment sessions and had well-formulated meanings surrounding the attachment injury. One participant pinpointed the attachment injury as the event which changed her overall trust toward her partner and she subsequently felt worse about herself, gained excess weight and "got depressed." The couple repeatedly "argued" about the injury. Other couples, however, may not be aware of how these critical events block intimacy, accessibility, responsiveness and trust. One participant stated that the attachment injury event would come up at "odd times" and "out of the blue" in seemingly unrelated conversations. She was aware that the relationship had changed, but could not identify satisfying reasons for the changes.

The process of working through an attachment injury may take persistence and patience. Injured participants tended to enter therapy showing restricted emotional

expression, shown through attacking and defending statements. Interpretively speaking, the injured showed a feeling of helplessness and overuse of secondary affect through critical or blaming statements and few primary affect expressions of needs and vulnerabilities. Their partners also showed high amounts of secondary affect through dismissing or withdrawal statements. Both partners gave or received little comfort.

This study showed that certain clinical events should happen before an attachment injury is resolved: there must be emotional engagement and access to underlying "primary" affect. The injured has to be emotionally engaged with his or her partner beyond blame and criticism, and experience the event more as a primary loss of security. The other has to acknowledge both the pain of the injured and their own. As indicated in re-engagement phase process measures, both have to be emotionally engaged and express their needs, vulnerabilities, and desire for connection.

Once the attachment injury is identified, clients tended to describe the event in detail. One participant described her thought processes, the sequence of events, what she was feeling, what she felt towards her partner, what she said, what he said. Another participant provided similar descriptions of an attachment injury and also remembered the specific wheat field in which it happened while driving through Saskatchewan with her husband. The therapist should provide a safe "holding environment" during such descriptions through reflection, validation, slow pacing, and later placing the injury into a relational context.

Qualitative Observations

Further validity. This study mapped change processes of attachment injuries through pre- and post-test measures and in-session process measures. Qualitative interviews also validated participant changes. Additional observations of change that offered supportive validity can be made. First, vocal quality changed over sessions. During first sessions, tone of voice tended to be more forced and loud by the injured and weaker and more hesitant by the withdrawer. In later session, particularly after the injury had been resolved, the pursuing participants tended to have softer and more relaxed vocal tones, and withdrawers stronger and less hesitant vocal tones. Also, conversation content and process conversations became more affiliative in later stages of treatment. At the beginning sessions, participants tended to speak in successive monologues, addressing the therapist. In later sessions participants addressed one another on shared topics.

Roles of the therapist. The therapists in this study used EFT as the treatment. Generally therapists practicing EFT attempt to create "safety" in the relationship by validating the experiences of both partners and by accessing underlying feelings. In this study, therapists in the first steps identified the presenting problems, secondary affect such as critical anger, and relational cycles. The couples began a de-escalation of negative affect and began to work through issues with fewer rigid ways of relating such as expressing a majority of statements

through criticism. When couples felt more connected in the de-escalation phase, the attachment injury surfaced and, despite previously "failed" attempts, couples began to resolve the attachment injury. Therapists asked participants to be as emotionally engaged as possible and began to put the incident in an attachment framework. Therapists asked the injured partner to express underlying feelings directly to their partner through such question as, "Can you turn to him right now and tell him . . ." or "Will you risk . . ." The therapist used attachment language to address relational needs with statements such as, "She is scared you will not be there . . ."

Therapists who work with couples with attachment injury play various roles. In this study, once the injury was acknowledged, the participant tended to need the therapist to stay fully present with them and guide them through a flood of powerful emotions such as anger, guilt and vulnerability. In addition, the therapist needed to include the withdrawing partner in the process and validate his or her own difficult experiences as well. The participants, hypothetically, can only go as far as what the therapist can tolerate in terms of "hot" affect.

Length of treatment. An inference from this study is that the length of treatment depends on the severity of the attachment injury and how the therapist addresses the injury in treatment. The length of treatment in this study varied among couples. Those with higher initial DAS scored tended to complete treatment within about 15 sessions. Couple three had lower DAS and RTS scores and the participant reported 2 attachment injuries. Both were "successfully resolved" according to self-report measures; however, the length of treatment was about 25 sessions.

Theoretical Contributions Through the Differences in the Rational and Empirical Models

The data from this study showed strong evidence that EFT in general and attachment injuries in particular are promising concepts for the field of couples therapy. Differences in the rational and empirical models were minimal. The "best session" markers in this study confirmed the rational model's stages of de-escalation, re-engagement and resolution. The empirical model confirmed that "successful"couples went through particular phases of treatment after the assessment phase such as de-escalation and re-engagement. Furthermore, the empirical model showed that couples may bring up the injury in the assessment sessions, but did not "successfully" deal with it until after several de-escalation sessions.

The findings in this study add to EFT theory by refining the existing EFT process of change model in light of a more specific presenting problem, an attachment injury. EFT has shown to be effective in dealing with marital distress; however, this study helped define a more specific type of distress and provided a model of guiding couples and therapists through this type of distress.

As in former EFT studies (Johnson, Hunsley, Greenberg, & Schindler, 1998), all couples in this study followed processes of de-escalation, re-engagement and resolution.

Within these phases, couples showed a softening of critical statements from injured participants, more engaged statements from withdrawn participants, and an expansion of emotional expression from both participants.

EFT interventions (Johnson, 1996) were further validated by their effectiveness in helping participants access both secondary and primary affect, and the use of an attachment framework help couples re-engage emotionally, and guide them towards resolution of the attachment injury. Forth, there has been a lack of discussion of non resolving couples in EFT. This study may help clinicians identify potential non resolving couples because an attachment injury was not satisfactorily addressed.

Other schools of family therapy. The concept of attachment injuries and EFT can have utility to other family therapy modalities. Narrative therapy, for example, guides clients in the "re-telling" (e.g., White & Epston) of relationship distress events. However, process and outcome research has not shown how Narrative interventions work (Literature Review). The use of EFT, however, allowed participants to tell their relationship "stories" from various emotional positions. In the re-engagement stages of therapy, the re-telling of the injuries was an integrated narrative of both self and other, and open expression of need and affiliation. For example, one participant described the injury as a sense of rejection and betrayal in the assessment stages. He was self-focused. In later stages, the participant, turning to his partner, re-told the same event as his inability to ask for comfort and affiliation during hard times.

This study may also be useful for the forgiveness literature (Coop-Gordon, Baucom, & Snyder, 2000). Some modalities tend to focus on the event itself and use insight and understanding of the negative event as guiding concepts for treatment. This study showed, however, that focusing on the relational attachment bond and re-experiencing the events "in the present" through his or her partner can be a powerful healing experience that re-engages the couple to higher levels of trust, intimacy and satisfaction.

Shortcomings

Audiotapes were used to collect the process data due to logistical complications of room and video equipment shortages at the Ottawa Civic Hospital. The use of audiotapes to analyze the force of expression and the reactions of partners likely became less obvious to raters over the course of the therapy sessions. Ideally, the use of videotape would offer a broader view of interactions and perhaps a more exact coding of emotional expression and interaction sequences.

The task analysis protocol in the first stages of building a rational/empirical model calls for studying a small sample or "few cases" (Greenberg, Heatherington, & Friedlander, 1996)

based on an expert clinician's observations of a particular clinical point of interest. The question of what is an adequate small sample can be raised. Three couples were chosen as an interpretation of a "few" and "small sample" due to the duration of data collection. With a larger sample, findings may have shown that attachment injuries can be resolved at various stages of treatment.

The rational/empirical model highlighted pursue/withdraw cycles. Some couples clinically may show pursue/pursue, withdraw/withdraw or pursue and withdraw cycles from both partners. The empirical pursue/withdraw model highlighted what may be most predominant pattern presented clinically. Also, with withdraw/withdraw patterns, couples may not express critical anger as the model suggests.

Future Research

Three couples were selected to build the preliminary attachment injury model based on task analysis protocol (Greenberg, Heatherington, & Friedlander, 1996). The next step in the task analysis protocol involves using a larger sample, such as 30 to 40 couples, comparing process to outcome, and comparing resolvers versus non resolvers. This strategy should be used in future studies, as a preliminary model, to develop a more detailed model of attachment injury resolution.

An inference that can be drawn from this study was that attachment injuries happen during attachment related events. Content examples of attachment injuries can include infidelity, miscarriages, a partner's inaccessibility during physical illness, or being ignored or excluded from an important event. Future studies could enumerate various types of attachment injuries and develop, perhaps through qualitative inquiry, an in-depth analysis of the nature of the injury and the specific meaning to the couple. In addition, future studies can involve a more specific outline of the nature of the attachment bond that precipitates an attachment injury emphasizing the process of the injury. What were trust and satisfaction levels and attachment styles before the attachment injury occurred? Can "secure attachment" couples sustain such injuries? If so, what internal and external events of change lead up to the injury?

Future studies could focus on the "injurer" and possible sustained injuries before the attachment injury dealt with in treatment. Also, the use of the word injury has broad connotations. If there is an injured, there usually is one who injures. The author has not implied a dichotomous distinction of victim/perpetrator. Relationally, partners in this study were caught in the same quality patterns, with the same amount of distance and disappointments. Some withdrawers perhaps experienced attachment injuries but ignored their need to process it until treatment. When their partner, later, was in need, they may have felt resentful and unwilling to be accessible since their partner had not been accessible to them. Hence results a cycle of injuries.

The pre- and post-RAAS scores suggested that couples showed adjustments in attachment style. Dismissing participants scored in higher Dependency ranges and preoccupied and fearful/avoidant participants showed lower scores in Fear of Abandonment subscales. Future studies could find positive correlations in EFT treatment and factors that suggest more secure attachment styles.

Future studies can investigate the "opposite" of attachment injuries or what events strengthen the bond in unusually powerful ways. The study may include when attachment event occurs or when one partner is particularly vulnerable, what are ways couples have successfully bypassed injuries and strengthened rather than injured the bond.

Many couples seek treatment when distressed and leave feeling closer and more satisfied in the relationship. Others, however, may seek treatment to help them through seemingly insolvable stuck points that hamper their feelings of intimacy and satisfaction. The focus of emotional experience and attachment framing of relationship events in therapy may give couples new ways of relating to one another and provide each other with mutual validation, accessibility, responsiveness, and deeper sense of intimacy and connection. This study hopefully will help couples find new ways of healing attachment wounds and creating a deeper connection.

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APPENDIX A

Information and Consent Form
Referrals for Outside Treatment

INFORMATION AND CONSENT FORM

Title of Project: Resolving Attachment Injuries in Couples Using Emotionally Focused Therapy: A Process Study.

Principle Investigator: John W. Millikin and Dr. Susan M. Johnson

Couple No._____

Purpose of this Research Project

This research project is designed for distressed couples who wish to improve the level of trust and security in their relationship. The purpose of this research project is to examine characteristics of the interactions between you and your partner and determine if these characteristics are predictive of outcome in a particular form of couples counseling.

Major Procedures

If you agree to participate in this project, both you and your partner will be required to complete questionnaires in order to assess your suitability for this study. If you do not meet the inclusion criteria for this study, you will be given feedback on your initial testing and referred for other counseling if you so desire.

If you meet our criteria for participation, you will be asked to complete questionnaires that are part of this research study. You will then be assigned to a counselor who will call you to arrange your first appointment. Both you and your partner will be seen for a total of ten (10) one hour sessions with the format being one week for each session. Sessions will be conducted by senior doctoral level interns under the supervision of Dr. Susan Johnson, a registered clinical psychologist at the Ottawa Civic Hospital. All sessions will be videotaped for supervision purposes and to ensure that the approach is faithfully implemented. The counseling sessions are free of change and will take place at the Centre for Psychological Services.

At the end of the final session, you will be asked to complete a set of research questionnaires. Ten to twelve weeks after the termination of the counseling sessions, you will be contacted to complete follow-up questionnaires (approximately 30 to 45 minutes). I also understand that debriefing on the more detailed procedures of the study will be offered after the completion of follow-up questionnaires, and summaries of the results will be sent to couples if requested.

Counseling Approach Used in This Study

The particular approach of couples counseling that you will be offered is called Emotionally Focused Couples Therapy. This form of couples counseling has been found to be successful in helping many distressed couples improve their relationships.

Benefits and Risks

No benefits will be guaranteed to couples and there will be no monetary compensation for their participation. Couples will receive free couples therapy. Some couples may experience less distress and more intimacy in the relationship. They may also begin to resolve past conflicts with more satisfaction.

The risks of the study include experiencing uncomfortable feelings in light of relationship problems during the therapy process due to the nature of the issues they may discuss, and couples may find that therapy does not adequately resolve their presenting issues. If this is the case, couples will be referred to therapy outside of the civic hospital.

Confidentiality

Confidentiality of all tape recordings and written responses will be respected according to the ethical guidelines of the College of Psychologists of Ontario and the American Association of Marriage and Family Therapy. Your names will be known only to the people who are directly involved in the research. These include the principal investigators, the clinical supervisor, and your counselor. Anonymity will be assured through the pooling of all data so that the published results will be presented in group format and no individual or couple will be identified. All videotapes and written forms will be securely filed at the Ottawa Civic Hospital.

If researchers wish to keep certain recordings such as videotapes or transcriptions for training purposes, you will be asked to sign a consent form to this effect. All other recordings will be completely erased after the end of the study. Written responses to questionnaires as well as progress notes written by the counselors will be kept in a confidential file at the Ottawa Civic Hospital.

In some situations, the investigator must break the confidentiality agreement. If child abuse is known or strongly suspected, investigators are required to notify the appropriate authorities. Is a participant is believed to be a threat to herself/himself or to others, the investigator may have to notify the appropriate authorities.

Consent for Services

I, _____, understand that I am being asked to participate in a study to examine couple characteristics that relate to success in a particular approach to marital therapy. I consent to the use of tape recordings of counseling sessions and of my written responses to the questionnaires for the purposes of this research with the understanding that all information gathered will be held in strict confidence within the limits of the law and according to the ethical principles of the College of Psychologists of Ontario, and that this information will be available only to those who are directly involved in this study.

Freedom to Withdraw

I also understand that my participation in this study is voluntary and I may withdraw from this project at any time and/or request that tapes be erased without penalty and without jeopardizing access to further counseling.

I have received a copy of this information and consent form and I have read and understood it. I hereby agree to participate in the testing and in this research project if I am selected.

Compensation

There will be no compensation for participation in this study.

Signature:_____

Witness Signature:_____

Telephone No.: (H)_____
(W)_____

Date:_____

Should I have questions about this research or its conduct, I may contact:

John Millikin (562-5800, Ottawa Civic Hospital)
Investigator

Dr. Susan Johnson (562-5800 ext. 4813, Ottawa Civic Hospital)
Faculty Supervisor

REFERRALS FOR OUTSIDE TREATMENT

If the clients report substance abuse ask if they wish to be referred for treatment elsewhere:

1. Al-Anon
2. Rideauwood Institute
3. Royal Ottawa Hospital

If the clients ask if they wish to be referred for treatment elsewhere:

1. Centre for Psychological Services
2. Family Service Centre of Ottawa
3. Ottawa Academy of Psychology
4. Ottawa Civic Hospital
5. Catholic Family Services
6. Royal Ottawa Hospital

APPENDIX B

SELF-REPORT MEASURES

Demographic Data Questionnaire
Dyadic Adjustment Scale
Relationship Trust Scale
Attachment Injury Measure
Revised Adult Attachment Scale
Post-Session Resolution Questionnaire
Target Complaint Discomfort Box Scale

DEMOGRAPHIC DATA QUESTIONNAIRE

Couple No._____

How many years have you lived together as a couple?_____

How many children do you have?_____

Have the two of you had any marital counseling before taking part in this project?
Yes_____ No_____

What is your gross family income (annual)?_____

Please state your age (in years)_____

What is your present occupation?_____

Have you had a previous marriage? Yes_____ No_____

Please indicate the highest level of education that you have completed to date:
_____ Grade 10 or less
_____ Grade 12 or less
_____ 2 years of post-secondary education
_____ Community college diploma program
_____ Bachelor's degree
_____ Master's degree
_____ Ph.D. degree

DYADIC ADJUSTMENT SCALE

Couple No._____ M____ F____

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list. (Please a checkmark to indicate your answer).

		Always Agree	Almost Always Agree	Occa-sionally Disagree	Frequently Disagree	Almost Always Disagree	Always Disagree
1	Handling family finances						
2	Matters of recreation						
3	Religious matters						
4	Demonstrations of affection						
5	Friends						
6	Sex relations						
7	Conventionality (correct or proper behavior)						
8	Philosophy of life						
9	Ways of dealing with parents or in-laws						
10	Aims, goals, and things believed important						
11	Amount of time spent together						
12	Making major decisions						
13	Household tasks						
14	Career decisions						
15	Leisure interests and activities						

		All the time	Most of the time	More often than not	Occa-sionally	Rarely	Never
16	How often do you discuss or have you considered divorce, separation, or terminating your relationship?						
17	How often do you or your mate leave the house after a fight?						
18	In general, how often do you think that things between you and your partner are going well?						
19	Do you confide in your mate?						
20	Do you ever regret that you married (or lived together)?						
21	How often do you and your partner quarrel?						
22	How often do you and your mate "get on each others' nerves"?						

		Everyday	Almost everyday	Occasionally	Rarely	Never
23	Do you kiss your mate?					
24	Do you and your mate engage in outside interests together?					

How often would you say the following events occur between you and your mate?

		Never	Less than once a month	Once or twice a month	Once or twice a week	Once a day	Often
25	Have a stimulating exchange of ideas						
26	Laughter together						
27	Calmly discussing something						
28	Work together on a project						

These are some things about which couples sometimes agree and sometimes disagree. Indicate if either item below caused differences of opinions or were problems in your relationship during the past few weeks (Check yes or no).

	Yes	No
29. Being too tired for sex.	___	___
30. Not showing love.	___	___

31. The dots on the following line represent different degrees of happiness in your relationship. The middle point, "happy", represents the degree of happiness of most relationships. Please circle the dot which best describes the degree of happiness, all things considered, of your relationship.

- -

Extremely Unhappy	Fairly Unhappy	A Little Unhappy	Happy	Very Happy	Extremely Unhappy	Perfect

32. Which of the following statements best describes how you feel about the future of your relationship?

______ I want desperately for my relationship to succeed, and would go to almost any length to see that it does.

______ I want desperately for my relationship to succeed, and will do all I can to see that it does.

______ I want desperately for my relationship to succeed, and will do my fair share to see that it does.

______ It would be nice if my relationship succeeded, but I can't do much more than I am doing now to help it succeed.

______ It would be nice if it succeeded, but I refuse to do any more than I am doing now to keep the relationship going.

______ My relationship can never succeed, and there is no more that I can do to keep the relationship going.

RELATIONSHIP TRUST SCALE

Couple No._____

M____ F____

Instructions

Please read each of the following statements carefully and decide whether or not you agree that it is true for your relationship with your partner. Indicate how strongly you agree or disagree by circling the appropriate number on the scale beside each statement. Please answer as accurately and honestly as you can.

1 = STRONGLY DISAGREE
2 = MODERATELY DISAGREE
3 = MILDLY DISAGREE
4 = NEUTRAL
5 = MILDLY AGREE
6 = MODERATELY AGREE
7 = STRONGLY AGREE

1	My partner has always been responsive to my needs and feelings.	1	2	3	4	5	6	7
2	I sometimes have concerns that my personal identity must be compromised to make our relationship work.	1	2	3	4	5	6	7
3	Resolving conflicts in our relationship is a give-and-take procedure. Though neither of us may be completely happy with any given solution, I'm usually satisfied that any action we take is in the best interests of our relationship as a whole.	1	2	3	4	5	6	7
4	I feel that my partner can be counted on to help me.	1	2	3	4	5	6	7
5	My partner is not someone who can always be relied on to keep a promise.	1	2	3	4	5	6	7
6	I feel extremely confident that my partner loves me.	1	2	3	4	5	6	7
7	When we are dealing with an issue that is important to me, I feel confident that my partner will put my feelings first.	1	2	3	4	5	6	7

8	If a better alternative were to come along, there is the possibility that my partner would at least consider leaving our relationship.	1	2	3	4	5	6	7
9	My partner is truly sincere in his/her promises.	1	2	3	4	5	6	7
10	Even when my partner and I are very angry, with each other, we still know that we love each other fully and unconditionally.	1	2	3	4	5	6	7
11	My partner is perfectly honest and truthful with me.	1	2	3	4	5	6	7
12	Through our concerted efforts at problem solving, we have managed to cope with the stresses on our relationship very efficiently.	1	2	3	4	5	6	7
13	Our marriage could easily be explained in terms of "(s)he contributes this" and "I contribute that". At times it doesn't feel like we're in it together.	1	2	3	4	5	6	7
14	It is sometimes for me to be absolutely certain that my partner will always care for me. Too many things can change in our relationships time goes on.	1	2	3	4	5	6	7
15	My partner and I are compatible enough that my personal needs can be realized in our relationship.	1	2	3	4	5	6	7
16	At times I am uncomfortable when I think about how much I have invested in my relationship with my partner.	1	2	3	4	5	6	7
17	In our day-to-day interactions, my partner consistently acts in ways that are positive.	1	2	3	4	5	6	7
18	There are times that my partner cannot be trusted.	1	2	3	4	5	6	7
19	I am never concerned that conflicts and serious tensions can damage our relationship because I know we can weather any storm.	1	2	3	4	5	6	7
20	My partner is not necessarily someone others consider to be reliable. (S)he can't always be counted on.	1	2	3	4	5	6	7
21	My partner is deeply committed to our relationship.	1	2	3	4	5	6	7

22	Problems in our relationship don't seem to sort themselves out over time. They seem to build up, mushrooming into concerns that are out of proportion to the problem at hand.	1	2	3	4	5	6	7
23	My partner treats me fairly and justly.	1	2	3	4	5	6	7
24	My partner has proven to be a faithful person. (S)he would never be unfaithful, even if there was absolutely no chance of being caught.	1	2	3	4	5	6	7
25	I feel that my partner does not show me enough consideration.	1	2	3	4	5	6	7
26	When problems have surfaced in our relationship, we have shown considerable ability to work through them successfully.	1	2	3	4	5	6	7
27	My partner is a thoroughly dependable person.	1	2	3	4	5	6	7
28	I feel that I can trust my partner completely.	1	2	3	4	5	6	7
29	Our two styles of dealing with conflicts make me concerned about our capacity to confront problems that arise in our relationship.	1	2	3	4	5	6	7
30	My partner typically behaves in ways that are very rewarding to me.	1	2	3	4	5	6	7
31	At the present time, do you trust your partner?	1	2	3	4	5	6	7

The Revised Adult Attachment Scale

Please read each of the following statements and rate the extent to which it describes your feelings about romantic relationships. Please think about all your relationships (past and present) and respond in terms of how you generally feel in these relationships. If you have never been involved in a romantic relationship, answer in terms of how you think you would feel.

Please use the scale below by placing a number between 1 and 5 in the space provided to the right of each statement.

1----------2----------3----------4----------5

Not at all characteristic of me — **Very characteristic of me**

1)	I find it relatively easy to get close to people.	_____
2)	I find it difficult to allow myself to depend on others.	_____
3)	I often worry that romantic partners don't really love me.	_____
4)	I find that others are reluctant to get as close as I would like.	_____
5)	I am comfortable depending on others.	_____
6)	I don't worry about people getting too close to me.	_____
7)	I find that people are never there when you need them.	_____
8)	I am somewhat uncomfortable being close to others.	_____
9)	I often worry that romantic partners won't want to stay with me.	_____
10)	When I show my feelings for others, I'm afraid they will not feel the same about me.	_____
11)	I often wonder whether romantic partners really care about me.	_____
12)	I am comfortable developing close relationships with others.	_____
13)	I am uncomfortable when anyone gets too emotionally close to me.	_____
14)	I know that people will be there when I need them.	_____
15)	I want to get close to people, but I worry about being hurt.	_____
16)	I find it difficult to trust others completely.	_____
17)	Romantic partners often want me to be emotionally closer than I feel comfortable being.	_____
18)	I am not sure that I can always depend on people to be there when I need them.	_____

PRE-TREATMENT ATTACHMENT INJURY MEASURE

Please describe as thoroughly as possible the nature of the attachment injury from your point of view. Include a description of the injury, how you dealt with the injury when it occurred, how you dealt with the injury generally until treatment at the Ottawa Civic Hospital. Also include how the injury affected the a) level of trust between you and your partner and b) the level of intimacy between you and your partner.

On a scale of 1 to 7, how do you rate the injury:

1 Not a Problem
2 Slight Problem
3 Moderate Problem
4 Very Much a Problem
5 Very Serious Problem
6 Severe Problem
7 Extremely Severe Problem

POST-TREATMENT ATTACHMENT INJURY MEASURE

Now that you have completed therapy, how do you rate how the injury affects you now:

1 Not a Problem
2 Slight Problem
3 Moderate Problem
4 Very Much a Problem
5 Very Serious Problem
6 Severe Problem
7 Extremely Severe Problem

POST-SESSION RESOLUTION QUESTIONNAIRE

Couple No._____ Session No._____

1. Was the issue that brought you and your partner worked on today the same or related to the issue which you brought into counseling ? Please circle one of the following:

1 ..... 2 ..... 3 ..... 4 5
Very Different Different Related Similar Same

2. How much progress do you feel you and your partner made in dealing with your issues in the session you have just completed? Please circle one of the following:

1 ..... 2 ..... 3 ..... 4 5
A Great Deal of Progress Considerable Moderate Some Progress No Progress

3. Are you and your partner any closer to resolving your relationship issues than you were when you came to the session today? Please circle one of the following:

1 ..... 2 ..... 3 ..... 4 5
Very Much Considerably Moderately Somewhat Not at all

4. How resolved do you feel right now in regard to the concerns you brought into counseling? Please place a tick in the appropriate box.

1 ..... 2..... 3 ..... 4 ..... 5 ..... 6 7
Totally Resolved Somewhat Resolved Not at all

TARGET COMPLAINT DISCOMFORT BOX SCALE

Couple No._____ Session No._____

Keeping in mind the issue that you and your partner selected as the focus of counseling, in general how much does this issue bother you now?

Please answer the question by placing an 'X' in the box that best describes the amount of disturbance you feel now because of the problem.

1 Couldn't be Worse	2 Very Much	3 Quite a Bit	4 A Little	5 Not at All

APPENDIX C

PROCESS MEASURES

The Structural Analysis of Social Behavior
The Experiencing Scale
Implementation Checklist

THE EXPERIENCING SCALE (ES)

General description of the seven stages:

Stage 1: The chief characteristic of this stage is that the content or manner of expression is impersonal. In some cases the content is intrinsically impersonal, being a very abstract, general, superficial, or journalistic account of events or ideas with no personal referent established. In other cases, despite the personal nature of the content, the speaker's involvement is impersonal, so that he or she reveals nothing important about the self and the remarks could as well be about a stranger or an object. As a result feelings are avoided and personal involvement is absent from communication.

Stage 2: The association between the speaker and the content is explicit. Either the speaker is the central character in the narrative or his or her interest is clear. The speaker's involvement, however, does not go beyond the specific situation of content. All comments, associations, reactions, and remarks serve to get the story or idea across but do not refer to or define the speaker's feelings. Thus the personal perspective emerges somewhat to indicate an intellectual interest or general, but superficial, involvement.

Stage 3: The content is a narrative or a description of the speaker in external or behavioral terms with added comments on feelings or private experiences. These remarks are limited to the events or situations described, giving the narrative a personal touch without describing the speaker more generally. Self-descriptions restricted to specific situations or roles are also part of Stage 3. Thus feelings and personal reactions come into clear but limited perspective. They are "owned" but bypassed or rooted in external circumstances.

Stage 4: At Stage 4 the quality of involvement or "set" shifts to the speaker's attention to the subjective felt flow of experience as referent, rather than to events or abstractions. The content is a clear presentation of the speaker's feelings, giving a personal, internal perspective or account of feelings about the self. Feelings or the experience of events, rather than the events themselves, are the subject of the discourse, requiring this experiencing, the speaker communicates what it is like to be him or her. These interior views are presented, listed, or described, but are not the focus for purposeful self-examination or elaboration.

Stage 5: The content is a purposeful elaboration or exploration of the speaker's feelings and experiencing. There are two necessary components: First, the speaker must pose or define a problem, proposition, or question, about the self explicitly in terms of feelings. The problem or proposition may involve the origin, sequence, or implications of feelings or relate feelings to other private processes. Second, the speaker must explore or work with the problem in a personal way. The exploration or elaboration must be clearly related to the initial proposition and must contain inner references that have the potential to expand the speaker's awareness of experiencing.

Stage 6: At Stage 6 the way the person senses the inner referent is different. There is a *felt sense* of the there-and-yet-to-be-fully-discovered, that is, of an unclear inner referent that has a life of its own. It is a sense of potentially more than can be immediately thought or named. This felt sense is more than recognizable feelings such as anger, joy, fear, sadness, or "that feeling of helplessness." If familiar or known feelings are present, there is also a sense of "more" that comes along with the identified feelings.

Stage 7: The content reveals the speaker's steady and expanding awareness of immediately present feelings and internal processes. He or she clearly demonstrates the ability to move from one inner referent to another, linking and integrating each immediately felt nuance as it occurs in the present experiential moment, so that each new sensing functions as a springboard for further exploration and elaboration.

Short Form of Experiencing Scale

Stage	Content	Treatment
1	External events; refusal to participate	Impersonal, detached
2	External events; behavioral or intellectual self-description	Interested, personal, self-participation
3	Personal reactions to external events; limited self-descriptions; behavioral descriptions of feelings	Reactive, emotionally involved
4	Descriptions of feelings and personal experiences	Self-descriptive; associative
5	Problems or propositions about feelings and personal experiences	Exploratory, elaborative, hypothetical
6	Felt sense of an inner referent	Focused on there being more about "it"
7	A series of felt senses connecting the content	Evolving, emergent

Note. Reprinted from M.H. Klein, P. Mathieu-Coughlan & D. J. Kiesler, The experiencing scales, in L. G. Greenberg & W. M. Pinsof (Eds.), The psychotherapy process: A research handbook (pp. 22-23). New York: Guilford Press.

STRUCTURAL ANALYSIS OF SOCIAL BEHAVIOR (SASB)

Focus:
1=other, 2=self

Quadrant:
1=Affiliative
2=Distant
3=Hostile
4=Friendly

Cluster:

Other
1=freeing and forgetting
2=affirming and understanding
3=loving and approaching
4= nurturing and protecting
5=watching and controlling
6=belittling and blaming
7=attacking and rejecting
8=ignoring and neglecting

Self
1=asserting and separating
2=disclosing and expressing
3=joyfully connecting
4=trusting and relying
5=deferring and submitting
6=sulking and scurrying
7=protesting and recoiling
8=walling off and distancing

IMPLEMENTATION CHECKLIST

Couple No. _____ Session No._____ Rater_____

Instructions to raters: Place one check mark on the rating form beside an intervention each time that intervention is noted. An intervention is defined as a therapist statement.

Intervention Checklist

Definition of Problematic Event

1. ____The problematic event is defined/redefined in terms of the emotions and needs underlying the positions taken in the relationship.

2. ____The therapist elicits the couple's ideas/theories/beliefs about why the problematic event has developed.

3. ____The therapist clarifies and elaborated the basic positions taken by the partners in the relationship.

4. ____The therapist asks the couple to disclose biographical data that may be relevant to explaining why the relationship is the way it is, such as how the parents' marriage influenced their own.

Attacking Behavior

5. ____The therapist validates or develops the positions implied by negative behavior such as name calling; such behavior is interpreted in terms of underlying needs and feelings.

6. ____Negative behavior such as blaming or name calling is immediately stopped with authority on the part of the therapist and/or is defused by asking the blamer's theory on how he/she was attracted to and got involved with such a person.

Process Focus

7. ____The therapist probes for and heighten emotional experience, especially fears and vulnerabilities, clarifying emotional triggers and responses and focusing upon inner awareness.

8. ____The therapist avoids and suppresses affective interchange, and/or behavioral interpretation, or confrontation. No feeling or behavior is accessed, confronted or interpreted.

9. ____The interacting sensitivities underlying behavior are clarified and the meaning of individual emotional experience is interpreted in terms of the other partner and the relationship.

10. ____The therapist invites the couple to speculate about general explanations they might consider for couples with similar problems and/or offers a possible theory to trigger the partners' thinking.

11. ____Therapist keeps a focus on what is occurring in the present between partners.

12. ____Therapist takes what is happening in the present and brings it back to the past, to their parents' relationship, to their background and upbringing.

Resolution of Problematic Event

13. ____Therapist facilitates expression of affectively based needs and wants to the partner.

14. ____Therapist helps each partner identifying and express to the therapist his/her expectations from the other partner without basing them in feelings.

15. ____Therapist helps clients to share their new perspective of each other and/or of the relationship, and to explore their new feelings in response to this new perspective.

16. ____Therapist asks each partner to disclose opinions/thoughts/theories about what throughout the sessions has led to improvement.

APPENDIX D

Attachment Injury Measure Self-Report Descriptions

Attachment Injury Measure Self-Report Descriptions

Couple 1: Male reporting an attachment injury.

> The event that has had the most significant effect on our relationship is one that has existed for the sum total of our relationship. All three children in our family unit have presented us with challenges, hurt, and disappointments far beyond what I believe to be the norm. There have been several events which have stopped me in my tracks, left me wondering if I can stay afloat. I cannot believe what we have been subjected to through the years, culminating with the youngest child, Kip. He is a bright kid with severe ADHD, ODD, and a substance abuse problem. The last "event" has put him in drug rehab in another city. His disruptive behaviour had lead to our seriously considering splitting up at least twice. In fact, we have both taken private breaks from the situation to recharge our batteries, and try to gain a sense of normality again. These have also been used as small "trial separation." My feelings have been stomped on time and again. Hurt, anger, pain, hopelessness, and grief are common, everyday feelings. Personal, mental and physical health has suffered accordingly. Depression rules the day.
>
> Since we've spent all or most of our energies with these "battles," we've had little time to develop our own relationship to what we envision, in our "golden years." We've no role models from our own families to follow, and I'm afraid of being with Rhet, alone at last, yet afraid, and still alone, because we don't know how to be a loving, nurturing, healthy, fun-loving couple. I trust Rhet explicitly. We do not know how to be intimate with each other (or forgot).

Couple 1: Female scored a 3 or "very serious problem" and wrote:

> My children have put a strain on our marriage from the beginning. We have had to deal with different challenges with all three of them. However, Kip has by far been the most difficult challenge. Problems with his behaviour have escalated over the last few years. He finally was placed in a group home this June. Before this happened, we were at a point in our relationship when I was put into a position where I felt I had to choose between my son or my husband. We were at a point where we were considering separating. How could I make such a choice? I could not turn my back on my son no matter what. Since Kip has been in the group home, there still has been a fair amount of stress, but not quite as constant. For a while I felt I felt like I shouldn't show love towards my son. However, I have resolved that. I felt resentful towards Rick for putting me in that position of choosing, I am afraid this situation may come up again.

Couple 2: Female scored a 2 or "severe problem" and reported an attachment injury:

> It's difficult to name one event but I guess an underlying problem has always been that Sam is unemotional. This became glaringly obvious after my miscarriages. He just didn't seem to know what to do. It hurts me that can't show me his feelings. I still trust him but I know that I can't depend on him for emotional support. The miscarriages themselves decreased the level of intimacy between us but I don't think that Sam's lack of feeling did.

Couple 2: Male scored a 4 or "very much a problem" and wrote:

> The problem which affects me the most in this relationship is that I feel that Sara has to be in control. She will imply or make remarks that make you feel inferior. There are times when we are discussing a small simple problem and it turns into a big argument. I feel most of the time the right way has to be Sara's way--this would be fine if her way is the better way but sometimes it is not.
> There are times when I give into her and agree with her even tough I think I am right but I do this just to avoid a heated extended discussion that goes nowhere!!

Couple 3: Female scored 1 or "Extremely Severe Problem"and reported an attachment injury:

> One year into our marriage, Mike was supposed to honour a promise a promise he made upon our marriage to support my career. If I didn't find work in my career in Ottawa after one year of searching, we would move to another city with better opportunities for me, i.e., Toronto. Not being fully bilingual was a serious handicap for my career choice in Ottawa. I had expressed concerns about finding work in Ottawa even while we courted. When the year was up, Mike refused to consider moving away. He was quite comfortable and secure in his position with a small computer software company. I was devastated that he was backing out on a very important promise. I had told him that I would never marry someone who didn't support my goal of being a career woman and mother. He had said that was the type of woman he wanted. I thought we were perfectly clear on this issue, even before marriage. I had financed my way through school on loans.
>
> Therefore, I had a large student debt to pay off. He totally justified not moving by saying that we could not afford to have him leave a good job for the "bog unknown." I couldn't see how we could afford to keep me out of work, due to our large debt-load. I went into a deep depression, developed a chronic health condition from the stress, and tried to get professional help without success. I was clinically depressed for over 4 years. I felt trapped. I was too depressed to leave the relationship, although I felt like leaving many times. My trust in him was completely destroyed along with my self-esteem. I gained over 30 pounds of extra weight and felt terrible. I felt I had no place, or money, or self-esteem to go anywhere or do anything. We

started fighting regularly after this event. I also lost a lot of respect for him as a person, and became quite bitter and critical. Many days I don't feel like I even like him. The is very little if any intimacy for me in this relationship. I don't feel like I can trust Mike to be there for me, or support my dreams and goals. Other incidents have happened since this event which confirm my doubts that Mike can be there for me, even in a crisis. Mike talks about how he wants to support me emotionally and with attaining my goals, but I don't think he has a clue how to do it. And when I really need his support, he backs out on me. About 1 ½ years ago, I had my second miscarriage in 3 months. I called Mike at work to tell him to come home because I was hemorrhaging and was really scared. He refused to come home because he was working late on an important project with a deadline. I begged him to come home, but he refused to come. He even called me to tell me he was taking his c-workers out for dinner and he would be home late. I had called a girlfriend to come over with me. She took me and my 3 year old son over to her house for the weekend. I didn't want to go home, but I felt I had no choice. I had no where else to go and had no money. This situation compounded my distance of Mike being there for me even in a crisis.

Couple 3: Male scored 4 or "Very Much A Problem."

A little less than a year ago, Molly has a major falling out with a long-time friend (they have not spoken since). Within a few weeks of that event, Molly had a major falling out with my mother and my sister. These events weighed heavily on Molly's mind and much time was spent talking about them. Although I recognized that Molly has a strong need to "talk it out", I found that these conversations were emotionally exhausting. At times, these intense talks could last a couple of hours. Molly would spend much time putting down my family. When I tried to put ground rules for discussing her hurts (namely to stop putting down my family), she responded by accusing me of siding with my family and not supporting my wife.
It was during this time that my grandmother died. I was close to my grandmother and felt fortunate to be at her bedside when she passed away. A couple of days after her death, Molly resumed talking about her unresolved hurts. I explained that I was emotionally unable to deal with her issues at that time. She continued on with her unresolved issues, and I responded by raising my voice to get the message across. Molly was very angry at me for taking the position I did and accused me of being selfish and uncaring about her. In spite of my attempts to identify to Molly that I needed a break from her issues so I could have time to mourn the death of my grandmother, Molly kept bringing up her issues. I felt that my needs were being ignored. I felt she was stalking me with her issues at a time when I wanted to come to terms with the death of a loved one.

APPENDIX E

"Best Session" Transcripts for Markers of Change

"Best Session" Transcripts for Markers of Change

Couple # 1

Assessment Phase

Sam: I feel that I am here to defend myself. The way she talks to me, she asks a question and she uses this harsh tone with me. She gets short with me.

Therapist: What is the tone like that she uses?

Sam: It is short. . . abrupt. She will tell me a lot of the time, "That was a stupid question."

Sara: I just get exasperated with him.

Therapist: I get a sense that you get angry with him, disapproving with him and then he shuts down and withdrawals?

Sara: Yes. I get angry with him, but I always have a good reason.

Sam: Like last night, the baby puked on the floor and she came up to me and shouted, "Don't just stand there. Don't just look at him." I was in shock.

Sara: I was mad at him. He was just standing there watching and the baby needed comforting, like he is only five years old and he just stands there. I think, "Do something." I feel mad now thinking about it. [1]

Sam: I was going to. (*Pause*) [2]

Therapist: What happened after that?

Sara: Well he just went into his shell and I was left to clean up the mess off the floor and do all the other stuff too. I'm fed up. I just kind of slap him down....I have a short fuse, especially when I have a bad day or a headache. He should just know. It takes a lot for me to get really angry and sometimes I have to get really angry just to get a reaction. [3] Sometimes I feel I have to stay and have a fight so I can get a reaction just so we can communicate about something. And I am running out of energy. Fighting is getting pointless now. If I just gathered my things and left, he would let me walk out the door and be just fine.

Therapist: Do you feel you are not fighting for the relationship?

Sam: I just feel that if she really doesn't want to be with me, then just go, if that is how you feel, I don't want you to stay around. [4]

Sara: Well I want to be able to rant and rave once and a while and say, "If you don't do this, I'm leaving" and have him say back to me, "Please don't leave me." But I know he wouldn't say that. He needs to put more effort into this. [5] I just don't matter to him, that's what I feel like. I tell him how I feel and he doesn't say anything.

Sam: I don't want her ranting and raving about everything that comes up. She does it all the time. And I tell her, if she has problems, go find someone, one of your friends to talk to. [6] I mean, I don't mind if she has a problem and needs to say something, but she gets upset all the time and tries to make me feel stupid.

Sara: Well like with Bobby last night, you should know that that was a problem and I needed help and when you just stand there, I can't help but try you to have a reaction and do something. [7] He needed help.

<u>De-escalation Phase</u>

Therapist: What is it that you want from him? What do you need from him?

Sara: On a day-to-day basis, affection. I said this to him so many years ago that I want him to see no further than me and he said, "Excuse me? That will never happen." And I told him that so not that he can't look at other people, but I want to be the center of his life and the most important thing in his life.

Therapist: That's how you feel. You want to be the center, the focus and what I hear from you is that when you don't get that, you make a lot of noise, you get angry and you start picking at the smaller, less significant things and. . .

Sara: He sees that as controlling.

Therapist: Yes. And what I also hear from you, Sam, is that you do care and you try to do things to lighten up her load.

Sam: She wants me to make her feel cherished, like when she says I can't see anyone else but her, but it's hard for me to do that and deep down I am feeling angry at her and then I end up feeling stupid when the anger wears off. [8]

Therapist: Can you talk a little more about your anger?

Sam: Well, when she picks at me for every little thing, I feel resentful and feel she is laying all her frustration on me. And I feel she is just trying to control me when a lot of times she is out of control. So when she says, "Don't look at anybody except me," I feel she is still trying to control me and then I get upset. [9] I mean, I am not out looking at people and she knows that. I really like helping her and I do, but I don't want to be controlled.

Therapist: My sense is that your intentions are good.

Sam: Yes. I have them up in mind, but then I get stuck. . . Should I do it or shouldn't I do it.

Therapist: So you know what is right but. . .

Sam: If I don't do what she wants, I am shot down. If I do what I think is right but she disagrees, then I am shot down again. I want to help her because she is important to me, but when we get in these ruts and I feel she is picking on me, it's hard to do. Anyway, she by no means makes me feel like I am the center of her life.

Sara: I am glad to hear that I am important to you. Sometimes, I just don't know how you feel about me or how you feel about anything. [10] I used to say to him that I was sorry to hurt his feeling (*laughter*) because I thought he only had one.

Sam: Well, I have never been a very expressive person, never talked a lot, but she knows that I do have feelings but I just don't talk a lot about them. I do want to talk more about them, but I just don't want to be criticized. My parents didn't have a good marriage and were mad a lot, so I just don't want to go through that again.

Therapist: What happens for you when she is critical towards you?

Sam: Well, it hurts. When I come into the house and she says I just got a headache, I feel she is saying something to me, that it is about me, and that hurts to hear. She may see them as passing comments, but they aren't to me.

Sara: I didn't know that. . .

Sam: So I just pass it off or just deal with it. [11]

Attachment Injury Phase

Sara: After I had the miscarriage in the bathroom, I remember blood was all over the place and I realized that I had just lost this baby. I was ok at that time. I thought I was able to handle this and that when I saw Bob everything would be ok and we would go to the hospital and take care of everything.

Therapist: What happened after that, after you realized that you had lost the baby?

Sara: I called for Sam to come down and help me. He came down, but was frozen, like he didn't know what to do. [12] I just remember thinking that if I go off the deep end here, at what point will he pick up the phone and call. . . at what point will he come over to comfort me. Well I didn't want him to call anyone. I wanted him to take care of me and I thought . . .

Therapist: Take care of you how?

Sara: To. . . (pause) to hold me and do what people do when somebody dies. To me if somebody I knew died, I would ask if they are ok and say that I am really sorry and if they wanted to talk about it, I would listen and if they started to cry, I would comfort them. [13] You kind of have to say something. Everything just seemed so solid and he didn't seem upset by it.

Therapist: So, you really needed him to be there and to hold you.

Sara: Yes.

Therapist: And he didn't even have to say anything, just be there for you.

Sara: Yes. But he shut down and then went away and I just remember being alone. And then my sister came in and gathered us up and we got into the car and drove to the hospital. I remember that she didn't really say anything either. She was just trying to rush us off and when I was in the car, I was there feeling totally alone staring down at a butter container filled with my baby. I just wanted them to be there, really be there for me so I could cry.[14] After that I just knew I would have to deal with this on my own.

Therapist: Deal with this on your own?

Sara: Yes, I knew right then that I was alone in this and realized that is how it has been for a while now. And for us things kind of fell apart from there....

Re-engagement Phase

Sara: I just think that old habits die hard sometimes thinking that if he wanted to, he would say things. I try to remember that I have to see him a whole new way.

Therapist: Which is what?

Sara: Which is that he wants to say things but he is afraid of the way I will react to him, like which way am I going to slap him down this time for saying something (laughter). [15] And it makes me feel really bad to know he is afraid of how I'm going to react to him. . . I feel bad that I put him in that position and I don't think about that because I know if he were to treat me that way, I would feel the same way and respond the same way. If I thought about that, I would be more perceptive to him.

Therapist: So you don't want to be as critical or come across as being critical?

Sara: Right, and I'm not even thinking how I might sound to you and how I make you feel.

Sam: Well over time I have just learned that you will have your good days and your bad days and I know you think I don't feel anything, but I do and I try hard to make you happy. You may not know what I am feeling, but I feel and I want to be practical at the same time. . . to take care of as much as I can.[16] (*Slowly*) Well, like when you had the miscarriage, I came home and I knew something was wrong and I felt a shock because I could see it on your face. I wanted to help you, so I decided to keep my head together and be as practical as I could about it. [17] Then when I found out what really happened, I ran in ten different directions to make sure everything was okay before we went to hospital.

Therapist: Did you know this is how Sam was feeling at the time? That he was in shock and tried to take care of things?

Sara: No, I didn't know. And I guess I never gave you a chance. I never knew and I wish I did now. Had I known all of that, the whole thing would have been different. I can accept now that Sam feels a lot but just doesn't talk a lot about them. [18] I feel good knowing that he cared that day and that I wasn't really alone like I thought.

Sam: No, I was definitely there for you. I will try to do things differently. I was very concerned about you. I was very scared for you. [19]

Therapist: You were concerned for her and you didn't want to put extra pressure on her because you knew she was in shock. I pick up on a lot of care and concern from you.

Sam: Yes, I a lot of concern.

Sara: I know that. And I appreciate that he does all that he does for me. I know if over the years if I hadn't criticized you so much, you may be more open to me and trust me more. [20]

Sam: I totally trust you. [21]

Sara: I really am seeing you differently. Not for who I want you to be, but who you are. But not that I expect a totally emotional person all the time, but find different ways for us fit together.

Couple #2

Assessment Phase

Rick: For the longest time I have tried to get Rhet to see that Kip was walking all over her. She was becoming a doormat and he rubs his feet all over her time after time. And all I could do now was sit there and watch. I had a role in parenting, I know, but I couldn't take all the responsibility of this kid with all the drugs and dealing and trouble he was getting into. That was her responsibility and she was muting herself. Why? [22]

Therapist: What was it like for you to sit there and watch, watch Rhet be walked on by Kip?

Rick: I got angry. I just wanted to scream and yell sometimes and say, "Why do you put up with this crap from him?" I took over for her so many times and took a stand on his drug use and disobedience, but he doesn't listen to me. I am not his Dad and he just brushes me off. [23]

Therapist: Can you talk to Rhet about that anger you felt, the anger you may feel now?

Rick: Well, it is frustrating to see you deal with Kip. I know you want to be nice to him, but there are limits to nice. You let him get away with murder time after time and I now you have been through a lot with him and the other kids too, but you just sit there and let the daemons take over and I wish you would take a stand once in a while. [24]

Rhet: I know. (*Pause*)

Therapist: What happens for you, Rhet, when Rick is upset with you?

Rhet: Well, I understand why he gets mad. I guess I feel stuck in between a rock and a hard place. I have Rick over here and Kip over there and it's like I have to make sure I do the right thing for both.

Therapist: And what does doing the right thing look like?

Rhet: I just freeze. . .Don't really know what to think, what to do. I know that I don't do enough. (*Pause*) [25]

Therapist: Will you talk to Rick about how hard it is?

Rhet: I think he knows. I do the best I can, but it is not enough.

Rick: I know you do your best, but you take a road of inaction so much that I, well. . . I used to get so mad and now, recently, I have been thinking that it would be easier if I wasn't in the picture. You could just deal with him and I wouldn't have all this constant conflict. I thought we would have a peaceful marriage, but since day one, we have had crap hit the fan nonstop. I am tired of it. That's enough. [26]

<u>De-escalation Phase</u>

Rick: We have been spending less and less time together especially during the past year and a half. My computer business is going well, so I spend evening time planning the next steps for the business. I will just go downstairs and work.

Rhet: Yes, you will disappear for hours down there and I wonder if you are still alive or not. (*laughs*)

Therapist: Is it just for work reasons that you go downstairs, or are their other reasons too?

Rick: Well, there is some truth to that. I do have work on my mind and have a lot to do. But some of it can wait for the next day. To tell the truth, I go downstairs in my little covey-whole to stay away from all the conflict between Rhet and Kip. [27] I just block it out of my mind. I wish I didn't have to go to my private space, but I feel I have no other choice.

Therapist: Rhet, what is it like for you to have Rick downstairs? Where are you? What are you doing?

Rhet: Well I usually sit upstairs and watch TV and wait for Rick to come up. Kip is out so much that we don't even spend much time together. And of course over the past few months, Kip has been in the rehab home, so he is not even there.

Therapist: And what is it like for you when Rick is downstairs?

Rhet: I would like to spend time with him. Sometimes I go to the basement door and peek down to see what he is doing and wonder when he will finish.

Therapist: You have a desire to see him, connect with him?

Rhet: Yes. I will stand by the door.

Rick: I didn't know you stood by the door and I didn't know you were waiting for me. I always thought you were absorbed in your TV shows or when Kip is there that you spend time with him and if I'm not getting in the middle, you and he can have a more relaxed time. Come to think of it, I am waiting sometimes for you to knock on the door and say hello and ask if I want to come upstairs to watch TV or even better escape to bed sometimes. [28]

Therapist: So it sounds like even though there has been conflict at home over the past years, at the same time you both desire to spend time together and you are both waiting for the other to initiate the contact.

Rick: Yes. It seems kind of silly to think we are both waiting for the other and nobody says anything. When we don't have problems with Kip, we get along fine. I guess my worry too is that sometimes I don't know what to say. . . I just have computer stuff on my mind and that must be boring for her. [29]

Rhet: It's not boring to me. Well, I can't talk about computers all day, but it's not boring. I guess we end up talking about Kip and his problems and we just stop talking because the conversation goes the same way every time.

<u>Attachment Injury Phase</u>

Therapist: Can you talk a little more about the night you got into [the fight] with Rhet?

Rick: This was about a month before Kip went to the rehab home after he was arrested. I noticed that my wallet had been moved on the dresser and I looked in it and all my money was gone except a five-dollar bill. He must have stolen 40 dollars at least because I had been to the bank earlier.

Therapist: Did you talk to him about it? To Rhet?

Rick: Well, yes and no. Well, I talked to Rhet about it first. I told her that Kip had stolen money out of my wallet and probably went straight out to buy dope.

Therapist: And then what happened?

Rick: So told Rhet that Kip had stolen the money and she really had no reaction. It seemed like she was either frozen in her tracks or didn't give a damn one or the other.

Therapist: How did you feel at that time?

Rick: God, I get pissed now just thinking about it. First, this crap had been going on for years. First with Janice, then with Judy, and now with Kip. I told her that he would hear it from me when he got home and she needed to do something about it too. This was the FINAL showdown with all this. And you know what her comment was to me? She said that he was her kid and you are not his Dad. Well I hit the roof. [30] Of course he is her kid and I am not his Dad, but I support him and he steals from me to get high. I can barely understand his behaviour, but I don't understand Rhet's doormat role in this family. I was more pissed at her than at Kip then.

Therapist: What did you say to her then? Did you tell her what was going through your mind?

Rick: I was so enraged. . .devastated. I thought to myself, "I have no ally in this house." I didn't tell her this, but I thought it would be better if I weren't here. . . that it would be better if she just dealt with this alone. I knew I would just walk out right then, but I knew I would go to my corner and she goes to hers and there would be a wall between us. I can just focus on my work and let the house go straight to hell. No more hassle with Kip. No more rides for the others. Just stay away from all of them like I am a border renting a room. [31]

Therapist: Is this a part.? . .

Rick: And then Kip comes home stoned. . . I could see it in his eyes and smell it on his clothes.

Therapist: So, part of the devastation for you was that you knew there was a wall between you and Rhet and there was no coming together on what to do.

Rick: Yes, I knew right then that I had to change everything. If I wanted peace of mind, I would have to cut the ties, whether I stayed there or not. And that is what I did. I'm out of the ring and gloves off. [32] I can't deal with her passivity. I can't change her. And will not try. If it means putting her out of the picture, okay. I've been depressed recently and have to keep things moving at work.

Therapist: Rhet, What was this like for you? Did you know Rick had such a strong reaction to this situation?

Rhet: I knew he was really upset. I didn't know that it was this much. [33]

Therapist: What was happening for you during all this?

<u>Re-Engagement Phase</u>

Rick: Kip came home for a week last Friday and I have been surprised that everybody has gotten along. I have tried to stay calm when he starts to manipulate Rhet or gets upset with her and I also try to stay around for her.

Therapist: Stay around?

Rick: Yes, well over the past weeks we have made efforts to spend time with each other. I still go down to the basement to work, but we make dates for later to watch TV or to take a walk. So if we have a problem, I try not to either get too anxious, and you know how anxious I can get, and I try not to disappear off the face of the earth. [34]

Therapist: How is that for you Rhet, spending more time with each other and making. . . strategies for conflict?

Rhet: I have loved the times together.

Therapist: Can you tell Rick that now?

Rhet: Yes. Well, I love the times together when we walk. We both need to exercise and the walks help because we can work out and talk at the same time. I'm not sure if we have a lot of strategies (*laugh*), but we see things differently now. [35]

Therapist: Differently, how so?

Rhet: As we talked about before, I am trying to be more assertive and stick to the rules. I really need Rick's help with that because. . .

Rick: Well I need help with it too! I am Mr. Social Phobia and can barely initiate a conversation. Sorry (*to Rhet*). . . [36]

Rhet: I need help with that because you know I try to please everybody and end up no where with everybody. When you're around like that, I feel a lot more confident laying down the law.

Rick: I appreciate that. Your laying down the law so to speak ironically keeps me from getting so upset. (*Pause*)

Therapist: And for you Rick, how are those times for you, when you get together?

Rick: They help a lot. We actually look foward to doing things together

Therapist: To her.

Rick: I look foward to doing these things together and what is most important is that we are building, you know, all the things we have talked here, trust and a sense of teamwork. That's what it feels like, a sense of teamwork like we are in this thing together and (*pause*) I really appreciate that. [37]

Therapist: How is that for you to hear that from Rick?

Rhet: It feels really good. I know we have a lot of things to work through, but I feel we have a path and we just need to keep moving. [38]

Couple # 3

<u>Assessment Phase</u>

Molly: When we got married, I told him specifically that I did not want to come to Ottawa to live. I don't have family here like he does, and I can't find a job in my field like he can. I came here with the agreement that we would stay for a year or so and then move to Toronto where I could have a job and be in a more exciting city. But it never turned out that way, he always seems to arrange things so they come out his way and I am left with zero. [39]

Therapist: So you had an agreement to. . .

Molly: Yes, an agreement that was soon ignored.
Therapist: Right, a life plan that you feel left out of and now you are left feeling. . .?

Molly: I am feeling cheated out of my part of the agreement. And then we had our first child and I always wanted children and love them, but this is not how I wanted it to happen, you know, raising kids alone at home with no life outside. I went to university too, you know. [40]

Therapist: You feel he has taken something away from you, cheated you out of something you wanted. What is that like for you?

Molly: I resent him for it. Wouldn't you? I put my trust in him to help me the same way I help him day after day. . .

Mike: Can I say something here? What Molly doesn't understand is the amount of sacrifice and effort I put into the family [41] so that we can live comfortably and so that she can have what she needs. And she doesn't understand that I can't drop this job, my job is a very good one, and move to another city in hopes that another will give us the same lifestyle that we have now. We have a sizable mortgage to pay and quite a few expenses and we are saving for the kids education and our retirement.

Molly: But Mike, you can get another job anywhere. I have to speak French to work around here. (*Pause*) This is where we end up every time, right here, stalemate.

Mike: I think we need to learn a more effective way to problem solve and communicate in a way that facilitates a better understanding of our problems.

Molly: Yes, I would problem solve with you if you didn't just state your position as if it were facts for us both. I communicate pretty well. You are just so wound up in your world that you can hear anything anyone else says.

Therapist: Mike, I see your hands are going up into the air. Are you hands expressing the stalemate?

Mike: Yes, partly the stalemate in the actual conversations about where to live and partly because she digs and digs into them so that the hole is so deep, it's difficult to get out of them.

Therapist: Can you go into what digs and digs means?

Mike: Well she won't let up. She will take a problem and grind it until there is nothing left, like all the stuff with where to live and stuff with my family, especially my mother, and she won't let up.

Therapist: She will grind it until there is nothing left. . . of the topic or. . . . ?

Mike: She grinds me and will criticize me, my job, my family, everything. . .

Therapist: And what do you do when that happens?

Mike: I try to talk things out for a while, then I know where the conversation is going, so I just wait until the storm passes and stay out her way. [42]

<u>De-escalation Phase</u>

Molly: I have been so depressed and so unhappy for the past few years now with everything, the marriage, my life. I am just happy about the kids and that is about all.

Therapist: So, over the past few years, you have been depressed as you say and unhappy. How has that impacted you? How has that been for you?

Molly: Well actually over the past year especially, I have been overwhelmed with the kids, with the newborn and our four-year old, and when I get a chance to be alone, I just feel (*pause)* so mad at Mike because he seems to be in his own little happy world doing exactly what he wants to do and getting his way all the time. He has his career, me and the kids and everything is great for him. Mike is the kind of person who is very methodical and unemotional and I am free and emotional and say what is on my mind.

Therapist: You say he is methodical and unemotional. How does his being unemotional affect you?

Molly: I just what to scream and tell him to stop hiding behind his walls and his job and his being so cognitive about everything. He is like a computer sometimes, well, it makes sense because he programs them all day, so he comes home like that.

Therapist: So you get very frustrated with him because you feel he is hiding behind something and hiding from you in times when you want to be with him or be close to him. Am I getting a sense of how it is?

Molly: Yes.

Mike: Well, she assumes that I am unemotional, but she is so stuck in her problems that I think sometimes she can't even see what I offer.

Molly: Well, I know. . . I know. It's just when all I see is you giving me a lecture or going out on the deck to smoke a cigar during a talk, it just seems like you don't feel anything at all and don't really care what happens or care what is going on for me.

(Minutes later in session)

Molly: Sometimes I really need him to listen to my point of view and at least take it in as a part of his thinking. . . [43]

Therapist: What would that mean to you, if he took your point of view in?

Molly: I would at least know he cares and isn't so far away from me. [44]

Therapist: Is that something you need, for him to be closer to you?

Molly: Yes I need that. It would take a lot of work and a lot of settling old wounds, but it really would change so much for me.

Therapist: Like what would it change?

Molly: I would feel closer to him and wouldn't get like I had to scream to be heard or to be taken seriously. It hurts to be ignored all the time. I know myself well and I know I want my independence, but at the same time I need some support there. I need a partner there.

Therapist: Mike, how is it to hear Molly say when she is trying to talk to you that it hurts to be ignored?

Mike: I have no intention to hurt Molly. . . I don't sit there during conversations and devise ways to undercut her efforts. If she came to me in a pleasant mood when I got home and attempted to understand my efforts and, many days, my exhaustion, I would appreciate interacting with her and generally feel better about being around her in the evenings. [45]

Molly: (*Laughter*) And maybe we could both sleep in the same room once in a while and give the couch a break. [46]

Attachment Injury Phase

Molly: Everything seemed to happen all at one time a few years ago. We had been going back and forth about whether to live here or moved to another town where we both could get good jobs. One night in particular, I approached Mike about a graduate program in Toronto and it seemed like I was going to my dad to ask him if I could go, but I broached the subject with him after I had done pretty careful research on their reputation and had called to talk to one of the professors, and his response was. . . well he just tightened his face and gave me a cold stare and said, "No well in hell" and stormed off. I knew right them that it was over. [47]

Therapist: You had been cut off and you knew that it was over?

Molly: Yes, our marriage was failing miserably and I knew that I had a choice, either put up with this life or leave and have the life I wanted. But we had Stevie then, he was a two year-old boy, and I don't see my self as a divorced parent. A kid needs both his mom and dad. I knew I would have to just stay quiet and for the matter stay as far away as possible.

Therapist: So you were ready to make a sacrifice in one way, but you also had decided in that moment to distance yourself from Mike and live separate lives.

Molly: Right.

Therapist: And what was that distance like, deciding to shut off from him?

Molly: I felt a sense of freedom, like I was just retreating from the war and I wasn't going to fight any more and perhaps I could put my energy somewhere else, something where I could feel a sense of peace.

Therapist: What else did you feel about it?

Molly: And it also was devastating. (*Pause*) That I (*crying*) knew that our relationship was two people living together without love or respect. I needed you, Mike, and you treated me like dirt, like I was your worst enemy. [48]

(Later in session)

Molly: And a week after his decision to stay in Ottawa, I was about 10 weeks pregnant at the time and I know that I was under a lot of stress. I got up off the couch and knew something was wrong. I won't go into now, but I was about to miscarry the baby.

And this was the second in one year and I was terrified that I was losing this baby and terrified that we wouldn't be able to have kids again.

Therapist: What happened when you realized that you were about to miscarry the baby? Did you call for help or. . . . ?

Molly: (*Pause*) I call Mike at work and asked him to come home, that I was about to miscarry and needed him there to help me. I couldn't handle this all alone. And he told me, "No, I can't come home right now. I have a huge deadline later today" and that he has told me and I needed to call his mother or someone else to help. So I called a friend to help. Mike didn't come home until 9 P.M. or so, and I found out that he and his co-workers had gone out for dinner to celebrate their project.

Therapist: So you had this terrifying thing happen to you and you felt like Mike had left you totally on your own to take care of everything and you needed him there with you.

Molly: And I really needed him that time. I had nothing left in me. I mean, he gave me two huge blows like that in one week. I didn't even have the energy at that point, I just felt so demolished. [49] I walked around stunned like the world had crashed, that my world was not like it used to be and I had to deal with it. Did you have any idea what I went through?

Mike: (*pause*) Yes, I do know. I have apologized profusely for it, but I can't seem to get that through to her. And from my point of view, she had called several times that week saying that she was miscarrying and the first few times, I got off work and ran home and it was a false alarm. It was like crying wolf five times in one week and then that time, I decided to stay at work. It would have been so difficult to leave at that point in the day considering the circumstances. [50]

<u>Re-engagement Phase</u>

Mike: My mother has been diagnosed with cancer this week and I realize how much I need Molly. You have helped me so much with taking care of things at home and staying in touch with my family and I know how hard it is for you to put aside all the things that have happened with them. I just need. . . (pause, *crying)* [51]

Molly: Mike, I love you so much. (*crying, couple hold each other*) We can get through this. [52]

(Minutes later in session)

Molly: I have realized that I have been angry at you for so many things and I know that I have put myself in these situations. I see that. I needed you and I know I was putting so much pressure on you to help me work through my things.

Mike: Thank you.

Molly: I have my friends at church who have been so helpful to me and I will start the education program this Fall and I think that having these things in place helps me see that I was relying on you to fill in the gaps that I needed to take care of. We still have things to work out and I know I will get frustrated, but I am ready to stop the analysis and just go on with things and show as much love as I can when I can. [53]

Mike: I need a break from the analysis of our problems too and try to get things normal. I was going to say get them back to normal, but I think they never were normal. (*laughter*) I feel a definite change with both of us. With our working through your going back to school and our working on the financial programs at home at night, I know we will start working together on things. It may be slow, but I feel different about it now. [54]

Therapist: Hearing you both talk, it sounds like both of you see each other differently now and have a sense of trust that you have not had for a long time.

Molly: Well, I know we will re-build our trust. I mean Mike is very trustworthy when it comes to the family and planning our future and our own sense of trust will get better over time. This is a beginning. [55]

Therapist: And you Mike, do you feel a sense of trust like Molly?

Mike: I feel a change in her and I agree with her that it will take some time, but it certainly is a lot different.

Therapist: What change do you feel in her?

Mike: She is less focused on my faults and more focused on what she wants and I can feel a relief, like a ton of brick have been taken off my back. And we have a tough time coming up now with my mother and I really have needed her to just be there and not go into her frustrations when we talk about it, and she has been there and given me space when I need it. [56]

Therapist: You can count on her?

Mike: Yes, like I hope she can count on me.

APPENDIX F

Post-Treatment AIM Interviews

Post-Treatment AIM Interviews

1. Couple 1

Male reporting attachment injury

Researcher: In your assessment statement, you write about events that happened that you felt distress about. You write: The last "event" has put him in drug rehab in another city. His disruptive behavior had lead to our seriously considering splitting up at least twice." How do you feel about that now?

Rick: A lot has changed since we began therapy last September. Kip has gone through the rehab home, and not without slips and falls, but he is moving in a better direction now. We have had times alone and he was quite charming and some of those times I actually forgot about all the turmoil just last year.

Researcher: And what about you and Rhet, how have things changed since September?

Rick: We have gone through so many changes, both personally and as a couple. I can say changes for the positive. We spend a lot more time together now and when we do, we are on the same page. She and I have dealt with my social phobia problem quote unquote and we go out now and I don't feel so uncomfortable.

Researcher: How did you two deal with it?

Rick: We talked about it sessions, of course, and I think we just know more about each other on an emotional level, so it helps when she knows what I am going through. We take long walks now and that gives us time to debrief and get back in touch.

Researcher: You also say, "Hurt, anger, pain, hopelessness, and grief are common, everyday feelings. Personal, mental and physical health has suffered accordingly. Depression rules the day." How do you see that now?

Rick: Well I don't feel depressed now. I don't think I ever was depressed in a significant way. I think that our situation was depressing me and I was down a lot. Now that we have new understandings and have really opened up to each other, I don't think that anymore. And that goes for the hurt, hopelessness. . . What were the rest (laughter)?

Researcher: Let's see, anger pain and grief.

Rick: (Laughter) I was in a state then. Of course I feel anger from time to time. I think they all came together when we had the big blow up and I thought we were going to separate as a result of it. It feels different now. I mean, we haven't gone through

major personality overhauls, but we know we can handle things that used to get us down. And it seems simple now. I stop hiding and talk about it.

Researcher: You said that the event with Rhet and Kip was a “severe problem." Do you still see it that way?

Rick: It was severe. And there is no control over a teenager sometimes so I expect problems to come our way. But as I said, we can handle it. . . Or we can handle ourselves as a couple. I have come to realize that I need Rhet’s help sometimes and can ask her for it and I know not to get in the middle and put her in a place to decide between me and her kids.

Researcher: You write in your assessment that I gave you at the beginning that, you said, "Before this happened, we were at a point in our relationship when I was put into a position where I felt I had to choose between my son or my husband." Where are you now on that issue?

Rhet: I don't feel that I have to choose between Kip and Rick like I felt last year. I see now that Rick was also put into a difficult position and had to make a lot of decisions that I needed to make. I was trying to please everybody and ended up not pleasing anyone.

Researcher: What decisions did you need to make? How do you see it now?

Rhet: I felt I was putting a lot of the disciplining on Rick's shoulders where he wasn't in a position to make a lot of the parenting decisions. He was trying to help, I know.

Researcher: And trying to please everyone, you said you ended up not pleasing anyone?

Rhet: Yes, it was my low self-esteem. I try to make everyone happy and it doesn't turn out that way. I know now that I am responsible for myself and I also know that Rick will help me. We are not against each other it feels like now. It is more like we are working together and we are allies.

Researcher: So you can be responsible for yourself and go to him at the same time?

Rhet: Yes. That has made a difference.

Researcher: You also say in the assessment, "Since Kip has been in the group home, there still has been a fair amount of stress, but not quite as constant." How is the stress level now?

Rhet: It got so much better, especially the past two months. Kip being away helped us get closer and the stress was nothing like it was. We still have conflicts like with work and my other two kids, but we cope with it better now. Kip is coming back soon, and we are a little worried about the adjustment and I know things won't be perfect all the time.

Researcher: And do you feel more comfortable showing love towards Kip?

Rhet: Yes I do. I know he needs it and I need it. And now that Rick and I are closer, I think we have an understanding that I need to be close to Kip too and not decide between them.

Researcher: You also say, "I felt resentful towards Rick for putting me in that position of choosing, I am afraid this situation may come up again."

Rhet: It may come up again, but the difference now is that Rick and I can talk about it without getting so upset with each other.

2. Couple 2:

<u>Female reporting attachment injury</u>

Researcher: In the assessment statement, you mentioned that Sam is unemotional. How do you hear that statement now?

Sara: Well, I certainly wouldn't say he is unemotional. I would say that he has a hard time expressing his emotions. I used to take it personally. I figured that if he loved me, he wouldn't be like that. If he cared about me, he wouldn't want me to feel that way.

Researcher: Have you found that he loves you and he is quite too?

Sara: Yes. And that is a break through for me. I think that in time he will express a lot more to me and I know that it is up to him. I can't make him talk and I can't make him listen. I will try to encourage him, but it is who he is and I can't make him.

Researcher: You say also that you cannot depend on him for emotional support. Has that changed?

Sara: I think that I have changed the way I feel more than I cannot depend on him. I have changed myself a lot and how I think about this. He tries to do things for me, I know.

It just wasn't the way that I thought they should be, so it felt like he was not trying. He didn't know what it was.

Researcher: Can you tell him that?

Sara: It is hard for me and I don't just come out and day it, but I try more now.

Researcher: You have changed. How do you know that?

Sara: I thought that when we started therapy that I was always reaching out and he was pushing me away. But I see now that I have been throwing myself at him and he just didn't know how to deal with me. So I have learned that he does have feelings and I need to back off a little bit and let him deal with his feelings and later I can deal with my feelings. I know it is not my fault that he is not jumping in to save me. I used to blame him and blame myself.

Researcher: It sounds like you are giving each other more space and have become less reactive to one another.

Sara: Yes we do. We are much less reactive now. Sometimes I still wonder whether he really wants to be with me or he will just get fed up and leave. I am more comfortable saying it and he can say, "I am not leaving" and I am ok with that. I feel more comfortable backing off a little. Like when we are in a fight, I can back off and think that maybe I am not doing the right thing here. Like now when we talk about something and I still don't do what we agreed on, I will very quickly say now, "You are absolutely right."

Researcher: You also say that he didn't know what to do after you miscarried and that was a big issue between you.

Sara: Yes, big, big, big, big issue.

Researcher: How do you put that into perspective now?

Sara: I think it was because he didn't know how to help me. I think I always knew that he did know how to help me, like I knew that it wasn't because he didn't care about me and didn't want to do anything, but he just didn't know what to do. For a long time, I blamed him for not knowing what to do. I thought that if he loved me, he should have known what to do. I feel now that had he known what to do, he would have done it. And had I said what I needed, he would have known. (*Laughter*)
It seemed that every time we had a fight, it was so bizarre, I would always end up bringing up the miscarriage. We would be fighting about where the knives go, for

example, and all of a sudden I would say, "You just didn't understand" and "Why didn't you see what this was about?" But it never comes to that now. We dealt with it. I did what I needed to do and it seems like a thing of the past now. It is different. It feels so good to have it behind us. I mean, I will never forget it, but it doesn't have the impact that it used to. I know what I would do, but I don't know what others should do. He took care for me in his own way. He thought I was upset and I needed to be left alone and I know he was trying to help. I was upset that he left me alone. And I feel a lot more trust now than before.

Male

Sam: She is more open-minded now.

Researcher: How so, she is listening more?

Sam: Yes, listening more and trying to listen to my point of view and understand my point of view instead of just her going with her point of view. This is the first time I have seen her include other ways of seeing things.

Researcher: What is the effect on you that fact she has changed like that?

Sam: It makes me feel a lot better because I knew I was right and I would give in just to give in. But now, we can talk about this and we can decide the fair thing to do.

Researcher: Has your concept of right changed? The way you both describe it, it seems like there has been a right and a wrong. Has that changed?

Sam: Yes. Three is a wider range of possibilities, and there is a lot more gray area. We are communicating better. We have a ways to go, but we are getting along a lot better and being a lot more patient with each other.

Researcher: You also said at one point in your assessment statement that she always makes you feel inferior. How do you hear that statement now?

Sam: I felt inferior because I was always wrong and she was always right. That was the way we set things up. She was always in control it seemed. Even if I had a point or was right.

Researcher: And your strategy was to avoid problems?

Sam: Yes, just agree with her with whatever. It was very lonely though. It took the manhood out of me. There was a time that I was lonely. I am not a talker and don't

show my emotions and I know that is a problem and I am trying to do better. I mean we went through some hard times, especially the miscarriage, and I went through some hard times. Had I known more about what was happening to her on a deeper level, it would have helped. And it would have helped if she had understood what was going on with me. I didn't tell her much, so there was no reason for her to know. And I think I have a lot going on inside. I just don't make it public. I don't think the same thing would happen again if we went through a crisis like that now. We know to ask each other what is going on and help each other.

3. Couple 3:

<u>Female reporting attachment injury</u>

Researcher: When you wrote on the assessment measure about the miscarriage, you said it was a pivotal event. How do you look back on that event now?

Molly: I think I understand where he (Mike) was at then at that time, although it was very painful for me.

Researcher: Where was he at that time?

Molly: He was very preoccupied with a major project at work and also I think our emotional baggage got in the way that day. Had we been less distant and less antagonistic towards each other, he would have been there. I know he would have been.

Researcher: And what about today, if that were to happen?

Molly: I am pretty sure that if I had a miscarriage today, he would not react the same way again. I think he learned a hard lesson from that experience. And I am watching him with his mother now in treatment, and he is so there for his mom that I am surprised and frankly jealous (*laughter*). But I am pretty sure he would be there for me like that. I trust that he would be there for me. Like when I hurt my back this summer and couldn't move around for a few weeks, he just jumped right in and was there for me the whole time. And that is tremendous progress.

Researcher: How do you feel about the miscarriage now?

Molly: Wow. Big question. Things have been tough. We considered separation and have been in crisis mode for such a long time. But I am determined to be ok with things . And it is time to focus and be positive. I want to be positive and set the example. Do it for myself and for Mike and for my family. We used to get so down. When he was

down, I was down too. I will not be pulled down anymore. I feel that this is a new start for me. I have surrounded my self with loving friends and have made new ones, will be starting school soon. I feel sturdy now. And as things have changed so much in the past few months, I know that if we put our minds to it, we can really be there for each other when things like a miscarriage happen. I am doing my part and that is a huge change. I am ready to take whatever comes I am ready to take a role. I am not just an actor in this play of our relationship, but actor director. And Mike is actor director also.

Researcher: What else has changed for you?

Molly: If you look through the trust scales, you will see the changes in us. In February, I was in a terrible place, and now I feel a sense of empowerment and I take care of me and take care of Mike and the family. I trust Mike, I trust that we will work things through, but I still feel the weight of some of the problems sometimes. I still not stick my neck out at all costs and stay in a relationship that is incredibly unhealthy, but I will do everything I can possibly do. I feel really good about myself. From this therapy, I have gotten such a sense of peace and confidence, that I feel a sense of joy and empowerment that I can take care of things.

<u>Male</u>

Mike: Over the past few weeks, I have experienced a great deal of blueness because of my mom. And so it is hard to make an assessment right now.

Researcher: In terms of how you feel now, do you feel she is there for you?

Mike: From my perspective, she desires to be there and tried with success, but she may feel threatened because the challenges we have, and I feel very vulnerable right now. There is such a culmination of events now, the sickness, layoffs in my company, our discussing separating a few months ago. It is threatening.

Researcher: Are you there for one another during these times?

Mike: Being there for her is a type of therapy for me. It is a reciprocal process and it I express love and I feel I will get it back. It is a positive sharing. Sometimes coming together has caused so much friction and we are showing the good ingredients now. I really try to show that I care.

Researcher: What do you need from her now?

Mike: I just want to use fewer words sometimes and use a few, more powerful words when we talk. I think that her ears are more open to what I say now. I need to ask for room sometimes.

Researcher: How can she be there for you?

Mike: She tries. (*Client cries*). I feel so vulnerable now. I really hope Molly can be a part of this. I hope we can continue to lay off fighting every time we sit down and talk about something significant. We have started to set time aside to talk, and I really need that more.

Researcher: (*Later in interview*) Do you trust Molly more now?

Mike: Well, I trusted her in the past with many things. She is a trustworthy person. What has caused problems is her wanting to fight and put me and my family down. She has not done that so much recently and especially the past few days with my mom, she has been supportive and has given me space, even when I know that it is hard for her. So our trust is much better and little by little, I am hopeful that it will be strong and not an issue at all.

Researcher: Part of therapy has concerned the miscarriage that Molly had a few years back. How do you see that event now?

Mike: Well, I know it was very difficult for her and actually it was very painful for us both. If that were to happen today, undoubtedly I would drop what I was doing and be there. We were so tangled up in conflict then and there had been so many false alarms that I could make that kind of decision then. Now I could not do that.

VITA

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