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The Attachment Injury Resolution Model in Emotionally Focused Couple Therapy: A Psychotherapy Process Study of In-Session Client Performances and Therapist Behaviours

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The Attachment Injury Resolution Model in Emotionally Focused Couple Therapy: A Psychotherapy Process Study of In-Session Client Performances and Therapist Behaviours

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About 12 years ago, while rummaging through bookshelves at a local bookstore, I stumbled upon an inspiring, and life-transforming book called Creating Connections by Dr. Susan Johnson. The book influenced my life by providing me with a blueprint to understand my own world of adult attachment and emotion, and eventually shaped my academic interests in this area. I would like to thank Dr. Johnson for sharing her rich, clinical wisdom and insights with me throughout my doctoral studies. I am delighted to have been able to contribute to a rich body of theoretical and empirical knowledge related to Emotionally Focused Therapy for Couples.

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This work is dedicated to my parents, Domenica and Landino Zuccarini. I could not have embarked upon this journey without a lifetime of love and support from you.

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Summary

This doctoral thesis consists of two articles that represent scholarly efforts to build on previous theoretical and research work related to the development and empirical substantiation of a forgiveness and reconciliation clinical model, known as the Attachment Injury Resolution Model (AIRM), in Emotionally Focused Couple therapy (EFT) (Makinen & Johnson, 2006; Millikin, 2000). In Article 1, attachment and emotionally-focused clinical theory are employed to understand the nature of couple partners' emotional distress and the clinical process of repair as partners move toward forgiveness and reconciliation in the aftermath of aversive interpersonal incidents, known as attachment injuries. In Article 2, an original, in-depth psychotherapy process study of the AIRM is conducted. This study deepens previous knowledge about how clients change as a result of AIRM implementation, validates the model, and identifies key EFT interventions at each model component.

Attachment injuries occur as a result of aversive interpersonal events in which a partner is betrayed, or abandoned during a critical moment of need for support and care, and as such, relational trust is seriously violated (Johnson, Makinen, & Millikin, 2001). The incident creates long-lasting emotional injuries and ruptures the couple's attachment bond. An indelible imprint is left on the relationship when the incident becomes a marker for the other's dependability and trustworthiness. An injured partner's recollection of the injurious incident often triggers a traumatic reaction in-session (Johnson et al., 2001). Within EFT, such injuries are often the cause of therapeutic impasses, moments in which the therapeutic process is halted (Johnson et al., 2001; Millikin, 2000). The AIRM has been developed to specifically address these impasses.

The clinical process of repair within the AIRM is also akin to a forgiveness and reconciliation process in couple therapy.

The articles in this dissertation contribute to both theoretical and empirical knowledge about how clients change as they resolve an injury and therapist behaviors that facilitate this change process. In the first article, which is theoretical in nature, attachment theory is used to shed light on the nature of partner's emotional responses post-injury, and the process of relational repair and renewal in the aftermath of an injury. The forgiveness and reconciliation process is placed within the context of attachment. Healing attachment injuries involves emotionally processing the deep hurts, fears, anger and sadness related to the rupture of an attachment bond. Restoring emotional accessibility and responsiveness to these emotional expressions is viewed as crucial to the forgiveness and reconciliation process. This process facilitates the renewal of an emotional connection and restores relational trust in the aftermath of the injury.

This article also builds upon previous scholarly efforts by placing the AIRM within the context of the theory of change in EFT, which includes a synthesis of experiential, systemic, and attachment theory (Johnson, 2004). EFT clinical theory provides a systematic framework to explain how couple clients change as they resolve an attachment injury. Unprocessed emotion responses related to an injurious incident evolve into rigid, emotional signals and negative interaction patterns that block emotional engagement related to the injury. Partners engage in a predictable and constricted manner of emotional processing when caught in an injury-specific negative interaction cycle (i.e., pursue-withdraw). An injury-specific cycle may emerge as a consequence of the injury or reinforce a pre-existing negative, rigid interaction cycle in

the relationship and contribute to attachment insecurity. Emotional engagement related to the injury is thus impeded (Johnson, 2004). Client change involves shifts in emotional processing of the injurious incident.

In terms of the client change process, the first four stages of the AIRM involve a de-escalation of an injury-specific cycle. Injured partners are supported to unpack secondary emotion responses (i.e., anger, hostility, feelings of betrayal) and de-escalate negative interaction cycles to potentially access and explore deeper, more primary emotions (i.e., fears of abandonment, loss, sadness) related to the rupture of the bond caused by the injury. Client change leading to attachment injury resolution is captured in subsequent steps in an injury-specific softening event. The injured partner increasingly risks more vulnerable emotion and need expression to an increasingly accessible and responsive withdrawn partner. Reparation of the ruptured bond requires that the offending partner be emotionally accessible and responsive to these primary emotional experiences and attachment needs related to the injury (Johnson et al., 2001). The offending partner's responsiveness serves as a traumatic antidote, and marks the completion of a new bonding event in the relationship, which promotes greater relational trust.

Article 2 presents empirical findings from a psychotherapy process study of the AIRM. A task analytic research methodology (Greenberg, 1991) has guided numerous research studies in both the development (Millikin, 2000) and empirical substantiation of the AIRM in both process (Makinen & Johnson, 2006; Naaman, Pappas, Makinen, Zuccarini & Johnson, 2005) and outcome research studies (Makinen & Johnson, 2006).

According to this methodological framework for clinical model development (Greenberg, 1991), ongoing empirical investigations of the AIRM was warranted.

Three research objectives were identified for the study found in Article 2. The first objective was to enrich previous knowledge about the client change process by enriching empirical description of the client change process. The Experiencing Scale (ES) (Klein, Mathieu, Gendlin & Kiesler, 1970), a measure that captures client in-session depth of experiencing, and the Structural Analysis of Social Behavior (SASB) (Benjamin, 1981), a measure of interpersonal responses, had been used in an initial process study to describe client processes at each stage of the model (Millikin, 2000). In this study, the Levels of Client's Perceptual Processing (LCPP) (Toukmanian & Gordon, 2004), a measure of client's in-session perceptual processing, was added to deepen knowledge about how clients are changing in-session as a result of AIRM implementation. The second objective of this study was to validate the AIRM. From a task analytic research perspective, a clinical model may be validated by determining whether the effective ingredients of the therapy, the model components, discriminate successful versus unsuccessful cases. Finally, the third objective of this study was to identify therapist behaviors associated with client performance tasks at each stage of the model. Empirical findings related to these important next steps in the clinical model development process are presented in this article.

Together these articles, one theoretical and the other empirical, provide a clinical blueprint of the steps to forgiveness and reconciliation in couples beleaguered by an attachment injury. Implications of these studies for subsequent EFT clinical training and research are set out.

Chapter 1 (Unpublished Article)

Transforming power of emotion in forgiveness in EFT:

An emotional processing model

Transforming power of emotion in forgiveness in EFT:

An emotional processing model

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University of Ottawa

Running Head: TRANSFORMING POWER OF EMOTION IN FORGIVENESS

Abstract

This article contributes to theoretical knowledge about the process of client change in the Attachment Injury Resolution Model (AIRM) within Emotionally Focused Therapy for couples (EFT). Attachment theory provides a frame to understand the significance of targeting primary, attachment-related emotional experiences and needs in forgiveness in couples. Emotional processing of anger, sadness and fear underlying emotional injuries is essential to a forgiveness process in couples. AIRM steps are also uniquely placed within the context of EFT clinical theory to shed light on the clinical process of repair. The final 4 steps of the model represent an injury-specific softening event in which the injured partner moves toward more vulnerable expressions related to the injury. Forgiveness is associated with critical shifts from secondary to primary emotional processing of the injury. The offending partner's accessibility and responsiveness serve as an antidote that repairs the frayed attachment bond. Increased partner emotional accessibility and responsiveness restores an emotional connection and relational trust, which are cornerstones for post-injury reconciliation. The AIRM can be readily integrated within the traditional EFT treatment framework.

Keywords: Attachment, Emotion, Forgiveness, EFT

Introduction

Historically, the constructs of forgiveness and reconciliation were mostly the province of western and eastern religious discourses. However, in the past 25 years, these constructs have become of increasing interest to those in the clinical and counseling psychology fields. Forgiveness and reconciliation are employed to support healing of emotional wounds in the aftermath of interpersonal injuries in both individual and couple therapy. Various couple therapy models have emerged to address emotional injuries in couple relationships (Abrahms-Spring, 1996; Coleman, 1998; DiBlasio, 1998, 2000; Glass & Wright, 1997; Gordon et al., 2005; Hargrave, 1994; Hargrave & Sells, 1997; Johnson et al., 2001). Within the context of Emotionally-Focused Therapy (EFT) for couples, a forgiveness and reconciliation model, known as the Attachment Injury Resolution Model (AIRM), has evolved and has been subject to numerous empirical investigations (Johnson et al., 2001; Makinen & Johnson, 2006; Millikin, 2000; Naaman et al., 2005). This dissertation contributes to this body of knowledge by specifying client processes and therapist behaviors as couple clients move toward the process of forgiveness and reconciliation in EFT couple therapy.

Dimensions of the forgiveness process and previous forgiveness-specific interventions for couples are now reviewed. The AIRM emerges from this context. Previous research to develop and empirically substantiate this model is also reviewed, and rationale for the theoretical article and two empirical studies conducted for this dissertation are outlined.

Definitions of Forgiveness and Reconciliation

What is forgiveness and reconciliation? Forgiveness may best be understood as a process involving intra-psychic, interpersonal and contextual dimensions. Forgiveness has been defined as a process involving an intra-psychic response that culminates in psychological change toward an offending party (Coleman, 1989; Enright, Eastin, Golden, Sarinopoulos, & Freedman, 1992; Fitzgibbons, 1986; Haaken, 2002; Human Development Study Group, 1991; McCullough, Pargament, & Thoreson, 2000). In individual forgiveness models, this process unfolds without the presence and independent of the offending party's expressions of remorse, regret or an apology (Enright, Freedman, & Rique, 1998; Haaken, 2002; Scobie & Scobie, 1998). An individual forgiveness journey is clinically appropriate in cases of abuse, where the offending party is no longer alive (Malcolm, Warwar, & Greenberg, 2005), or where no current or future relationship is possible (Rusbult et al., 2005). Forgiveness with couples may, however, involve both intra-psychic and interpersonal process. Offending partner's responses to the injured partner's expressions may facilitate internal healing or hinder the process by aggravating an emotional injury (Gordon et al., 2005; Hargrave & Sells, 1997; Rusbult et al., 2005; Worthington, Kurusu, Collins, Berry, Ripley, & Baier, 2000).

Reconciliation is viewed as an interpersonal process that involves a restoration of trust (Enright et al., 1992; Gordon, Baucom, & Snyder, 2000, 2005; Hargrave & Sells, 1997; Worthington & Drinkard, 2000), commitment (i.e., relationship persistence, long-term relationship orientation) (Rusbult et al., 2005), and an emotional connection (Haaken, 2002; Scobie & Scobie, 1998) in the relationship. The injured partner must gain trust that the other will behave benevolently (Rusbult et al., 2005). An offering of

greater respect (Davenport, 1991; Hargrave & Sells, 1997), an expression of remorse, recognition and responsibility for harm, and a willingness to resolve (McCullough et al., 2000) are essential to this process. Reconciliation does not necessarily restore the relationship to its previous state as the relationship may continue with alterations in norms and expectations (Gordon et al., 2005; Rusbult, et al., 2005).

Finally, forgiveness and reconciliation are viewed as distinct, yet possibly integrated processes (Coleman, 1998; DiBlasio, 1998, 2000; Enright et al., 1992; Gordon et al., 2000, 2005; McCullough et al., 2000). Forgiveness seems to increase pro-social relationship maintenance behaviours (i.e., accommodation, willingness to sacrifice, pro-social acts) associated with reconciliation (Karremans & Van Lange, 2004), and diminish hostile emotion and retaliation (Exline & Baumeister, 2000; Waldron, Kelley & Harvey, 2008). Forgiveness, however, may or may not evolve into reconciliation as couple partners may decide to terminate their relationship afterward (Gordon et al., 2005).

Intrapsychic dimensions of the forgiveness process

Emotion

Individual or couple therapy with injured individuals often involves intense negative emotional experiences at the onset (Coleman, 1998; DiBlasio, 1998, 2000; Enright et al., 1992; Gordon et al., 2000, 2005; Human Development Study Group, 1991; Johnson et al., 2001; Makinen & Johnson, 2006; Malcolm et al., 2005). Emotional reactions cited in the individual forgiveness process literature include: intense anger associated with hurt (Davenport, 1991; Fitzgibbons, 1986, 1998), residuals of past hurts from previous interpersonal injuries (Rowe & Halling, 1998; Rowe, Halling, Davies,

Leifer, Powers, & van Bronkhorst, 1989), self-protective anger to elevate one's self worth when vulnerable (Malcolm & Greenberg, 2000; Malcolm et al., 2005), excessive anger that may create shame and guilt (Fitzgibbons, 1998; Rowe et al., 1989), fear related to the offending other (Denton & Martin, 1998; Hargrave & Sells, 1997; Worthington, 1998) and resentment (Denton & Martin, 1998; Hargrave & Sells, 1997).

In forgiveness-based couple therapy models, intense emotional reactions, such as anger, hurt, and hostility are often cited (Baucom et al., 2006; DiBlasio, 1998, 2000; 2008; Gordon et al., 2005; Hargrave, 1994; Hargrave & Sells, 1997). Anger, hurt, anxiety and hostility have been found to be particularly common injured partner emotional expressions in the aftermath of a transgression (Leary, Springer, Negel, Ansell, & Evans, 1998). Managing these intense emotional experiences is associated with a greater likelihood of forgiveness (Hodgson & Wertheim, 2007).

With forgiveness, psychological change toward an offender often consists of a shift in emotional experience toward an offender (Enright et al., 1998; Fitzgibbons, 1998; Human Development Study Group, 1991; Malcolm et al., 2005; North, 1987). Unforgiving emotions (i.e., resentment, bitterness, hatred, hostility, anger and fear) are transformed into more positive other-oriented emotions (i.e., love; Enright et al., 1998; Fitzgibbons, 1998; Human Development Study Group, 1991; North, 1987) empathy (Malcolm et al., 2005), compassion, or sympathy (Fitzgibbons, 1998; Human Development Study Group, 1991; North, 1987). In cases of trauma, however, intense negative affect may be surrendered to improve life quality without a shift toward positive emotional experiences (Malcolm & Greenberg, 2000; Malcolm et al., 2005). Qualitative studies affirm that transforming emotions and feelings about the self and

other, particularly lingering hurt and distancing anger, is essential to the forgiveness process (Rowe & Halling, 1998; Rowe et al., 1989). These negative emotional experiences must be transformed if reconciliation is to occur (Enright et al., 1992; Gordon & Baucom, 1998; Gordon et al., 2000, 2005; Rowe et al., 1989).

When emotional shifts occur, forgiveness has been described as internal forgiveness, as opposed to a more hollow external expression of forgiveness (Friesen, Fletcher, & Overall, 2005). Internal forgiveness involving experiential shifts has been associated with more positive perceptions of relationship quality and lesser partner blame (Friesen et al., 2005). External forgiveness, on the other hand, is not necessarily anchored in internal emotional change related to the transgression (Baumeister, Exline and Sommer, 1998; Friesen et al., 2005). It has been suggested that emotionally unanchored external forgiveness, a form of pseudo forgiveness, may be expressed to maintain harmony (Friesen et al., 2005) or reduce attachment fears of rejection and abandonment (Hill, 2001; Mikulincer, Shaver, & Slav, 2006).

Cognition

Cognitive processes also influence the forgiveness process. Self and other related meanings, assumptions, and beliefs about the relationship and the world are often altered in the aftermath of injury and transformed upon forgiveness (Enright et al., 1992; Enright et al., 1998; Gordon et al., 2005; Rowe et al., 1989). Confusion about self and other meanings related to the interpersonal injury, obsessive review or rumination about events related to the injury, and blameful attributions are commonplace in injured partners (Rusbult et al., 2005). Injured partner rumination is associated with lesser victim forgiveness (McCullough, Bono, & Root, 2007; McCullough & Hoyt, 2002;

McCullough, Rachal, Sandage, Worthington, Brown & Hight, 1998), particularly for married females who are ruminative over a six-month period (Paleari, Regalia, & Fincham, 2005). Attitudinal ambivalence toward an offending partner before a transgression decreased the likelihood of forgiveness only when partners ruminated about the event frequently (Kachadourian, Fincham, & Davila, 2005).

In the forgiveness process, attribution changes are also important to shift an injured individual toward a more forgiving stance toward an offending other (Gordon et al., 2005; McCullough et al., 2000). Various studies suggest that when injury responsibility is solely attributed to the offending person, forgiveness is less likely (Boon & Sulsky, 1997; Bradfield & Aquino, 1999; Fincham, 2000; McCullough, Fincham, & Tsang, 2003). In long-term marital relationships, more benign attributions on the part of the injured partner, particularly female partners, have been associated with greater forgiveness for a transgression and greater marital quality (Fincham et al., 2002).

Finally, individuals who hold religious beliefs about forgiveness tend to be more forgiving of interpersonal injuries (Fox & Thomas, 2008; Oliner, 2005); however, individuals with intrinsic religious beliefs seem more likely to forgive an offender in the aftermath of a betrayal than those with extrinsic religious beliefs, who tend to be more vengeful and more easily swayed by others to forgive (Gordon, Frousakis, Dixon, Willett, Christman, Furr et al., 2008).

Empathy

The injured person's cognitive empathy, the capacity to understand the offending party's perspective or feelings related to an injury, is deemed to be an essential feature of the forgiveness process (Coleman, 1989, 1998; DiBlasio, 1998, 2000; Fitzgibbons,

1986, 1998; Freedman, 2000; Gordon et al., 2005; Hargrave & Sells, 1997; Human Development Study Group, 1991; McCullough, Worthington, & Rachel, 1997; Wade & Worthington, 2003). The injured partners' perspective taking, reframing of the offending partners behaviors (Enright et al., 1992; Enright et al., 1998) and insights into how past and current circumstances have contributed to the offending partner's behavior (Gordon et al., 2005; Hargrave & Sells, 1997) support the injured partner to increase his or her empathy for the offending partner. Empathy, however, has also been considered in emotional terms, as feeling empathic (Malcolm & Greenberg, 2000; Malcolm et al., 2005). As a core component of the forgiveness process, empathy may be important in shifting emotion and cognitive meanings related to an event. Without empathy, meanings related to the self, other and event cannot be reframed and synthesized, and therefore, the injured partner is likely to remain in a negative affective state and less forgiving toward the offender (Berecz, 2001).

Empathy has been linked to forgiveness in various research studies using different empathy and forgiveness measures (McCullough et al., 2003; McCullough et al., 1998; McCullough et al., 1997; Wade & Worthington, 2003; Welton, Hill, & Seybold, 2008; Worthington et al., 2000). Greater feelings of emotional empathy and empathy, as perspective taking, have been significantly correlated with the injured person's forgiveness of the other (Macaskill, Maltby, & Day, 2002; McCullough et al., 1997; Takaku, 2001), and associated with more positive feelings, emotions and attributions toward an offending person (Takaku, 2001). Empathy also diminishes the likelihood that an injured party will be motivated to avoid or to seek revenge in the aftermath of injury (McCullough et al., 2000; McCullough et al., 1998).

Greater empathy was found to influence forgiveness in relationship partners. An injured partner's forgiveness in undergraduate dating partners (Brown, 2003), shorter-term (Hargrave & Sells, 1997; Zechmeister & Romero, 2002) and longer-term relationship partners (Fincham et al., 2002) has been linked to increasing levels of empathy. An injured relationship partner's empathy seemed to have resulted in more benign interpretations of the meaning of a transgression (Zechmeister & Romero, 2002). Finally, with couples, injured husbands' but not injured wives' emotional empathy predicted forgiveness of a transgression in long term couple relationships (Fincham et al., 2002; Paleari et al., 2005).

While the injured partner's empathy for an offending partner has been subject to empirical investigation, no studies examining the effect of the offending partner's empathy on the injured partner could be found. It is suggested that a lack of empathy for injuries caused may be associated with narcissistic, antisocial or sociopathic tendencies, which diminish the offending partner's capacity to tap into the other's perspective and feelings (Gordon et al., 2005; McCullough & Hoyt, 2002).

Motivation

A shift in the injured partner's motivations from avoidance and revenge motivations to more benevolent motivations is an essential component of the forgiveness process of interpersonal injuries (McCullough et al., 2000). Intense anger is often associated with revenge and justice seeking behaviours (Rowe & Halling, 1998; Rowe et al., 1989). For example, greater negative affect and rumination has been related to the injured person's vengefulness toward the offender (McCullough, Bellah, Kilpatrick, & Johnson, 2001). A change in vengeful motivation can be attributed to

emotional shifts in the injured partner. Once the injured person's intense negative affect ceases, he or she is less likely to avoid, seek revenge or retaliate against the offending person (Denton & Martin, 1998; Hargrave & Sells, 1997; McCullough et al., 1997; Ripley & Worthington, 2002; Worthington & Wade, 1999) and is more likely to consider reconciliation if it is safe to do so (McCullough et al., 1997; Worthington & Wade, 1999). In cases of traumatic experiences of emotional, physical and sexual abuse, forgiveness may involve shifting negative emotions toward a more neutral stance, or holding the other accountable for the injury (Malcolm et al., 2005).

When couple partners are vengeful they are less likely to forgive (McCullough et al., 2001). Research with couple partners suggests that vengeful motivations and destructive behaviours toward an offending partner diminish over time (Rusbult et al., 2005). More benevolent behaviours (i.e., conciliatory responses) and forgiveness are associated with less injured female partner rumination and increased injured male partner empathy toward a female offending partner (Paleari et al., 2005). Avoidance or retaliation after an injury increases the likelihood of conflict and decreases the likelihood of forgiveness in female partners, while an injured female partner's benevolence post-injury results in more resolution and greater forgiveness (Fincham, Beach & Davila, 2004).

Interpersonal dimensions

The offending partner's remorse, regrets and apology

As indicated earlier, an injured partner's forgiveness process may be dependent on an offending partner's responses (Gordon et al., 2005). The offending partner's responses to the injured partner's injuries may facilitate or deter this process. Various

offending partner responses have been cited, including expressions of remorse, regret (Johnson et al., 2001; Wade & Worthington, 2003), guilt (Rusbult et al., 2005), and shame, which may inhibit an offender from requesting forgiveness to avoid re-experiencing shame related to the event (DiBlasio, 2000; Hill, 2001).

Research studies affirm that remorse, regrets, and amends (i.e., an apology and reparative efforts) reduce an injured person's anger, negative attributions (Fincham et al., 2002) and vengeance motivations (Rusbult et al., 2005). When an injured person perceives regret and remorse from an offending partner, positive feelings of forgiveness are more likely (Wade & Worthington, 2003). Repentance also reduces the injured partner's psychological aggression and increases forgiveness (Eaton & Struthers, 2006). Greater empathy and positive emotion toward the offender are more likely following these types of offender expressions (Hannon, Rusbult, Finkel, & Kumashiro, 2004; Rusbult et al., 2005). In studies of close relationships, the offending partner's guilt has been associated with sadness and remorse, concern for the victim, and inclinations toward an apology, confession, and amends (Baumeister, Stillwell, & Heatherton, 1995; Rusbult et al., 2005; Tangney, Wagner, Hill-Barlow, Marschall, & Gramzow, 1996). An apology and amends was also associated with a stronger link between partner forgiveness and a positive sense of well-being (Bono, McCullough, & Root, 2008). The offending persons' guilt and responsibility may serve as some form of repayment and reassurance against a repeat injury and reduce the injured person's experience of humiliation and risk in forgiving the other (Rusbult et al., 2005).

It has been suggested that an apology may facilitate forgiveness by enhancing the injured person's empathy (Worthington et al., 2000). It may represent to the injured

person the offender's empathy for the hurt caused by the injurious behaviour and, therefore, may arouse empathy toward the offender (McCullough et al., 2000; McCullough et al., 1998; McCullough et al., 1997). An apology may also suggest that the offender has the injured person's 'best interest in mind' (Worthington, 1998). Earlier studies found a positive effect of apology on forgiveness (Darby & Schlenker, 1982; Gonzales, Manning, & Haugen, 1992; Gonzales, Pederson, Manning, & Wetter, 1990); however, later studies indicate an apology facilitates forgiveness only insofar as the injured partner has empathy for the offender's perspective (McCullough et al., 2003; McCullough et al., 1998; McCullough et al., 1997), and the offences are unintentional (Struthers, Eaton, Santelli, Uchiyama, & Shirvani, 2008). Forgiveness may also be independent of an apology, according to qualitative research studies (Rowe & Halling, 1998; Rowe et al., 1989). An individual's belief in the significance of an apology (Oliner, 2005) and knowledge that an apology was motivated by the offending partner's guilt or shame, as opposed to pity, increases the likelihood of forgiveness (Hareli & Eisikovits, 2006).

Contextual dimensions

Relationship context also has an impact on the unfolding of a forgiveness process. A history of repeated and severe transgressions (Brown, 2003; McCullough et al., 2003; McCullough & Hoyt, 2002) and relational dissatisfaction prior to an injury (Fincham, 2000; Fincham & Beach, 2002; Fincham, Beach, & Davila, 2007; Fincham et al., 2002; Kachadourian, Fincham & Davila, 2004; McCullough, et al., 1998; Paleari et al., 2005; Worthington & Drinkard, 2000) diminish the likelihood of forgiveness. In couples facing real life transgressions, partners who were satisfied with their relationship tended

to blame their partners less and were more forgiving (Friesen et al.; 2005). In a longitudinal study, marital quality was found to increase the likelihood of forgiveness for both female and male partners; however, forgiveness improved marital quality only for female partners (Fincham & Beach, 2007)

Relationship commitment and trust also influence the psychological state of the injured partner. Commitment has been found to contribute to a greater likelihood of the injured individual's forgiveness of the offending party (Cann & Baucom, 2004; Hannon, 2001; Leary et al., 1998; McCullough et al., 1998; Worthington & Drinkard, 2000), more offending partner amends (Hannon, 2001), an increase in the injured person's benevolence, a reduction in avoidance and revenge motivation (McCullough et al., 1998), more injured party positive post-injury cognition (i.e., positive attributions), greater regulation of immediate negative emotional reactions, and quicker experiences of positive emotions (Finkel, Rusbult, Kumashiro, & Hannon, 2002). When partners reported feeling close and being committed prior to an injury, the injured individual's forgiveness has been associated with a more positive sense of well-being (Bono, McCullough, & Root, 2008).

According to recent studies (Burnette, Davis, Green, Worthington, & Bradfield, 2009; Burnette, Taylor, Worthington, & Forsyth, 2007; Finkel, Burnette & Scissors, 2007; Kachadourian et al., 2004; Mikulincer et al., 2006), insecurely attached individuals may be less forgiving than securely attached individuals. Kachadourian et al (2004) investigated how attachment working models of self and other influence forgiveness. The researchers found that greater injured party forgiveness was associated with attachment security, positive models of self (i.e., greater self worth and fewer

perceptions of abandonment and rejection) and other (i.e., confidence in others, partner perceived as trustworthy, dependable). A negative model of self was not associated with model of other in predicting who was likely to forgive. Positive models of self and other independently predicted the tendency to forgive transgressions for men; however, for wives, model of self and other interacted so that only injured women who had a positive model of self and a positive model of other were more likely to forgive their offending male partner. Greater attachment security, therefore, enhanced the tendency to forgive in women.

In subsequent studies, attachment anxiety and avoidance have been found to influence the forgiveness process differently. With attachment anxiety, the tendency to heighten emotion may contribute to increased ruminations upon attachment threat for the injured partner, which either impedes forgiveness or promotes premature forgiveness of the offending partner to lessen separation anxiety (Mikulincer et al., 2006). For avoidant attachment, the tendency to dismiss and minimize emotion may diminish empathy and thus disrupt relational repair and forgiveness. Various forgiveness studies employing attachment measures affirm these findings. Angry rumination has been found to mediate the link between attachment anxiety and a lack of forgiveness, whereas a lack of empathy accounts for the link between attachment avoidance and lesser forgiveness (Burnette et al., 2009; Burnette et al., 2007). With avoidant attachment, there were more revengeful and greater avoidance in response to hurtful incidents, and greater relational deterioration was experienced in their forgiveness efforts (Mikulincer et al., 2006). Insecurely attached individuals experienced higher levels of self-vulnerability, and were

less likely than securely attached individuals to perceive partners as accessible and responsive following a hurtful incident (Mikulincer et al., 2006).

Forgiveness couple therapy models

Over the past 20 years, various forgiveness-specific couple intervention models have been developed. The AIRM emerges within this context. Existing models have often viewed relationship betrayals as traumatic, and thus therapy proceeds on the basis of a trauma-recovery process (i.e., Abrahms-Spring, 1996; Baucom, Snyder, & Gordon, 2009; Coleman, 1998; Glass & Wright, 1997). Trauma-based forgiveness models synthesize a perspective on trauma with a process model of forgiveness to address betrayals of trust, and more specifically infidelity (Glass & Wright, 1997; Gordon & Baucom, 1998; Gordon et al., 2000, 2005; Snyder, Baucom, & Gordon, 2007). The traumatic response includes shattered perceptions of self and other, and of the basic beliefs about the relationship, and unpredictability that fuels intense emotional reactions and chaos, a loss of trust (Abrahms-Spring, 1996; Coleman, 1998; Glass & Wright, 1997; Gordon & Baucom, 1998; Gordon et al., 2000, 2005; Snyder et al., 2007), and partner avoidance in the aftermath of an infidelity (Abrahms-Spring, 1996). Some forgiveness models, however, have not integrated a view of trauma (i.e., DiBlasio, 1998, 2000; Hargrave, 1994; Hargrave & Sells, 1997).

These forgiveness couple models tend to employ empathy to facilitate change, albeit with different emphases. Enhancing injured and offending partner empathy is a primary strategy to diminish injured partner negative emotions, balance the injured and offending partner's account of the incident, and reduce vengeful motivation (Baucom et al., 2006; Coleman, 1998; DiBlasio, 1998, 2000; Gordon et al., 2000, 2005; Hargrave &

Sells, 1997; Snyder et al., 2007). Partners gain an understanding of the interpersonal context surrounding the betrayal and of the perspectives and meanings related to the event (Gordon et al., 2005; Snyder et al., 2007), and insight into the offending partner's childhood issues that may have contributed to betrayal (DiBlasio, 1998, 2000; Gordon et al., 2005; Hargrave & Sells, 1997; Snyder et al., 2007).

These models vary in terms of how forgiveness is incorporated into or employed in the therapeutic process. Forgiveness has been depicted as a discrete act based on a decision-based commitment to forgive (i.e., let go of negative emotions and vengeance) at therapy onset (DiBlasio, 1998, 2000), or a cognitive decision to forgive and/or to reconcile at the end of therapy based on partner interactions in therapy (Baucom et al., 2006; Baucom et al., 2009; Coleman, 1998; Gordon et al., 2000, 2005). Forgiveness has also been incorporated in therapy as a ritual preceding (DiBlasio, 1998, 2000) or at the end of therapy as a symbolic ritual to bring the healing process to completion (DiBlasio & Benda, 2008; Glass & Wright, 1997; Hargrave & Sells, 1997). Forgiveness has also been construed as a process that unfolds for the injured partner throughout the course of therapy (Abrahms-Spring, 1996), and as the outcome of a rational transaction in which the injured partner requests remedial action and the offending partner responds with compensatory behaviours (Hargrave & Sells, 1997).

Models vary in terms of the links between forgiveness and reconciliation. Some models conflate forgiveness and reconciliation (DiBlasio, 1998, 2000; DiBlasio & Benda, 2008; Hargrave & Sells, 1997). For Hargrave and Sells (1997), forgiveness automatically entails reconciliation, a restoration of the relationship through a renewal of trust. At the onset, DiBlasio (1998, 2000) and DiBlasio and Benda (2008) ask

partners to make a decision to forgive, which also entails a commitment to the relationship; reconciliation is implicit. Baucom et al. (2009) and Gordon et al. (2005), on the other hand, maintain that forgiveness and reconciliation are distinct yet integrated processes. A decision point is reached in which partners decide either to forgive or not to forgive, and to continue or not to continue in the relationship. Partners are either then supported to move on in their relationship or to move on as individuals (Baucom et al., 2006; Baucom et al., 2009; Gordon et al., 2005).

Some forgiveness-specific intervention models have been empirically investigated. Generally, study findings have been limited though as a result of small sample sizes, and therefore, the insufficient power to detect possible differences. Sells, Giordano and King (2002) outcome study employed Hardgrave and Sells (1997) forgiveness-specific model with five married couples for eight therapy sessions over an eight week period in a private practice setting. All couples had increases in forgiveness (i.e., insight, trust, and overt forgiveness), and marital satisfaction compared to baseline scores. At three months follow-up, only trust was maintained, while there was an increase in the injured partner's anger. The study authors suggested forgiveness might require greater support time (Sells et al., 2002).

Gordon, Baucom and Snyder's (2005) forgiveness-specific model, a synthesis of cognitive-behavioral and psychodynamic interventions, has also been investigated. Their intervention model was employed in a study of six couples who were seen in therapy for up to 26 sessions. Gains in marital satisfaction and reduction in global symptoms (e.g., PTSD) and depression for the injured partner were reported (Gordon, Baucom, & Snyder, 2004; Baucom et al., 2006). The offending partners were found to improve only

in terms of depression symptoms. Offending partners were not as individually distressed as injured partners at pre-test according to study authors. No comparison groups or control groups were used. A measure of relational trust, a necessary component of reconciliation, and a cornerstone of relational long-term security was not employed.

Finally, DiBlasio and Benda (2008) have recently empirically investigated the utility of a three-hour couple decision-based forgiveness session with 44 couples. Partners were supported to express pain, to understand the offending partner's motivation for the offence (i.e., past and current circumstances), and to surrender vengeance motivations and negative thoughts of resentment. Post-session outcome results suggested that couple clients were more forgiving and more satisfied with their relationship than both a problem-solving and control group (DiBlasio & Benda, 2008). DiBlasio and Benda's (2008) did not employ measures of relational trust. While momentary satisfaction may have been restored, the longer-term implications of the intervention on marital functioning may require further investigation.

Attachment Injury Resolution Model development within EFT

In recent years, a forgiveness-based couple therapy model has been developed and investigated within the context of an empirically validated couple therapy, EFT (Johnson, 2002; Johnson et al., 2001; Johnson & Whiffen, 1999). The model addresses a particular type of relationship injury, known as an attachment injury.

Attachment injury definition

An 'attachment injury' is formed when a partner is betrayed, abandoned or trust is violated, during a critical moment of great need for care and support from a partner (Johnson, 2002; Johnson et al., 2001; Johnson & Whiffen, 1999). According to

Bowlby's (1969, 1973) attachment theory, an innate attachment behavioural system is activated in response to internal and external threat, to gain proximity to an attachment figure to assuage distress. If attachment needs for proximity are unmet, the partner may feel abandoned and isolated while experiencing intense fear and helplessness. Separation from a loved one and isolation during moments of intense fear and helplessness is considered small 't' traumatic. An indelible imprint is left on the couple relationship (Johnson, 2002). The injury flowing from this event is deemed to define the trustworthiness and the dependability of the offending partner (Johnson, 2002; Johnson et al., 2001). The injury may fray the attachment bond, rendering a previously secure relationship as insecure, or the injury may become symbolic of the couples previous and current insecure attachment (Johnson, 2004). Risking emotional vulnerability and need expression in relationship becomes increasingly difficult as a result of the injury (Makinen, 2004; Johnson 2004; Johnson et al., 2001; Johnson & Whiffen, 1999).

There are also many different types of triggers for attachment injuries. The relationship events that precipitate injuries may vary for couples. Attachment needs for significant others are often salient during childbirth, physical illness (e.g., cancer diagnosis), life changes (e.g., retirement, immigration) and at times of loss (e.g., miscarriage or death of a child) (Makinen, 2004; Johnson, 2002, 2004; Johnson, et al., 2001).

In the past decade, a task analytic research methodology has been employed to create a clinical model to address attachment injuries in couples. A task analytic research methodology was devised specifically to construct clinical models to address clinical phenomena, such as an attachment injury. Numerous studies have been

previously undertaken to both develop and empirically investigate a clinical model that outlines the resolution path of an attachment injury (Johnson et al., 2001; Makinen & Johnson, 2006; Millikin, 2000; Naaman et al., 2005).

Empirical Investigations of Attachment Injuries

Task analysis research methodology

Task analysis research methodology allows psychotherapy researchers to identify, describe, analyze and predict the process of client change in psychotherapy, and to design clinical models that capture the steps, or components, inherent in the solution of a client cognitive-affective problem (Greenberg, 1991; Greenberg & Foerster, 1996; Rice & Greenberg, 1984). A recurring change event, a sequence of therapist and client interactions that resolve a problem, is explicated to understand patterns of client change. These sequences typically consist of an initial client problem marker (i.e., a statement or in-session client psychological state or condition), a therapist operation (i.e., therapist focus and intervention), and the client's performance (i.e., client's manner of engagement that may precipitate change). The marker alerts the researcher of the task that needs to be addressed followed by various other tasks and subtasks that may emerge in precipitating client change. The investigator then describes the in-session performances that mark the presence of the problem, along with the therapist behaviours that are thought to promote client change and problem resolution (Greenberg & Foerster, 1996; Rice & Greenberg, 1984). This research strategy, which usually requires numerous years and studies, allows one to build and empirically validate a model of client change and therapist behaviours that promote successful therapy outcomes (Greenberg, 1984).

There are eight steps in a task analytic method, but variations are common (Greenberg & Johnson, 1988; Heatherington & Friedlander, 1990). Steps one through six are discovery-oriented, rational and empirical. The first step involves explication of a clinical map and tacit knowledge (i.e., theories about the phenomena) by an expert clinician, outlining cognitive-affective tasks required for problem resolution, and identifying and empirically defining the marker for the commencement of the change event (i.e., client statements, psychological state or therapist behaviours) (Greenberg, 1984, 1991). The significance of the task is verified by delineating measures of the marker (Greenberg & Newman, 1996). Diagrams of client and therapist performances are constructed that include components and sequences of possible client performances and/or therapist interactions (Greenberg, 1984, 1991; Greenberg & Foerster, 1996; Greenberg & Newman, 1996). Hypotheses are set out about possible independent judges' ratings of these components using client process measures (Greenberg, 1991; Greenberg & Foerster, 1996; Greenberg & Newman, 1996), such as the Experiencing Scale (Klein, Mathieu-Coughlan, & Kiesler, 1986). Best prototypes of the change event are identified, models of these performances constructed, and eventually compared to transcripts of actual successful performances to further delineate the unfolding of components and sequences. Comparison of possible performances and actual successful performances results in construction of a specific model. This process of comparing possible and actual performances is repeated until no more components or sequences can be identified. A specific model that captures measurable components and sequences of client and therapist behaviours involved in task resolution is developed (Greenberg,

1984, 1991; Greenberg & Foerster, 1996; Greenberg & Newman, 1996). The newly developed model is considered a micro-theory about the phenomena (Greenberg, 1991).

The seventh and eighth steps involve a verification phase. Model validation consists of both psychotherapy process and outcome research. The order of these steps can vary. An outcome study may be conducted in which the new model is tested to determine whether model implementation leads to successful outcomes. Psychotherapy process research may be employed to compare actual successful and unsuccessful performances to validate whether components in the model can discriminate between these performances. Hypotheses are put forward that the components of successful performances and non-successful performance are different (Greenberg, 1984; Greenberg & Foerster, 1996). In these studies, component description may also be enriched with the addition of further empirical criteria or components (Greenberg, 1991; Greenberg & Newman, 1996). At any time, the investigator may also test the relationship between particular types of task performances (i.e., client processes or therapist behaviours within a component) and psychotherapy outcome measures (Greenberg, 1984, 1991; Greenberg & Foerster, 1996; Greenberg & Newman, 1996).

This research paradigm has been employed by researchers from different theoretical perspectives to study the in-session change process in psychotherapy (e.g., Clark, 1996; Friedlander, Heatherington, Johnson, & Skowron, 1994; Safran & Muran, 1996). Several advantages of task analysis and process research can be identified (Greenberg, 1984, 1991; Greenberg & Foerster, 1996; Greenberg & Pinsof, 1986; Hawley & Geske, 2000; Jacobson & Addis, 1993; Johnson, 2003a; 2003b; Johnson & Lebow, 2000; Pinsof, 1988). First, task analysis is useful since client and therapist actual

in-session behaviours are used in the development of models of performance. These models are, therefore, clinically important, useful and relevant in providing specific in-session information about what are the specific and effective ingredients in therapy (Greenberg, 1991). Second, task analysis results in the dissection of successful performances, and therefore, provides an understanding of the moment-by-moment experience of the resolution of the identified client problem and potential specific intervention points. Research findings are immediately relevant to clinicians. Third, task analysis can be used to build and refine models and to specify the active ingredients related to how a client changes as opposed to outcome studies that merely answer the question of whether change has occurred (Greenberg, 1991; Greenberg & Foerster, 1996; Greenberg, Heatherington, & Friedlander, 1996; Greenberg & Pinsof, 1986; Hawley & Geske, 2000; Jacobson & Addis, 1993; Johnson, 2003a; 2003b; Johnson & Lebow, 2000; Pinsof, 1988).

Previous application of task analysis to EFT for couples

Task analytic research methodology has been used to develop and empirically substantiate significant change events in EFT and has been applied to explicate components, and empirically specify client manner of engagement (Johnson & Greenberg, 1988; Greenberg, Ford, Alden, & Johnson, 1993) and therapist behaviours (Bradley, 2004; Bradley & Furrow, 2004, 2007). In EFT for couples, this methodology has been specifically employed to develop and investigate a 'softening' change event. In this change event, a previously critical, blaming partner accesses and expresses vulnerable feelings and needs. The withdrawn partner responds to these identified needs, which marks increased emotional accessibility and responsiveness. Initially, Greenberg

and Johnson (1985) had outlined a rational model of the change process, followed by research that resulted in greater specification of the change processes within the model (Greenberg, James, & Conry, 1988). Change processes were subsequently related to outcomes in a study in which change processes were analyzed in best sessions rated by couples and therapists of EFT for couples (Johnson & Greenberg, 1988). In this study, three couples with the most positive change and three couples with the least amount of change in marital satisfaction scores (i.e., Dyadic Adjustment Scale; Spanier, 1976) were analyzed and rated in terms of performances in the softening event using client process measures. Process measures included the Experiencing Scale (Klein et al., 1986), a measure that captures client in-session experiential processing that ranges from more superficial, glib processing at the lowest levels to increasing levels of internal exploration of inner experience at higher levels. The Structural Analysis of Social Behaviour (Benjamin, 1974), a measure of interpersonal interactions on the basis of three underlying dimensions: focus (other, self, introject), interdependence-independence and affiliation-hostility. Successful and non-successful performances were compared and it was found that successful performances involved deeper levels of experiencing on the Experiencing Scale and more autonomous/affiliate type interactions on the SASB (Benjamin, 1974) (Johnson & Greenberg, 1988).

In a process study conducted by Greenberg et al. (1993), successful and non-successful performances were compared once more. Using the Structural Analysis of Social Behaviour (SASB) (Benjamin, 1974), interpersonal shifts from hostility to affiliation were found in client's discourse from session 2 to session 7 in clients who had successfully resolved a softening event, as compared to a wait list couples group. In a

second study, in 'best sessions' as identified by couples, client discourse also contained more depth of experiencing on the Experiencing Scale (Klein et al., 1986) and more affiliate and autonomous interpersonal responses on the SASB (Benjamin, 1974) than sessions rated as 'poor'. In a third study, more emotional self disclosures by clients were more likely to lead to affiliate type statements than other randomly noted statements.

Recently, process research in EFT for couples has turned to exploring therapist behaviours in successful blamer-softening events, with the end goal of supporting therapists to navigate these change events (Bradley, 2004; Bradley & Furrow, 2004). An event marker was defined as the therapist's initiation of a softening enactment in which the therapist requested that the blaming partner turn to the other partner from an emotionally vulnerable stance and risk expressing needs and wants (Bradley & Furrow, 2004). Resolution of the change event occurred when the previously withdrawn partner became more engaged and responsive to these vulnerable expressions. Four sessions involving this marker and resolution were used. The rational empirical phase (steps one through six) of task analysis was completed.

Bradley and Furrow (2004) mapped out a rational model of a successful therapist performance in the resolution of a softening event based on previous EFT literature (Greenberg & Johnson, 1988; Johnson, 1996, 2004; Johnson & Denton, 2002; Johnson & Greenberg, 1988). Therapist behaviours were examined in two ways. First, EFT therapist behaviours were coded using the Emotionally Focused Therapist Coding Scale (EFT-CS; Bradley, 2004), a measure consisting of experiential and systemic EFT interventions. Second, content analysis was used to identify themes focused on by the therapist in therapist-client interactions during the resolution of the softening. The

therapists' foci consisted of specific client process related themes being emphasized by the therapist as he or she attempted to facilitate the resolution of a softening event. An initial model of therapist foci was developed and compared with other successful softening events and refined. A rational-empirical model was developed and the rational model was expanded and enriched as it was compared to five actual successful therapist performances. The refined model consisted of six therapist thematic shifts in the softening process and such shifts were linked to EFT interventions based on frequency of use (Bradley & Furrow, 2004). A final conceptual model or mini-theory of therapist behaviours (i.e., therapist themes and linked EFT interventions) in the blamer-softening event was set out. This rational-empirical model of thematic shifts and linked interventions provides a practical clinical map to support EFT therapists to clinically navigate the resolution of a blamer-softening event (Bradley, 2004; Bradley & Furrow, 2004). Therapist foci in resolving a softening was also compared to non-successful cases and it was found that only three therapist foci were present in the unsuccessful softening events (Bradley, 2004). The rational-empirical model was, therefore, able to distinguish successful from unsuccessful softening events.

Application of Task Analysis to Attachment Injuries

The task analytic research paradigm has been employed in the development and empirical investigation of therapeutic impasses, or moments in which therapy progress is halted during softening events. Relationship traumas, or attachment injuries, have often been speculated to interfere with successful resolution of softening events in EFT (Johnson & Whiffen, 1999). In initial attachment injury investigations, cognitive-affective tasks required for resolution, an event marker, and a rational-empirical model

of attachment injury resolution were defined using process measure criteria, such as the Experiencing Scale (Klein et al., 1986) and the SASB (Benjamin, Foster, Roberto, & Estroff, 1986) at each component (Johnson et al., 2001; Millikin, 2000). Richer descriptions of client performances and therapist foci within each component of the AIRM were also delineated (Johnson et al., 2001). An initial outcome study in which 15 of 24 couples resolved their attachment injury provided initial empirical support for the model (Makinen & Johnson, 2006). AIRM implementation improved forgiveness, relational trust, and dyadic adjustment in partners who had resolved their attachment injury. Resolved couples in the study had also significantly deepened their emotional involvement in therapy and were more affiliate in their interpersonal responses than non-resolved couples. In a final process-oriented study, the Experiencing Scale and SASB were applied to ten minute transcript segments across ten sessions of two resolved couple cases (Naaman et al., 2005). Increasing depths of experiencing and more affiliate interpersonal responding were found across these sessions.

General Objectives of Dissertation Articles

Article 1: Attachment, emotion and the client process of change

Article 1 places forgiveness in relationships within the context of attachment. Attachment theory assumes that emotional processing of anger, sadness and fear underlying emotional injuries is essential in forgiveness. This article places the AIRM and the forgiveness process with the context of EFT and attachment theory. The key interactions necessary for the creation of forgiveness are discussed.

Article 2: Psychotherapy process study

Makinen (2004) identified future directions within a task analytic research paradigm to further validate the AIRM. These directions form the basis of the psychotherapy process study found in the second article of this dissertation. Three study objectives were identified:

1) Client processes at each component of the model will be empirically specified to deepen knowledge about the client change process underlying attachment injury resolution. An additional process measure, the Levels of Client Perceptual Processing (Toukmanian, 1986, 1992, 1994), will be used alongside current process measures that define component criteria, the Experiencing Scale (Klein et al., 1986) and Structural Analysis of Social Behaviour (Benjamin, 1974; Benjamin et al., 1986).

2) The AIRM will be validated by comparing successful and non-successful couple therapy cases to ascertain whether the effective ingredients of therapy discriminate resolved versus non-resolved cases. It will be discerned whether the pattern of components found in the AIRM discriminate between resolved and non-resolved groups. This objective allows one to examine whether clients who resolve a cognitive-affective problem change as suggested by the model (Greenberg & Foerster, 1996).

3) Therapist foci identified in the AIRM will be linked to therapist interventions. Linking therapist foci with EFT interventions at each model component will provide EFT clinicians with guidance as to which interventions are most frequently used to facilitate successful client performances (i.e., task resolution)

(Johnson, Hunsley, Greenberg, & Schindler, 1999) and further clarify therapist-client performance sequences within the model.

This process study will contribute significantly to the further development of Emotionally Focused Therapy (EFT) for couples (Johnson, 1996, 2004) by advancing knowledge about the resolution path of an 'attachment injury' and clinical interventions that are likely to facilitate this process. The study also answers questions about whether clients changed as predicted by EFT theory, and thus, can provide evidence of the effectiveness of EFT for couples in resolved cases. Finally, EFT clinical practice and training is improved if the client change process and interventions used during these moments can be elaborated (Johnson, 2003b; Johnson et al., 1999).

Negative relationship events, such as infidelity and other major betrayals in couple relationships, are often the source of intense emotional reactions in couple therapy. In recent years, forgiveness and reconciliation have been increasingly employed in the context of couple therapy to facilitate the clinical process of emotional healing and relational repair in the aftermath of such injuries (Abrahms-Spring, 1996; Baucom, Snyder, & Gordon, 2009; Coleman, 1989, 1998; DiBlasio, 1998, 2000; DiBlasio & Benda, 2008; Glass & Wright, 1997; Gordon, Baucom, & Snyder, 2000, 2005; Hargrave & Sells, 1997; Johnson, 2004; Johnson et al., 2001; Ripley & Worthington, 2002). Addressing an injured partner's intense emotion experiences has often been considered a crucial initial therapeutic task in most models. In the forgiveness and reconciliation model in EFT, known as the Attachment Injury Resolution Model (AIRM), particular shifts in emotional processing of the injurious incident is deemed to be critical to healing injuries, restoring trust and ultimately promoting forgiveness and reconciliation in couples.

The role of emotion in forgiveness-based couple therapy

There is a general consensus that post-injury negative emotional reactions must be addressed in forgiveness-based couple therapy interventions, particularly when an ongoing relationship between relationship partners may be considered (Gordon et al., 2000). Forgiveness cannot occur until an injured partner's negative emotions, such as hurt, anger, hostility, shame, rage, and fear have shifted toward a more benevolent or positive emotional stance (Enright, Freedman, & Rique, 1998; Gordon, et al., 2000; Ripley & Worthington, 2002). Research affirms that anger, hurt, hostility and anxiety are common injured partner emotional residues following transgressions in couple

relationships (Leary, Springer, Negel, Ansell, & Evans, 1998). Injured partner emotional reactions following interpersonal betrayals, such as infidelity, have been likened to traumatic reactions (Abrahms-Spring, 1996; Baucom, Gordon, Snyder, Atkins, & Christensen, 2006; Baucom et al., 2009; Coleman, 1998; Glass & Wright, 1997; Gordon et al., 2005; Johnson, 2004; Johnson et al., 2001). The outcomes of such betrayals are often a shattered view of the self, partner and relationship, as well as a loss of control, a lack of predictability and emotional dysregulation (Baucom et al., 2006; Gordon et al., 2005).

Current forgiveness-based couple models offer divergent conceptualizations of post-injury emotional reactions. Emotions are deemed to flow from varying sources, including violated standards (Gordon et al., 2005; Hargrave, 1994), injustices, an imbalance of give and take (Hargrave, 1994; Hargrave & Sells, 1997), unmet relationship expectations and standards (DiBlasio, 1998, 2000; Gordon et al., 2005), and disrupted assumptions and negative attributions about the partner and relationship (Baucom et al., 2009; Gordon et al., 2005). Previous forgiveness-specific intervention models have not considered the significance of these emotion reactions in terms of their attachment significance. Post-injury emotional reactions may also be related to innate, hard-wired, predictable emotional responses upon separation from an attachment figure (Bowlby, 1969, 1973), which ultimately shape partners' responses and play a pivotal role in the clinical process of repair.

Various therapeutic tasks are also offered to diminish post-injury emotional reactions. These reactions are typically viewed as disruptive to the forgiveness process. A common emotional regulation strategy has involved enhancing cognitive empathy for

the offending partner (Coleman, 1998; DiBlasio, 1998, 2000; Gordon et al., 2000, 2005; Hargrave, 1994; Ripley & Worthington, 2002). Partners are encouraged to interact at a cognitive level to gain an understanding of the offending partner's account, meanings, and motives related to the event, and insight into the offending partner's childhood issues that may have predisposed them to such an offence (Baucom et al., 2009; DiBlasio, 1998, 2000; Gordon et al., 2005; Hargrave & Sells, 1997). The injured partner's compassion for the offending partner's guilt, fear, and shame increases (DiBlasio, 1998, 2000), and negative partner attributions are shifted to reduce emotional distress (Gordon et al., 2005). These strategies may not, however, allow partners to fully explore emotional reactions and meanings associated with these emotion responses. Engagement on the basis of deeper, emotional processing of the incident may be a source of emotional healing. With other models, emotional responses are possibly by-passed and not integrated into the clinical repair process.

Forgiveness-specific couple interventions often include interpersonally based emotional regulation strategies to modulate the injured partner's emotional distress. It is suggested that appropriate offending partner responses may have the power to alleviate the injured partner's past emotional difficulties, and reduce the possibility of repeat offences and future emotional distress (Gordon et al., 2005). Models vary, however, in terms of the offending partner's responses that are likely to alleviate the injured partner's distress. Identifying with the injured partner's anger, hurt and betrayal as a result of violated relationship standards and expectations (DiBlasio, 1998, 2000), taking responsibility for the offence (Gordon et al., 2005; Hargrave & Sells, 1997), offering an apology (Hargrave & Sells, 1997), planning to not re-offend, and ceasing further

aversive behaviour in the future (Baucom et al., 2006; DiBlasio, 1998, 2000; Gordon et al., 2005; Hargrave & Sells, 1997) have been cited as important offending partner tasks. In some cases, a rational discussion between partners about how to prevent future injuries is construed as restoring predictability and control and, ultimately, regulating negative emotional experience (Gordon et al., 2005). These models appear not to consider how the offending partner's emotional accessibility and responsiveness to the injured partner's emotion and need expression may regulate emotional distress related to the injury. Interpersonal tasks involving injured-offending partner emotional processing of the incident are not offered in these models, and thus, this form of interpersonal emotional co-regulation is not enacted.

Finally, forgiveness has also been employed as a structured therapeutic task to regulate post-injury emotional distress at therapy onset, or upon termination. Partners are asked to make a rational decision and commitment to forgive (i.e., let go of resentment, bitterness and vengeance) prior to therapy, or at the end of therapy, as a reminder of the rational decision to let go of painful emotions (DiBlasio, 1998, 2000). A forgiveness task at the end of therapy may also involve a rational decision-making process to forgive or reconcile with a partner based on the outcome of in-session partner interactions (Coleman, 1998; Gordon et al., 2000, 2005; Hargrave & Sells, 1997). Forgiveness on the basis of a rational act, the byproduct of rational decision-making and commitment, may be premature, however, if lingering hurts, sadness, and feelings of loss related to the interpersonal injury continue to linger in the hearts of betrayed partners. In these circumstances, partners may pre-maturely forgive without fully resolving their emotional injury to maintain some semblance of attachment. Forgiveness

may require an internal shift to these residues, or else emotional injuries seep into couple interactions, color subsequent moments of conflict, and promote ongoing emotional disconnection.

In summary, current forgiveness-specific couple therapy models do not offer any systematic conceptual and treatment framework for working with emotional responses and in-session interactions related to an injury. The potentially transformational role of emotions in facilitating a forgiveness and reconciliation process is not within the purview of the forgiveness-specific models reviewed herein.

An attachment perspective on forgiveness and reconciliation

In the EFT forgiveness-specific couple model, known as the AIRM, forgiveness and reconciliation unfold mostly on the basis of injured-offending partner emotional processing of the event. Attachment theory informs the EFT clinical model by providing a map into the process of attachment bonding and the ruptures which provoke predictable sequences of negative emotional displays upon separation distress. This body of theory contributes to our understanding of the nature, meaning and intensity of post-injury emotional responses and the process of restoring a frayed attachment bond in the aftermath of an injurious incident.

Attachment theory suggests that we are hard-wired to attach to others and that these attachments profoundly influence how the self and other is defined in close relationships. From the 'cradle to the grave', an innate, attachment system organizes partners' emotional and behavioural expressions to gain proximity to an attachment figure when facing internal or external sources of danger (Bowlby, 1973). Bonds are essentially emotional in nature (Bowlby, 1988). An attachment figure's emotional

accessibility and responsiveness to these cues assuages emotional distress and restores equilibrium, and a felt sense of security. Couple partners co-regulate emotional distress by reciprocally providing support and care during moments of need. Accessibility and responsiveness renders bonds secure and constructs positive models of self (i.e., lovable, worthy of care), and the other (i.e., dependable, reliable and trustworthy). Inaccessibility and non-responsiveness creates insecure attachment bonds and defines either or both the self in negative terms (i.e., self as unlovable and unworthy of care, and the other as undependable, unreliable and untrustworthy) (Bartholomew & Horowitz, 1991.

Given the emotional nature of bonds, attachment theory provides a frame to account for the intense emotional reactions following an interpersonal injury. Aversive interpersonal events, such as betrayals and infidelity, and abandonments during moments of high need, represent serious threats to attachment bonds. The intense emotional reactions in the aftermath of such incidences have been described as similar to traumatic reactions (Abrahms-Spring, 1996; Baucom et al., 2006; Glass & Wright, 1997; Gordon et al., 2005). The basis of the shattered sense of self and other post-injury, however, is not simply based on a loss of control or predictability, or a failure of relationship standards, as suggested by other models (e.g., Gordon et al., 2005). Instead, injured partners' emotional reactions are primarily hard-wired predictable expressions of alarm based on attachment bond ruptures. These injuries can be seen as attachment bond ruptures that are associated with high levels of emotional distress as a result of a partner's sudden and unexpected unavailability (Johnson, 2004). A predictable sequence of emotions is experienced upon separation from an attachment figure (Bowlby, 1973). The serious and intense emotional pain post-injury is best understood on this basis.

Predictable emotional responses include: attachment fears of abandonment and rejection, angry protest to restore proximity, deep hurt, despair, sadness and hopelessness, the anger of despair when unavailability is ongoing, and eventual emotional withdrawal and detachment.

Particular types of emotionally painful attachment bond ruptures have been referred to as attachment injuries, or small 't' relationship traumas (Johnson, 2002). Attachment injuries are relationship traumas which occur when a partner is abandoned or betrayed during a critical moment of need for support and care, or when relational trust is seriously violated (Johnson, 2002; Johnson et al., 2001; Johnson & Whiffen, 1999). The incident leaves an indelible imprint on the relationship and becomes a marker for the other's lack of availability, dependability and trustworthiness (Johnson, 2002). Anger, hurt, hostility, anxiety, and feelings of betrayal, are often cited as post-injury emotional reactions in forgiveness-specific models and forgiveness research with couples (DiBlasio, 2000; DiBlasio & Benda, 2008; Gordon et al., 2005; Leary et al., 1998). Some of these emotional reactions may be infused by primal expressions of separation anxiety, realistic fears of rejection or abandonment. These expressions may also be textured by emotional vulnerability related to the injured partner's isolation, helplessness, sadness and loss in terms of the momentary rupture to the attachment bond.

Attachment theory further provides insight into the self-protective strategies that may shape an injured partner's forgiveness and reconciliation experiences and how he or she will manage their emotions post-injury. Attachment strategies organize partners' emotional experience and relatedness in relation to an injury, and therefore, ultimately

influence the forgiveness experience (Burnette, Davis, Green, Worthington, & Bradfield, 2009; Burnette, Taylor, Worthington, & Forsyth, 2007; Haaken, 2002; Mikulincer, Shaver, & Slav, 2006). Interpersonal injuries provoke intense emotional responses, and thus, self-protective emotion responses to manage attachment fears of the other's accessibility and availability. Securely attached partners are less likely to suffer long-term injuries and are more likely to heal in the aftermath of such injuries. They are more likely to be forgiving and reconcile, given their abilities to regulate emotional distress, view the incident as an isolated event, and process more positive information about partner accessibility and responsiveness post-injury (Mikulincer et al., 2006). Emotional regulation allows for greater empathy and compassion for each other, which facilitates forgiveness (Hill, 2001). The offending partner's accessibility and responsiveness to the injury will allow secure partners to address negative emotional experiences, including attachment fears related to the offending partner's unavailability or inaccessibility. Insecurely attached partners are more likely to be injured and have greater difficulties healing these injuries given their difficulties in managing emotions related to them (Mikulciner et al., 2006).

With anxiously attached partners, attachment system hyperactivation may involve heightened emotional and behavioural expressions that signify deep attachment distress post-injury. Chronic hyperactivation may interfere with a partner's forgiveness experience. Anxiously attached individuals have been found to be excessively angry and ruminative about the injury and their partner's accessibility and availability in their forgiveness process (Burnette et al., 2009; Burnette et al., 2007). They may, however, also be more likely to pre-maturely forgive an offending partner to self-protect against

fears of abandonment, without fully emotionally processing the event and while remaining hyper-vigilant about the offending partner's accessibility and responsiveness to prevent subsequent hurts and fears related to abandonment (Mikulincer et al., 2006). The negative model of self found in anxiously attached individuals, whether reinforced or constructed as a result of the injury, tends to increase self-vulnerability, and feelings of worthlessness, hurt and shame post-injury (Mikulincer et al., 2006). Without processing these negative emotional experiences, these emotional residues maintain attachment anxiety and promote ongoing relational hyper-vigilance and attachment distress.

With avoidant attachment, attachment system deactivation includes dismissal or minimization of emotional experience, which blocks a coherent awareness of the injured partner's attachment hurts and loss and of the offending partner's emotional experience of the incident. Research affirms the injured partner experiences lesser empathy for the offending partner post-injury (Burnette et al., 2009; Burnette et al., 2007; Haaken, 2002; Mikulincer et al., 2006). The negative model of other that is part of avoidant attachment may result in difficulties receiving the offending partner's efforts to make amends and assuage emotional distress. Injured partners that are more avoidant may further have difficulties managing intense negative emotions related to the event and may, therefore, opt to remain detached or withdrawn in an effort to avoid conflict and maintain attachment (Mikulincer et al., 2006). They may assume a rejecting hostile stance toward the offending partner, as moving toward forgiveness would require that they process painful emotions such as hurt and fears of rejection. Protection against self-vulnerability related to the incident, along with a negative model of the other, may provoke strong

hostile reactions toward the offending partner. More rapid relationship deterioration post-injury has been found to be associated with this attachment strategy (Mikulincer et al., 2006).

Attachment theory further suggests that unresolved emotional distress within the context of an attachment bond contributes to insecure attachment bonds. When key attachment emotions, such as loss, are left unprocessed, both partners remain isolated in their emotional distress related to the incident, and remain emotionally disconnected. An injured partner may continue to be internally ambivalent about the partner and the relationship, or increasingly avoidant, if he or she cannot fully process the emotional residues of the injury. Emotional residues of hurt, anger, and attachment fears may result in chronic hyperactivation or deactivation of the attachment system, depending on the partner's habitual manner of emotional regulation in the relationship prior to, or as a result of relationship experiences post-injury. Injured partners may move beyond their anger, hurt, and betrayal once they integrate the deeper fears, sadness, loss, and grief underlying these emotional experiences. An offending partner may apologize and an injured partner may utter the words "I forgive you", but unprocessed emotional residues will continue to influence how both partners will experience self and other.

Finally, attachment theory further provides a map about the process of repair, which involves renewal of the partner as a potentially safe haven through renewed partner emotional accessibility and responsiveness (Johnson, 2004). Creating new attachment-caregiving interactions on this basis is essential to restoring greater emotional safety in the relationship and fostering more secure bonding. Typically, with attachment injuries, the offending partner may have been unavailable and inaccessible

prior to, during, and after the injury. Partner unavailability and inaccessibility is at the root of the current distress, and therefore, is an essential element to be addressed in the process of relational repair. Interactions involving accessibility and responsiveness to attachment-related emotional signals of distress and need are crucial to the forgiveness process. Processing couple partners' disowned emotional experiences and needs in their relationship prior to, during, and in the aftermath of an injury, is critical to the process of repair. This allows for the creation of new emotional signals (e.g., more primary, emotional and need expression) and the fostering of reassuring responsive interactions that have the potential to heal an injury.

Accessing emotions and enacting corrective emotional experiences is crucial to healing injuries, repairing the attachment bond and potentially promoting forgiveness and reconciliation. Emotional engagement pertaining to an injury allows partners to access attachment representations, meanings and needs, which cannot be accessed unless these emotions are explored. Offending partner accessibility and responsiveness to these expressions co-regulates the injured partner's distress. Responsive emotionally engaged interactions may underlie the experiential shift that has been postulated to be pivotal to the forgiveness experience (Rowe & Halling, 1998). Co-regulation of emotional distress through increased partner accessibility and responsiveness seems to incite an experiential shift in the injured partner that may underlie forgiveness, and ultimately restores emotional connection (Haaken, 2002; Scobie & Scobie, 1998) and trust (Rusbult, Hannon, Stocker, & Finkel, 2005), the bases of post-injury reconciliation. If unprocessed, emotions and unmet attachment needs for support and care prior to, at the time of the injury, and post-injury, are the source of ongoing attachment distress.

The key to forgiveness and a 'real' apology requires emotional engagement on the basis of these emotions and needs (Johnson, 2009).

EFT theory and the clinical process of repairing a frayed bond

In recent years, the AIRM has evolved as a clinical forgiveness and reconciliation model within the context of EFT couple therapy (Johnson et al., 2001; Makinen & Johnson, 2006), a clinically efficacious couple therapy (Alexander, Holtzworth-Munroe, & Jameson, 1994; Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Johnson, Hunsley, Greenberg, & Schindler, 1999). The transforming power of corrective emotional experiences in promoting forgiveness and reconciliation in couples beleaguered by interpersonal injuries has recently been investigated (Makinen & Johnson, 2006). In an initial outcome study, 63% of couples successfully resolved an attachment injury, ranging from major betrayals such as infidelity to momentary abandonment, in an average 13 couple therapy sessions. Implementation of the AIRM was associated with greater forgiveness, relational trust and diminished dyadic distress (Makinen & Johnson, 2006). Study authors suggested that lengthier treatment time may have been required to facilitate resolution in non-resolvers, many of whom had experienced multiple attachment injuries throughout the course of their relationship (Makinen & Johnson, 2006). Although the outcome study proceeded on the basis of the AIRM, the AIRM has yet to be placed within the language of EFT clinical theory.

EFT integrates experiential and systemic theory with an attachment-based view of adult romantic love to explain the client change process (Johnson, 2004). Experiential theory is employed to understand the role of emotion in facilitating client change. Primary, attachment-related emotional experiences prime perceptions based on

attachment needs and representations of self and other, and organize adaptive action tendencies in close relationships. Secondary emotional experiences are self-protective, defensive emotional reactions to deeper, more vulnerable emotion responses and negative views of self and other. These responses block access to primary emotional experience and thus impede adaptive self and interpersonal functioning. These expressions must be unpacked to access more primary, vulnerable, attachment-related emotional experiences, and needs for support, care and contact from the other. Accessibility and responsiveness on the basis of these primary emotional expressions is core to creating emotionally safe, loving bonds (Johnson, 2008).

In EFT, systems theory provides a framework to understand how partners' habitual secondary emotional responding and rigid, negative interaction patterns, such as pursue-withdraw, are reciprocally reinforced in the couple system (Johnson, 2004). The disparate, habitual manner of emotional regulation underlying each person's position in a negative relationship cycle is explained by attachment theory. An anxious attachment strategy underlies the pursuer's position and typically involves anxious preoccupation with the other's accessibility. An avoidant attachment strategy organizes a withdrawn partner's emotional responses, including numbing and detachment. These self-protective stances constrict each partner's emotional responses. Attachment fears are heightened when partners are inaccessible and non-responsive. Further emotional disconnection and attachment insecurity is promoted when partners are unable to be accessible and responsive. New positive cycles of engagement are promoted when partners take risks to interact on the basis of attachment-related emotion and need expression and are increasingly emotionally accessible and responsive to such expressions (Johnson, 2004)

The process of change in EFT has been delineated into three separate stages: cycle de-escalation, withdrawer re-engagement, and blamer softening (Johnson, 1996, 2004). In Phase I, de-escalation of couple conflict involves partners gaining experiential awareness of current emotional processing strategies that have contributed to a growing sense of disconnection. Secondary emotional responses, and the self-protective emotional regulation strategies employed in the couple's dance, are unpacked and placed within the context of the cycle. For example, an angry, critical partner is understood as pursuing a withdrawn partner to assuage attachment anxiety related to partner inaccessibility and non-responsiveness. An emotionally withdrawn partner's emotional detachment is framed in attachment terms as a self-protective strategy to diminish conflict and emotional distress, and maintain some semblance of secure attachment to the other partner. These responses reciprocally influence one another contributing to spiraling conflict escalation. At the end of Phase I, partners are aware of their habitual manner of engagement, and begin to access and express more vulnerable primary emotions underlying these positions. However, it is still difficult for partners to fully engage on the basis of these vulnerable emotions.

In Phase II, two critical change events in EFT, withdrawer re-engagement and blamer softening, occur. With these events, the withdrawer first, and then the pursuer, risk more vulnerable emotional expressions and needs, which results in new cycles of engagement that potentially promote more secure bonding (Johnson, 2004). Withdrawn partners become increasingly emotionally accessible and less reliant on their self-protective distancing strategy. The angry, critical, attacking spouses begin to access, express and explore self and attachment related emotions, such as fear, anger, and

sadness related to unmet needs and wants. In Phase III, partners consolidate their gains by processing couple issues in a more emotionally engaged manner.

The AIRM within the context of EFT treatment

Within the broader EFT treatment framework, the timing in which an attachment injury emerges during treatment varies. Attachment injuries may emerge in the context of Phase II of EFT treatment as a source of a therapeutic impasse, a moment in which therapy progress is halted (Millikin, 2000), or surface earlier in therapy as a presenting couple issue and part of the couple's negative interaction cycle. These injuries block partners from moving into a more vulnerable stance, and therefore, impede the growth of partner emotional accessibility and responsiveness. Regardless of the timing, processing of the attachment injury is facilitated by de-escalating couple conflict in the relationship within the usual treatment framework of EFT, prior to embarking upon a forgiveness and reconciliation process.

It is important to complete Phase I of EFT to support partners to gain an experiential awareness of how a cycle prior to, and subsequent to the injury blocked emotional engagement related to the injury. Couple partners' emotional responses, their habitual emotional regulation strategies, are construed as having interfered with emotional processing of emotions and needs in the relationship. Phase I facilitates containment of negative emotional experiences related to the injury as partners recognize how they had been ill-equipped to engage emotionally in a manner that would allow them to heal the injury. The cycle prior to the injury is viewed as having contributed to, maintained, and exacerbated the impact of injuries on the relationship by making it difficult for partners to address the emotional impact of the incident. For

example, a partner's emotional affair with a co-worker may have blossomed in a context in which the cycle blocked emotional connection between partners and thus blocked their capacity to process their growing sense of disconnection. Although the offending partner is held primarily responsible for the injury, the relationship context had placed the partners at greater risk for injuries.

Upon de-escalation, in Phase II, the EFT therapist facilitates significant therapeutic moments of increased emotional engagement, and efforts are made to remove emotional blocks prior to engaging in emotional processing of the injurious incident. Sometimes attachment injuries emerge at this point in therapy. A partner's refusal to risk engaging from a more vulnerable stance is blocked when memories of the attachment injury are activated and trigger a traumatic flashback and intense self-protective secondary emotion responses. This occurrence keeps the injured partner from accessing more vulnerable emotions (Johnson et al., 2001). At this point, the EFT therapist turns to the AIRM as a guide to promote a change event related to the specific injurious incident.

The AIRM, or the forgiveness and reconciliation model in EFT

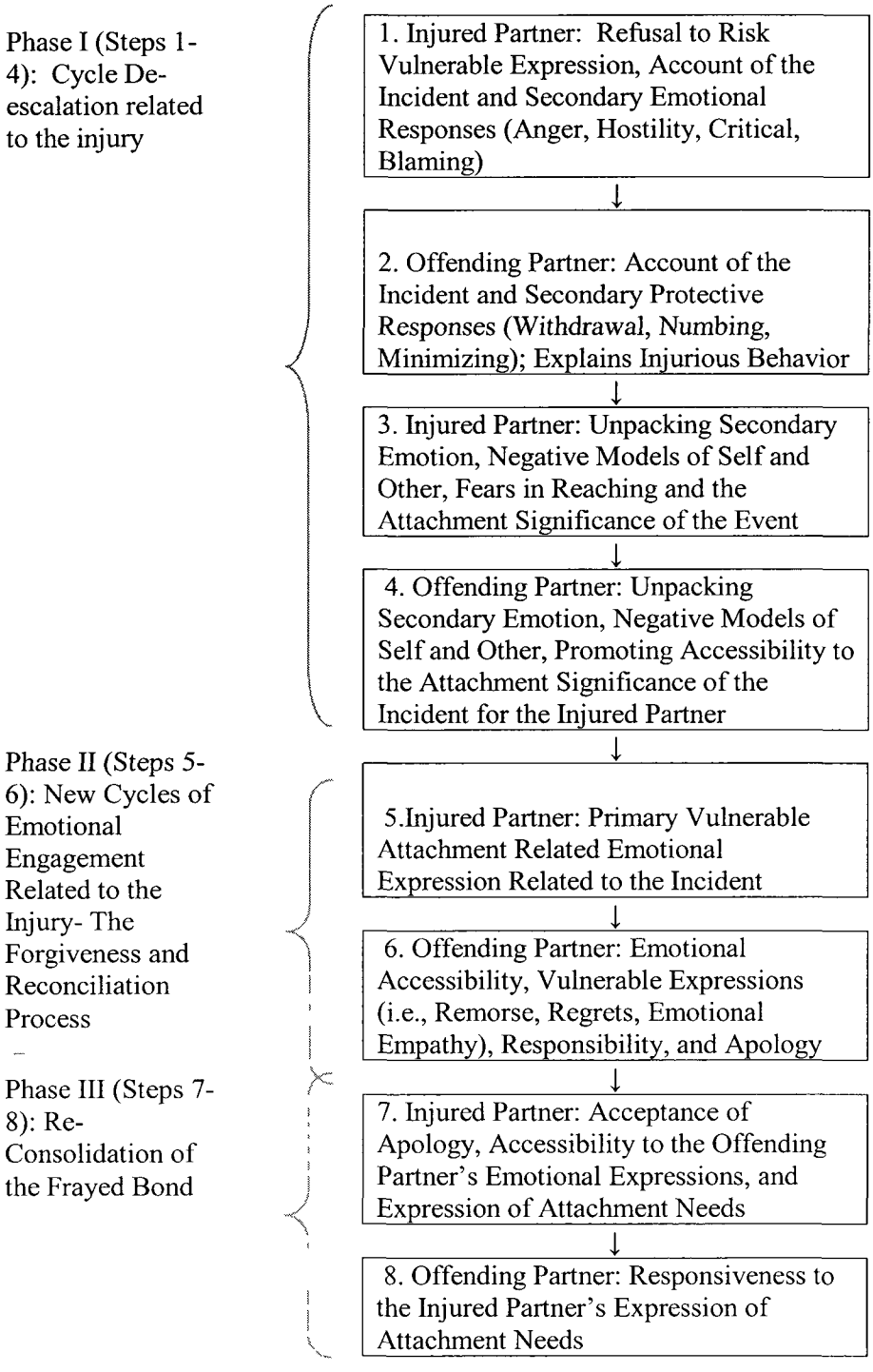
The AIRM mirrors the general clinical process of repair in EFT. Eight steps, sequences of injured and offending partners' in-session performances, are outlined and fall under three change phases: injury cycle de-escalation and new cycles of engagement related to the injury, and re-consolidation of the frayed attachment bond (see Figure 1).

Phase I: Cycle de-escalation related to the injury

Phase I, injury-specific cycle de-escalation, includes steps 1 to 4. Couple partners may oscillate between these steps as they move toward de-escalation. Steps 1

Figure 1

AIRM components: Steps to forgiveness and reconciliation



and 2 involve explicating the rigid, negative interaction cycle (i.e., pursue-withdraw) and the partner secondary emotional responses fueling positions in the injury-specific cycle. In Step 1, the marker for the attachment injury change event, the injured partner may express intense secondary emotion reactions (i.e., anger, hostility) and assume a critical, attacking stance as he or she provides an account of the injurious incident. For example, an injured partner in this study recounts "I had sent her some urls..and I saw an email from him...she said she didn't know him...then I found numerous ones...she lied". In Step 2, the offending partner's account and self-protective responses (i.e., numbing, emotional detachment) represent a minimization of the emotional impact of the event on the self and other and a withdrawn stance. In response to the injured partner's account of the injury, an offending partner is this stage relates to his injured partner, "...you get really upset about all the stuff that's happened almost 2 years ago...I don't understand why you aren't over it." Habitual emotional responses related to the incident reinforce each partner's position in the couple's dance (e.g., pursue-withdraw cycle) related to the injury. Emotional processing of more vulnerable primary attachment-related emotions related to the injury (i.e., attachment fears, sadness, grief, and loss) is impeded and thus underlying attachment distress remains unprocessed.

With Steps 3 and 4, couple partners' secondary emotion responses and associated negative representations of self and other are unpacked, and fears in accessing more vulnerable emotions related to the injury are explored. The EFT therapist places these responses in the context of the injury-specific negative, rigid interaction cycle that blocks emotional processing of the injurious incident. Unable to emotionally process the injury, each partner remains stuck in his or her position in this

cycle reinforcing the impact of the original injury. Secondary responses, such as, rage and guilt, block awareness of underlying attachment-related emotion and limit exploration and processing of the injury. Partners gradually become aware that their manner and level of emotional engagement in dialogues about the injury is preventing closure and healing.

In Step 3, the injured partner's secondary emotional reactions are reframed in terms of their attachment significance. For example, anger is re-framed as an angry protest about the partner's lack of availability when the bond was ruptured. An anxiously attached injured partner's hyper-vigilance, controlling and demanding behaviours post-injury, may be empathically interpreted as flowing from deep fears of abandonment. An avoidant injured partner's hostility, and vengeance motivation, may be understood as desperate self-protection efforts to avoid painful emotions related to rejection. An injured study participant proclaims , "I just feel like I am sticking my neck out and it's going to get chopped off...I would rather be pissed off and cold and say fine I don't need you anyway." More vulnerable expressions related to the injury may be accessed and experienced as the offending partner becomes increasingly accessible in-session.

In step 4, the offending partner's avoidant strategy, which was opted for in an effort to minimize conflict and a negative sense of self (i.e., shame, hurt, feelings of inadequacy, failure, and guilt), begins to dissolve. Awareness that the injured partner's intense emotional reactions signify attachment distress and his or her significance to the injured partner, as opposed to his or her personal inadequacies, diminishes self-protectiveness. Vulnerable expressions are also perceived and responded to in a more

emotionally accessible manner (i.e., expressions of sadness, hurt). Toward the end of step 4, the offending partner integrates previously unarticulated emotions about the incident and provides his or her experience of the incident. For example, an offending partner in the study communicates his or her emotional empathy by remarking "I just felt ignored, so I guess I turned away when he needed me. I was numb, so I didn't hear him". This step represents the withdrawer's renewed accessibility in terms of the emotional processing of the injurious incident.

Moving beyond step 3 and 4 is particularly difficult when the injured partner has experienced repeated injuries involving abandonments and betrayal. Emotional reactions may be more intense, and accessing softer emotions may be seriously impeded by a need for self-protection. Repeated transgressions make the likelihood of resolving an attachment injury and forgiveness less likely (Makinen & Johnson, 2006). An injured partner may also remain perpetually stuck in anger and hurt, while an offending partner obstructs progress through ongoing minimization.

Phase II - New cycles of emotional engagement related to the injury: The forgiveness and reconciliation process

The AIRM is unique among forgiveness-specific couple models in structuring relational client tasks involving emotional engagement related to the injurious incident. Increasing emotional accessibility and responsiveness allows for interpersonal co-regulation of emotion laden attachment distress, and potentially revises negative attachment representations associated with the injury. With steps 5 and 6, both partners risk more vulnerable, primary emotional expressions related to the incident. These steps represent an injury-specific softening event in EFT. The EFT therapist facilitates

partners to express new primary, emotional signals and structures new interactions on the basis of vulnerable expressions. These interactions represent new cycles of engagement related to the injury.

In step 5, the injured partner begins to differentiate and integrate disowned vulnerable emotions (i.e., attachment fears, sadness at loss) experienced in response to the injury. Accessing these emotional experiences represents an initial step in the softening process. The EFT therapist deepens these expressions in the presence of an increasingly accessible offending partner. For example, an injured partner in the AIRM outcome study recounts, "It's like you had died because...like you had gone away...it was silence..a big black, hole...you were stuck in a rut, and I was afraid you would just keep going down... I felt so alone, and abandoned." Expression of primary, emotional signals related to the injury suggests that the injured partner perceives sufficient safety to explore these more vulnerable expressions. This experiential shift represents an initial first step toward forgiveness. A more integrated and complete articulation of the injury can now occur, and the injured partner risks more vulnerable engagement with the offending partner.

In step 6, the withdrawer continues his or her re-engagement when remorse, regret and primary, attachment emotions about the injurious event are accessed and expressed. Emotional empathy for the injured partner's fears, attachment loss, and sadness activates greater openness to emotional experience. From this stance of engagement, an ability to take responsibility for the emotional injury and an offer of an apology often follows. For example, an offending partner remarked "I do feel sad when I see you, when I see you getting upset, and see that you are still upset because of

me,...I feel really sad that you were alone, are alone....I am so sorry...". Remorse, regret and emotional empathy for the injured partner's emotional experiences suggest that the offending partner is now attuned to the injured partner's emotional reality. These responses further support the regulation of the injured partner's attachment distress about the offending partner's availability and accessibility. The injured partner sees that the offending partner feels for his or her pain and that this pain matters to him or her. At the end of this step, the offending partner's expressions of more vulnerable emotions associated with his or her growing sense of disconnection prior, during and in the aftermath of the injury are processed further. These expressions further confirm the significance of the injured partner to the offending partner in a way that is re-assuring to this partner.

Phase III: Re-consolidation of the frayed bond

In steps 7 and 8, in-session couple interactions involving riskier emotional processing of the incident promote a renewal of trust and restoration of an emotional connection. The end of Phase III completes an injury specific softening process and represents the reconciliation phase within the AIRM. In step 7, the injured partner may expressly accept the offending partner's apology, forgive and emotionally empathize with the offending partner's vulnerable expressions about the incident, including attachment fears in losing the injured partner. New cycles of emotional engagement in prior steps creates an emotionally safe context that allows the injured partner to risk asking for comfort and care from the offending partner that was unavailable at the time of, or after the injurious incident. Asking for needs to be met by the offending other represents reconciliation, a restoration of trust and an emotional connection. For

example, an injured partner reaches for an offending partner once more within the context of the relationship when she expresses, "I need you to be available, so that I can actually let down my guard...your reassurances are important to me...that this won't happen ever again...".

In Step 8, increasing offending partner sensitive attunement and responsiveness to the injured partner's softer primary emotion and need expression serves as an antidote to the relationship trauma. Responsiveness to the injured partner's primary, emotional signals and need expression heals the injury and repairs the ruptured bond. An offending partner reaches back to an injured partner by responding "I can reassure you that it won't happen again...and I can reassure you again and again." At the end of this step, the injury-specific softening, a new bonding event related to the injury, has been completed. More positive, benevolent emotions, greater empathy, compassion, and trust for each other evolve upon this completion of the AIRM steps. Renewal of trust and an emotional connection represents reconciliation. Upon completion of the AIRM, EFT treatment continues as per usual with Phase III of EFT. Any outstanding conflicts or attachment injuries are addressed by the couple partners in a new manner of engagement marked by increased emotional accessibility and responsiveness.

Conclusion

Unlike other models that have a more limited view of the role of emotion in promoting forgiveness and reconciliation in couples, the AIRM, the forgiveness and reconciliation model within EFT, offers both injured and offending partner tasks that involve working with emotional experience to resolve interpersonal injuries. The forgiveness and reconciliation model uniquely offers interpersonally-oriented tasks that

involve guided deeper levels of emotional engagement related to the injurious incident. Emotional engagement is necessary to process the emotion residues of such incidents, which if left unprocessed, linger in the emotional worlds of couple partners. Attachment theory provides a conceptual frame to understand the process of relational breakdown and repair in the aftermath of an injurious incident, as well as the predictable emotional sequences underlying couple distress. EFT theory sets out a clinical map of the process of repair of a ruptured bond. Working with emotion is essential to this process. Promoting couple interactions that restore emotional accessibility and responsiveness, such as softening events in EFT, is necessary to revise models of self and other, restore relational trust and a felt sense of emotional connection.

In this article, the AIRM was placed within the broader treatment context and clinical language of EFT. The process of repairing the ruptured bond in the AIRM is akin to a forgiveness and reconciliation process. From an attachment perspective on forgiveness and reconciliation, processing core attachment emotions and needs is central to the repair process of a ruptured attachment bond. The AIRM facilitates interpersonal tasks involving emotional engagement related to the injury for the purpose of restoring an emotional connection. There is a need for empirical investigations that elucidate the transforming power of emotions and corrective emotional experiences in promoting client change that leads to forgiveness. Process psychotherapy research may be employed to substantiate the role of emotion in promoting forgiveness by examining differences in client processes in resolved versus non-resolved partners. From an EFT perspective, without deepened emotional engagement, exploration and integration of hurts, fears and needs in a forgiveness and reconciliation process, the path to secure

bonding in the aftermath of an injury will be extremely difficult, as it is likely to be riddled with the residues of attachment hurts and fears.

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Chapter II (Unpublished Article)

Forgiveness and reconciliation in EFT for couples: The client change process and therapist interventions

Forgiveness and reconciliation in EFT for couples: The client change process and therapist interventions

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Running Head: FORGIVENESS AND RECONILIATION IN EFT FOR COUPLES

Abstract

This article presents psychotherapy process research findings related to the forgiveness and reconciliation model, known as the Attachment Injury Resolution Model (AIRM), within the context of Emotionally Focused therapy for couples (EFT). Audio-tapes of nine resolved and nine non-resolved EFT couple client cases were used to study the client change process, the validity of the AIRM, and EFT interventions used at each stage of the model. Study findings suggest resolved couple clients engaged deeply with their internal experience, were more deliberate and controlled in their processing, and more affiliative in their interpersonal responses in comparison to non-resolved couples. Resolution versus non-resolution client in-session performances were discriminated on the basis of four model components associated with significant shifts from secondary reactive to primary, attachment related emotional processing of the injurious incident and interactions that focus on shaping responsiveness to deeper emotions. Key EFT interventions employed in successful attachment injury resolution are also identified.

Key words: Forgiveness, Reconciliation, Client Change Process, EFT

Interpersonal injuries leave long-lasting emotional wounds that indelibly mark couple relationships. In recent years, several forgiveness-specific clinical models have emerged to address such injuries in couples (Abrahms-Spring, 1996; Baucom, Snyder, & Gordon, 2009; Coleman, 1998; DiBlasio, 1998; 2000; DiBlasio & Benda, 2008; Gordon, Baucom, & Snyder, 2000, 2005; Hargrave & Sells, 1997; Johnson, Makinen & Millikin, 2001; Makinen & Johnson, 2006). Some of these models have been empirically investigated in outcome studies (DiBlasio & Benda, 2008; Gordon, Baucom, & Snyder, 2004; Makinen & Johnson, 2006); however, questions about how couple clients change in therapy as they move toward forgiveness and what type of interventions facilitate such change remain unexplored.

The client change process and interventions employed throughout each stage of the AIRM in EFT has yet to be fully empirically examined. Such investigations may yield research findings that support clinicians in their work of promoting forgiveness and reconciliation in couples beleaguered by interpersonal injuries. The goals of the present psychotherapy process study is to investigate the client change process underlying the AIRM, validate the AIRM model and identify EFT interventions associated with successful resolution of an injury.

Psychotherapy process research in the couple therapy field

Psychotherapy researchers have typically been interested in outcome research, which answers the question "Does a particular therapy work?" by considering whether the therapy produces significant change on outcome measures. Process researchers, on the other hand, ask "Did clients change in the way that is suggested by the model of therapy used?" (Greenberg, 1991). Process research is of increasing interest to couple

and family therapy researchers as it deepens knowledge about how clients are changing in-session as a result of treatment (Greenberg, 1991; Hawley & Geske, 2000; Jacobson & Addis, 1993; Johnson, 2003a,b; Johnson & Lebow, 2000; Pinsof & Wynne, 2000). Clinical model development based on process research that specifies a resolution path for client problems and interventions that facilitate change is most relevant to clinicians in the field (Hawley & Geske, 2000; Johnson, 2003a; Johnson & Lebow, 2000; Pinsof & Wynne, 2000). Such research, therefore, bridges the gap between theory, research and clinical practice in the field of couple therapy (Johnson, 2003a). Within an EFT research context, task analytic research methodology has been employed to both develop and empirically substantiate the AIRM.

AIRM development and task analysis research methodology

The AIRM consists of 8 components or empirically defined performance tasks that must be completed along the attachment injury resolution path. An attachment injury occurs when a partner is betrayed, or is abandoned, and trust is violated at a moment of critical need for support and care (Johnson et al., 2001). The injury is traumatic as the injured partner is left with a sense of helplessness, isolation and intense fears about the other's availability. An indelible imprint is left on the relationship and the incident becomes a barometer of the offending partner's trustworthiness, dependability and reliability (Johnson et al., 2001). Steps to forgiveness and reconciliation are set out within the AIRM to address lingering hurts and anger and heal the frayed bond. Primary attachment-related emotional processing of attachment fears, sadness, and loss related to the injury that ruptured the bond serves as an antidote to the

injury when the offending partner's accessibility and responsiveness to these emotions restores emotional connection and allows for renewal of trust.

The important steps leading to attachment injury resolution were defined and empirically verified using task analytic research methodology over a number of research studies (Johnson et al., 2001; Makinen & Johnson, 2006; Millikin, 2000; Naaman, Pappas, Makinen, Zuccarini, & Johnson, 2005). This methodology has been used to develop and empirically investigate significant change events, or moments of in-session client change, in both EFT individual (Greenberg, 1984; Greenberg & Foerster, 1996) and couple therapy (Bradley & Furrow, 2004, 2007; Greenberg, Ford, Alden, & Johnson, 1993; Johnson & Greenberg, 1988). Within the context of EFT couple research, the effective ingredients of a blamer softening event (Greenberg et al., 1993) and therapist interventions employed during these change events (Bradley & Furrow, 2004, 2007) have also been previously identified using this approach.

Following this methodology, AIRM development began with an initial discovery-oriented step in which the attachment injury resolution map was set out based on clinical theory and experience. A performance diagram consisting of a client marker (i.e., the beginning of the change event), and sequences of injured and offending partner performance tasks, was identified. An iterative process in which a conjectured performance diagram was compared with three actual in-session therapy performances resulted in empirical specification of the client change process (i.e., manner of engagement required for performance task completion at each stage) (Millikin, 2000). Process measures used to empirically specify these tasks included: the Experiencing Scale (ES; Klein et al., 1986) and Structural Analysis of Social Behavior (SASB;

Benjamin et al., 1986). Model stages and therapist foci at each component were then further clarified (Johnson et al., 2001).

In task analysis, model validation strategies involve outcome studies, linking client process to outcome, and comparison of the presence or absence of model components in resolved versus non-resolved cases (Greenberg 1991; Greenberg & Foerster, 1996). An initial outcome study was conducted in which 63% of couples fully resolved an injury in approximately 13 sessions. Significant differences between resolvers and non-resolvers were found on measures of forgiveness, dyadic adjustment, and relational trust (Makinen & Johnson, 2006). In first compared to best sessions, resolved couple clients' were found to deepen their level of experiential involvement on the ES (Klein et al., 1986) and moved toward more affiliative responses on the SASB (Benjamin et al., 1986; Makinen & Johnson, 2006).

The client change process and interventions in EFT for couples

EFT for couples, an empirically validated therapy (Johnson, Hunsley, Greenberg, & Schindler, 1999), places emotion at the clinical forefront as both the target and primary mechanism of client change. Emotion primes perceptions, colors meanings, views of self and other, raises awareness of self and attachment needs, and organizes action tendencies in close relationships. Important shifts in emotional processing from secondary to primary attachment-related emotion are required to precipitate client change. Secondary emotion responses are reactive, self-protective responses, such as anger in response to a partner's inaccessibility. Accessing and integrating primary vulnerable attachment related emotions and needs that underlie secondary expressions is viewed as adaptive in close relationships. These expressions are the basis of coherent

attachment signals to an attachment figure. For example, the emotional signal of sadness provides an important internal and outward cue about a need for contact-comfort and soothing response from a partner.

Systems and attachment theories are employed to understand how secondary reactive emotion responses contribute to maladaptive relationship patterns and attachment insecurity (Johnson, 2004). Secondary emotional responses, such as angry blaming and numbing withdrawal, fuel negative, rigid interaction cycles, such as pursue-withdraw. These responses and interactions are mutually reinforcing since these interactions block partners from more positive emotional engagement on the basis of more primary emotions, and needs. Disparate emotion regulation strategies, anxious preoccupation or avoidance of emotion, underlie each partner's position in the couple's cycle. Anxiously attached partners typically pursue their partners with heighten emotional expressions to solicit proximity (i.e., attention, contact, and comfort). Avoidantly attached partners minimize self and other emotional experience to diminish conflict and thus withdraw to maintain attachment. These responses block awareness of more primary emotions and needs.

Client change occurs in three phases. In Phase I of EFT, or cycle de-escalation, secondary emotion reactions are placed in the context of the cycle and construed as promoting emotional disconnection. In Phase II, two critical change events, withdrawer re-engagement and blamer softening, mark a shift in the partners' emotional processing as partners access and integrate disowned, primary, attachment-related emotion and needs. With blamer-softening, a key change event, the pursuing partner risks primary emotional engagement and attachment need expression asking for care and support. His

or her partner's new ability to show accessibility and responsiveness then brings to an end the rigid, negative interaction cycles that block the open emotional engagement that typifies secure bonds.

In EFT, experiential and systemic interventions are employed to facilitate the client change process. Experiential interventions (i.e., empathic reflections/attunement (R), validation (V), evocative responding (EVOC), heightening (H), empathic conjectures and interpretations (ECI)) are used to facilitate access to, exploration and expansion of primary attachment-related emotions and needs. Systemic interventions (i.e., tracking and reflecting process (TR), reframing partners' experiences/interactions in terms of the pursue/withdraw cycle or in context of attachment emotion and needs (REFR), and restructuring and shaping interactions (RSI)) are used to restructure negative interaction cycles, and facilitate new cycles of deeper emotional engagement that fosters more secure emotional bonding.

In a recent EFT intervention analysis of four softening events, overall EFT interventions identified during these change events included: Evocative Responding (20%), Heightening (16%), Validation (17%), Empathic Conjecture/Interpretation (8%), Reframing (7%), Restructuring Interactions (6%) and others (5%) (Bradley & Furrow, 2004). Experientially-oriented interventions supported the pursuer to access and express vulnerability, such as fear of abandonment and a need for reassurance, while systemic oriented interventions facilitated the creation of new enactments that are characterized by new cycles of engagement involving partner accessibility and responsiveness (Bradley & Furrow, 2004).

The present AIRM process study uniquely links client performance tasks and therapist behaviours at each stage of the model. This research is significant for clinicians since it serves as a guide as to what interventions might work as clients are trying to complete a particular task on the attachment injury resolution path. The therapist focuses on a particular client process at each stage of the model.

Measurement of client change in EFT research

Process measures are employed to measure critical shifts in client's manner of engagement that contribute to successful outcome. In EFT, primary emotions are accessed, explored and expanded to facilitate client change toward more adaptive, integrated emotion and need expression in relationships. This shift involves greater experiential involvement in therapy as clients focus inward on their mean-making process. Client experiential involvement in therapy has been assessed using the ES (Klein et al., 1986). As a client's level of experiential involvement deepens, the client's discourse shifts from superficial and impersonal to more internal self-referenced statements (Klein et al., 1986). The ES has been employed to delineate critical shifts in client engagement during therapy associated with successful therapy outcomes in EFT for couples (Greenberg et al., 1993), and to measure client in-session change that predicts positive psychotherapy outcomes (Johnson & Greenberg, 1998; Makinen & Johnson, 2006).

A client's manner of processing and articulating primary, emotional experience may also be critical to the client change process. The Levels of Client Perceptual Processing (LCPP) (Toukmanian, 1990, 1992; Toukmanian & Gordon, 2004) classifies client discourse from automatic, rigid, and undifferentiated (i.e., quick, pre-reflective,

undiscriminating), to more flexible, differentiated, reflective and integrative (i.e., slow, deliberate) modes of perceptual processing. Client representations are primarily changed through controlled modes of processing that allow a wider range of information (e.g., emotions, thoughts, images) to be integrated. Automatic processing constricts the ability to attend to, differentiate, reflect upon and integrate available information related to client problems (Toukmanian, 1990, 1992; Toukmanian & Gordon, 2004). A more controlled mode of perceptual processing (i.e., differentiated, reflective, integrative) of emotional experience has recently been found to be linked to a reduction in depression symptoms and improved interpersonal functioning in EFT for individuals (Missirlian, Toukmanian, Warwar, & Greenberg, 2005). This measure of client manner of engagement has not been used in the context of EFT couple therapy previously. The present study also provides an answer as to whether accessing, exploring and expanding primary emotion and needs in couple therapy occurs concomitant with a more deliberate, controlled mode of processing internal experience.

Client in-session manner of interpersonal responding, as measured by the SASB (Benjamin et al., 1986), changes as clients become increasingly accessible and responsive to primary emotion and needs in EFT couple therapy (Greenberg et al., 1993; Greenberg & Johnson, 1988; Makinen & Johnson, 2006). EFT couple research suggests that partners typically move from more hostile, unfriendly, to more affiliative interpersonal responses (Greenberg et al., 1993; Greenberg & Johnson, 1988; Makinen & Johnson, 2006). More affiliative responses include 'trusting and relying' and 'comforting and nurturing' client in-session statements.

The AIRM client change process

Emotional processing of attachment-related emotional experience related to an injurious incident is critical in facilitating client change resulting in attachment injury resolution. The offending partner's emotional accessibility and responsiveness to the injured partner's attachment-related emotions (i.e., fears, sadness, loss and hurt) and attachment needs for contact-comfort, support and care related to the incident serves as an antidote to the traumatic injury. Healing of the ruptured attachment bond diminishes attachment distress, including lingering hurts. Figure 2 outlines the three phases, and eight components, injured and offending partner performance tasks, associated with attachment injury resolution.

In Phase I, de-escalation of a negative, rigid injury-specific interaction cycle (i.e., pursue-withdraw) occurs. In Step 1, the change event marker, the injured partner, or the pursuer, speaks of the injury in an emotional, self-protective manner (i.e., hostile, angry, critical, blaming). The offending partner's dismissive responding in Step 2 minimizes the injured partner's emotional pain and impedes deeper, more focused, attachment-related emotional processing of the incident, which is required to repair the ruptured bond. With steps 3 and 4, secondary, more superficial, emotion responses and associated negative views of self and other are unpacked and placed within the context of the cycle. The injured partner's intense emotional reactions and the offending partner's non-responsiveness are reframed in attachment terms. For example, an angry, critical pursuer's behaviour may be reframed as a desperate need for the withdrawer's accessibility.

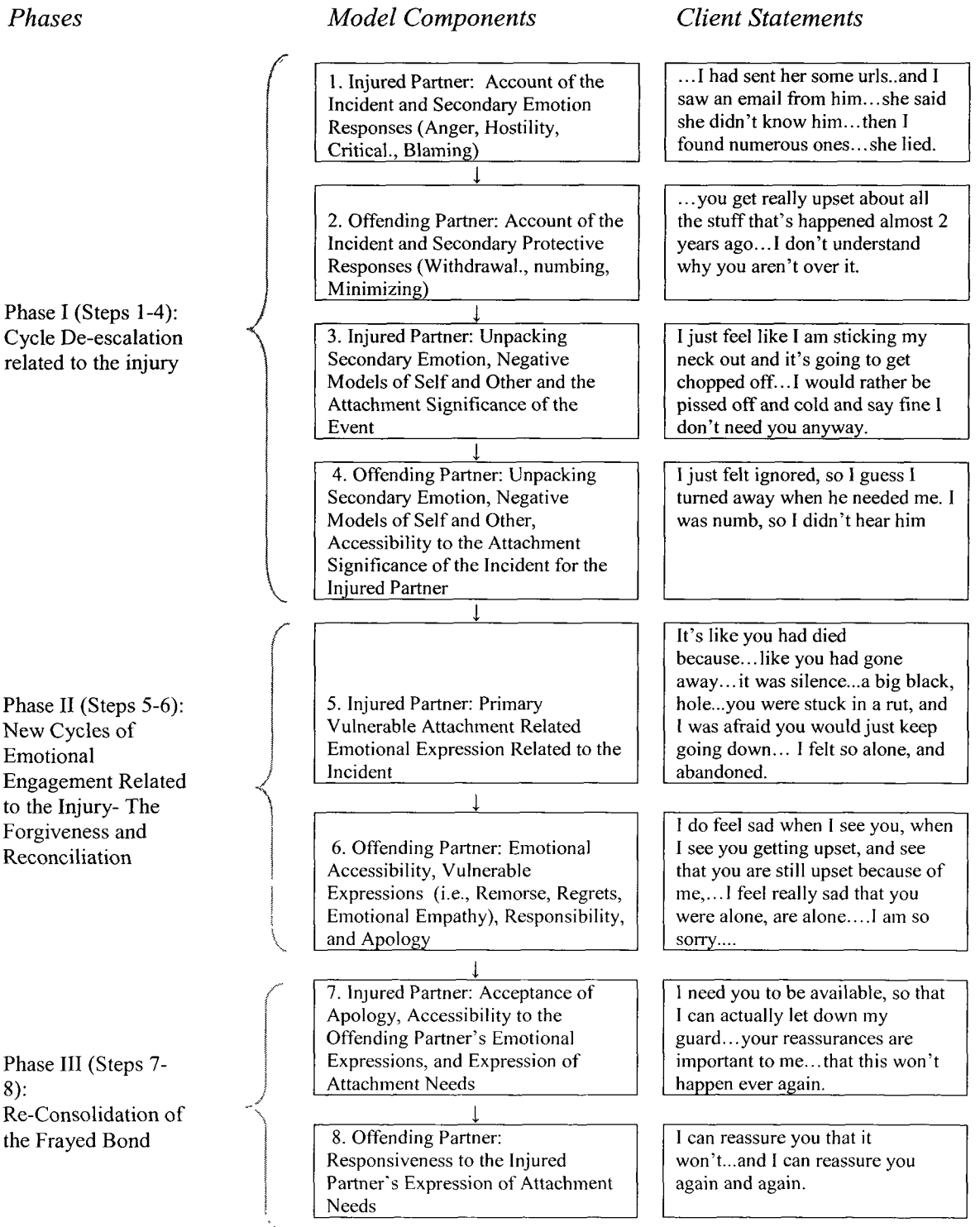
In Phase II, new positive cycles of emotional engagement related to the injury are promoted. An injury-specific blamer softening process begins as the injured partner accesses and integrates disowned attachment-related emotions related to the incident. The essence of the attachment injury is clarified and new signals of hurt and longings are communicated. From an emotionally-engaged stance, the withdrawn partner expresses his or her regrets, remorse, takes responsibility and offers an apology for causing the injured partner emotional pain. He or she also shares sadness and fears about the momentary rupture to the attachment bond. In Phase III of the AIRM, the injured partner risks asserting attachment needs for comfort and support related to the injury. The offending partner's responsiveness now serves as an antidote to the rupture to the bond. Reconciliation, the restoration of trust and an emotional connection, transpires as a result of this change process.

Ongoing AIRM development and empirical substantiation

Further empirical investigation of the AIRM is warranted from a task analytic research approach. Empirical verification and definition of the client change process using process measures remains a significant research task. Different process measures can be used to empirically specify critical shifts in client processing associated with successful resolution in this case. Knowledge of client's manner of engagement as they resolve an attachment injury guides clinical decision-making as to whether client's manner of engagement is sufficient to resolve a performance task. Further model validation strategies are also necessary to verify whether completion of specific performance tasks, or components, of the therapy distinguishes resolved versus non-resolved case; that is, whether they are in fact associated with successful completion of

Figure 2

AIRM process of change



an injury. Finally, the examination of therapist interventions employed to facilitate client change in each component is also beneficial in guiding clinical work at each stage of the model.

AIRM process study: Client change process, model validation and EFT interventions

The present study had three objectives: first, to empirically specify injured and offending partners' manner of in-session engagement as they complete steps in the attachment injury resolution path; second, to empirically validate specific steps in the AIRM, and third, to specify EFT interventions associated with successful attachment injury resolution.

Two sets of hypotheses were generated to address the first two objectives. The first set of hypotheses was established to further delineate and empirically specify client performances associated with successful resolution. Empirical description of AIRM components was delineated using process measures used in previous EFT research, the ES (Klein et al., 1986) and the SASB (Benjamin et al., 1986) and further enriched by the addition of the LCPP (Toukmanian & Gordon, 2004). Critical shifts in client engagement in therapy were expected as clients successfully completed performance tasks. It was hypothesized that as injured and offending couple clients successfully moved through the AIRM steps, they would deepen their experiential involvement in therapy, perceptually process emotion information in a more internally differentiated, reflective and integrated manner, and become more affiliative in their interpersonal responses. This shift in client manner of engagement was expected beginning at stage 5 of the model.

The second set of hypotheses was set out for the purpose of model validation. Validation occurs through empirical verification of whether the presence or absence of model components discriminates successful versus non-successful performances. It was expected that the presence of model components 3, 4, 5, 6, 7, and 8 in resolved cases would discriminate resolved from non-resolved couples. It was assumed that non-resolved cases would remain stuck in steps 1 and 2 of the AIRM. Non-resolved couple clients would remain reactive and have difficulties completing cycle de-escalation of the injury-specific cycle. They would be unable, therefore, to de-escalate their conflict and have access to and engage on the basis of primary emotions and needs in a manner necessary for injury resolution. Non-resolvers would therefore, have difficulties moving into steps 3 and continuing onward past this stage.

Finally, it is assumed that EFT experiential and systemic interventions play a significant role in promoting critical shifts involving deeper, emotional processing of the injurious incident and attachment-caregiving interactions based on accessibility. It was expected that particular EFT interventions would be more frequently used at different stages of the model to support deeper emotional processing and to shift rigid, negative interaction cycles and promote more secure relatedness.

Method

Selection of Couple Cases and Clinical Process Events

Couple cases for this study were selected from audiotapes of an AIRM outcome study in which 24 couples were provided couple therapy sessions ($M = 13$) for the purpose of resolving an attachment injury (Makinen & Johnson, 2006). Fifteen couples

resolved and nine did not resolve their injury. Injury resolution was determined on the basis of: (1) a 10-point score on a couple client self-report measure, the Attachment Injury Measure (Millikin, 2000); (2) the perspective of the therapist; and (3) a clinical judge. Of the 24 injured partners, 19 were women, 5 were men. Most of the couples were Caucasian with the exception of an East Indian couple. One couple was of European descent. All couple partners were heterosexual. The couple partners' ages ranged from 25 to 52 years ($M = 39.8$). Attachment injuries reported varied. They included: actual abandonment (n = 3), perceived abandonment following a miscarriage (n = 2), infidelity (n = 10), flirtation (n = 4), exotic massage (n = 1), internet relationship (n = 1), friendship with opposite sex (n = 1), insulting remark (n = 1), and financial deception/loss (n = 1). Nine of the resolved cases were randomly selected from the 15 available and were selected for the purpose of this study, to enable the comparison of nine resolved cases to nine non-resolved cases.

Process Measures

The ES, SASB and LCPP were employed to empirically measure and define the AIRM components.

Experiencing Scale (ES; Klein et al., 1986): The ES, a 7-point continuous rating scale used to rate in-session therapy talk turns, was employed to assess couple partners' experiential and emotional involvement in therapy. At the lowest levels, clients engage in a detached manner. Level 1 and 2 are marked by impersonal and superficial content. As the scale increases, clients are more self-referential in their experiencing. Level 3 marks the beginning of internal self-referencing when personal reactions related to an event are integrated into the clients' discourse but remain unexplored. Level 4 involves

greater internal experiential descriptions. At higher levels, individuals are processing and exploring feelings and emotions. Level 5 consists of propositions about the self (i.e., feelings and emotions). Level 6 and 7 suggest in-depth exploration of inner experience to direct the self. Peak scores, the highest rating achieved on each transcript of a component, are used for this study.

The scale validity of the ES has been explored in studies in which client variables, introspection and cognitive complexity, were found to be correlated with the ES and to predict client change (Orlinsky & Howard, 1986). Inter-rater reliability coefficients are reported as ranging from .76 to .91 (Klein et al., 1986). A rating – re-rating correlation coefficient of .80 has also been reported (Klein, Mathieu, Gendlin, & Kiesler, 1970).

Structural Analysis of Social Behavior (SASB; Benjamin, 1974, 1986): The SASB, a circumplex model of social interactions, was employed to measure quality of couple client interpersonal responses. Behaviours are represented in terms of three two-dimensional grids, or focus, (1 = self, 2 = other, 3 = introject), consisting of two axes. Interpersonal behaviours are assessed in terms of a horizontal axis representing degrees of affiliation (friendly-unfriendly), and a vertical axis representing degrees of interdependence (autonomous-submissive/controlling). For this study, two grids, or focus, were used (1 = self, 2 = other). For each grid, there are four quadrants (i.e., affiliative, distant, hostile, friendly) and eight clusters (i.e., 1 = assert, separate/free, forget, 2 = disclose, express/affirm, understand, 3 = approach, enjoy/nurture, comfort, 4 = trust, rely/help, protect, 5 = defer, submit/watch, manage, 6 = sulk, appease/belittle, blame, 7 = defend, withdraw/attack, reject, 8 = wall off, avoid/ignore, neglect). Thirty-

six behaviour statements clarify cluster meanings, and therapy talk turns are unitized into segments (i.e., single thought containing noun, verb, object). Raters establish the focus, quadrant and cluster for each segment. Mode scores were used for the purpose of this study.

Factor analysis, circumplex analysis and dimensional ratings have established the validity of the instrument. Kappa coefficients between .70 and .85 have also been achieved in previous studies (Benjamin et al., 1986).

Levels of Client Perceptual Processing Classification System (LCPP; Toukmanian, 1986, 1992; Toukmanian & Gordon, 2004): The LCPP, a seven category coding system, evaluates clients' processing of in-session experience (i.e., analyzing, organizing and conveying thoughts and feelings), as opposed to the content of their discourse (Toukmanian, 1986, 1992; Toukmanian & Gordon, 2004). Seven mutually exclusive categories defining different mental operations are used to rate client discourse: (1) recognition, (2) elaboration, (3) externally focused differentiation, (4) analytic differentiation, (5) internally focused differentiation, (6) re-evaluation, and (7) integration. With Levels 1 and 2, an automated, habitual, undifferentiated, non-reflective manner of processing self or other experience is depicted. Levels 3 and 4 involve a more controlled but restricted mode of processing, as certain domains of experience are processed in client meaning-making. Clients differentiate external aspects of experience or employ external frames of reference to construct meaning. Levels 5, 6, and 7 suggest a controlled mode of processing involving greater differentiation and integration of internal experience associated with self and other meaning structures. More flexible and

adaptive responding at these levels promotes self and other schematic change. Mode scores are used for the purpose of this study.

Inter-rater reliability estimates of the LCPP range from a kappa of .68 to .88 (Biggs, 1995; Day, 1995; Levitt & Angus, 1999; Sinclair, 1990). It has also been shown that the LCPP is sensitive to expected changes in clients' manner of in-therapy processing (i.e., shifts from simple to more complex processing) from early to late therapy in experiential and psychodynamic therapies (Toukmanian & Jackson, 1996; Toukmanian & McKee, 1998; Zink, 1990), and has been associated with symptom reduction (Missirlian et al., 2005).

Emotionally Focused Couple Therapy Coding Scale (EFT-CS; Bradley, 2004; Bradley & Furrow, 2004). The EFT-CS was employed to identify therapist interventions used within each of the AIRM components. The scale has been devised to code EFT interventions used in EFT couple therapy. The scale consists of various codes that represent both experiential and systemic interventions in EFT. Bradley and Furrow (2004) report kappa coefficients of .83 to .92 using the EFT-CS and construct validity when correlated with the Classification System for Counselling Responses. *Procedure*

Transcript segment selection for rating: The researcher, who had previous training and experience with study process measures and the attachment injury model, was initially blind as to whether couples were resolved or non-resolved. All AIRM outcome study audio tapes were listened to by the researcher to identify components until no components could be found, and until no more sessions were available. Once a component was identified on the audio-tape, a boundary, consisting of four minute segments, was set for transcription. Transcribed therapy talk turns representing model

components were identified and reviewed by an EFT expert clinician. The researcher and EFT expert clinician had to agree that the selected dialogue sequences were representative of a model component to be included in the study. Transcribed segments of components were then given to independent process measure raters in random order for rating.

Raters and reliability: Three clinical psychology graduate students were trained using process measure training manuals and standardized training procedures to rate psychotherapy talk turns (ES-Klein et al., 1986; SASB-Benjamin, 1981; LCPP-Toukmanian & Gordon, 2004). Raters were trained using practice segments and discussions of ratings, until satisfactory reliability was achieved (i.e., kappa coefficient ≥ 0.70 for LCPP and SASB, and intra-class correlation coefficient ≥ 0.80 for ES). Talk turns were segmented according to unitizing rules set out in manuals for each measure. Peak scores were used for the ES, whereas modal ratings were used for the LCPP and SASB. Two of the three trained raters were assigned to each measure and asked to provide ratings.

Two clinical graduate students trained in the practice of EFT were selected and trained to use the EFT-CS on sample transcripts until a kappa coefficient greater than, or equal to .70 was obtained. All therapist talk turns within each component were coded.

Results

Inter-rater reliability coefficients exceeding acceptable standards were established for all three process measures and the EFT intervention coding scale. An intraclass correlation coefficient of 0.82 was achieved for the ES. A kappa coefficient of 0.72, 0.73 and 0.78 was achieved for the LCPP, and the SASB cluster and quadrant

ratings, respectively. Inter-rater reliability by virtue of a kappa coefficient of .83 was established using the EFT-CS.

Table 1 provides an overview of component ratings in terms of empirical criterion, and presence or absence of component, in resolved versus unresolved cases. As predicted, during earlier stages of the AIRM (steps 1-4), cycle de-escalation of the injury-specific cycle, each couple partner's manner of engagement involves lower levels of experiential involvement, automatic modes of perceptual processing, and non-affiliative responding as partners remain stuck in an injury-specific, rigid, interaction cycle fueled by secondary emotion responses. From Phase 1 to Phase II of the AIRM, there is a critical shift in clients' manner of engagement at step 5 for resolved partners.

With Phase II, increasing injured partner emotional accessibility is reflected in the injured partner's softer stance in relation to the injury. This softer stance is captured by process measures in terms of deeper experiential involvement, a more reflective, differentiating and integrating mode of perceptual processing, and more affiliative responding. Partner responsiveness is also marked by a similar manner of engagement. Partners who were unable to resolve an injury, however, could not engage in such a way as to facilitate the completion of performance tasks in Phase II. In Phase II, in which new cycles of engagement related to the injury are created, only resolvers were able to complete steps 5 and 6.

Optimal client in-session process associated with injury resolution involves a deepening of emotional involvement, more controlled and deliberate modes of perceptual processing, and more affiliative responding as clients proceed through the steps to forgiveness and reconciliation. This client manner of engagement coincides with

Table 1

Occurrence of Components in Resolved and Unresolved Events

Empirical Criterion	Presence or Absence of Component	Resolved	Unresolved	*p*
ES = Level 3; SASB 1-6, 1-7; LCPP ≤ Level 2	Component 1			1.00
	Present	8	9	
	Absent	1	0	
ES = Level 2; SASB 1-8, 2-7, 2-8; LCPP ≤ Level 2	Component 2			.47
	Present	7	9	
	Absent	2	0	
ES = Level 3; SASB 1-6, 1-7, 2-1; LCPP ≥ Level 3 ≤ 4	Component 3			.08
	Present	9	5	
	Absent	0	4	
ES ≤ Level 3; SASB 2-7, 2-8; LCPP ≥ Level 3 ≤ 4	Component 4			.13
	Present	8	4	
	Absent	1	5	
ES ≥ Level 4; SASB = 2-2; LCPP≥ 5	Component 5			.00*
	Present	9	1	
	Absent	0	8	
ES ≥ Level 4; SASB = 1-2, 2-2; LCPP≥ 5	Component 6			.00*
	Present	9	0	
	Absent	0	9	
ES ≥ Level 5; SASB = 1-2, 2-1, 2-2, 2-4; LCPP≥ 5	Component 7			.00*
	Present	7	0	
	Absent	2	9	
ES ≥ Level 5; SASB = 1-2, 1-3, 2-2; LCPP≥ 5	Component 8			.00*
	Present	7	0	
	Absent	2	9	

* $p < .05$

Note. ES = Experiencing Scale (1 = refusal to participate, 2 = behavioural/intellectual self-descriptions, 3 = personal reactions with limited self-descriptions, 4 = description of feelings and personal experiences, 5 = problems or propositions about feelings and personal experiences, 6 = felt sense of an inner referent, 7 = series of felt senses connecting the content); LCPP = Levels of Perceptual Processing Classification System (1 = recognition, 2 = elaboration, 3 = externally focused differentiation, 4 = analytic differentiation, 5 = internally focused differentiation, 6 = re-evaluation, 7 = integration); SASB = Structural Analysis of Social Behaviour (Quadrant 1 or 4 - 1-2 affirming and understanding, 1-3 nurturing and comforting, 2-1 asserting, 2-2 disclosing and expressing, 2-4 trusting and relying; Quadrant 2 or 3 - 1-6 belittling and blaming, 1-7 attacking and rejecting, 1-8 ignoring and neglecting, 2-7 protesting and withdrawing, 2-8 walling off and avoiding).

relationship partners differentiating and integrating primary, attachment-related emotions and needs and engaging on this basis. In Phase III, consolidation of the bond, with steps 6 and 7, resolved couple partners continue to be experientially and emotionally involved in therapy, internally focused, re-evaluative and integrative in their construal of experience related to the incident. Trusting and relying interpersonal responses emerge as the injured partner shares attachment needs and the offending partner responds to these expressions.

In terms of hypotheses concerning model validation, using Fisher's exact test, resolved and non-resolved groups were found to be significantly different ($p < .01$) in terms of the presence of components 5, 6, 7, and 8. As expected, the first two components were present in both resolved and unresolved cases. Components 3 and 4 did not discriminate resolved and non-resolved cases as predicted, which suggests some of the non-resolved partners were able to de-escalate their injury specific rigid, interaction cycle momentarily.

Frequency percentages of interventions employed at each component of the AIRM were compiled. Table 2 presents interventions most frequently identified by EFT-CS raters at each component. A decision was made to identify the most frequently used interventions, and thus those interventions that fell below a frequency percentage of 10% were not included. Listing the most frequently used interventions facilitates clinical decision-making in terms of intervention options.In Phase I of the AIRM, EFT therapists used interventions commonly used in cycle de-escalation in traditional EFT treatment. In step 1 and 2 in this study, secondary emotion reactions were reflected, emotional realities validated, and the defensive cycle tracked and reflected. The EFT therapist used

a wide variety of interventions to unpack secondary emotion reactions and fears of processing more vulnerable emotions in steps 3 and 4 of the AIRM. Secondary reactions were reframed to help the injured partner to understand his or her attachment needs and concerns related to the injury. Empathic conjecture and interpretations about partners' emotional experience were also employed to facilitate partners' accessing of underlying emotional signals of distress related to attachment fears, loss and sadness associated with the incident. Evocative responding and heightening interventions were opted for to access primary emotion and needs underlying each partner's position in the injury-specific cycle. Newly experienced primary emotional responses were reflected, and validated, but not fully explored until step 5.

In Phase II and III of the AIRM, EFT therapists used interventions commonly used in promoting a softening change event in traditional EFT treatment. With step 5 in this study, the therapist turned his or her focus toward processing the injured partner's primary emotional experience related to the injury. Here evocative responding and heightening interventions were employed to deepen experiential involvement and exploration of attachment-related emotion. Restructuring and shaping interactions were used to promote engagement on the basis of these expressions. Offending partners were supported to engage and reach out to the injured partner in an emotionally engaged manner in step 6. Primary emotion expressions (i.e., regret, remorse) were often reflected. Evocative responding and heightening interventions were employed to support the offending partner to access these emotional experiences. Restructuring and shaping interactions were used to invite the offending partner to interact with the injured partner

Table 2

EFT Therapist Focus and Percentage Frequencies of EFT Interventions

AIRM component	*Therapist focus*	*EFT intervention*
Component 1	Processing Injured Partner's Account	RSE (31%), V(36%), TR (20%), Other (13%)
Component 2	Processing Offending Partner's Response and Account	RSE (29%), V(40%), TR (24%), Other (7%)
Component 3	Unpacking Injured Partner's Secondary Emotion Reactions and Accessing Attachment Significance of the Injury	REFR (11%), ECI (14%), EVOC (27%), H (14%), V (15%), RUE (10%), Other (9%)
Component 4	Unpacking Secondary Emotion Reactions and Promoting Withdrawer's Accessibility to the Attachment Significance of the Event for the Injured Partner	REFR (13%), ECI (13%), EVOC (28%), H (16%), V (15%), RUE (11%), Other (4%)
Component 5	Processing Injured Partner's Primary Attachment-Related Emotional experience and Expression to the Offending Partner	RUE (28%), EVOC (24%), H (24%), RSI (16%), Other (8%)
Component 6	Processing Offending Partner's Primary Emotional Responses (i e , sadness, remorse, regrets, emotional empathy for injured partner) and Promoting Offender's Expression of Responsibility and Apology	RUE (24%), EVOC (26%), H (24%), RSI (18%), Other (8%)
Component 7	Processing Injured Partner's Accessibility and Responsiveness (i e , acceptance of apology, empathy for offending partner's emotional experience) and Expression of Attachment Needs Related to the Injury	RUE (40%), RSI (38%), V (13%) Other (9 %)
Component 8	Processing Offending Partner's Responsiveness to the Injured Partner s Expression of Need	RUE (42%), RSI (42%), V (12%), Other (6%)

Note Experiential interventions (RSE=empathic reflection of secondary emotion reactions, RUE=empathic reflection of underlying attachment-related emotions, V=validation of client emotional realities, EVOC=evocative responding, H=heightening, ECI=empathic conjecture, interpretation, inferences), systemic interventions (TR=track and reflect, REFR=reframing in the context of the cycle and/or underlying attachment emotion and needs, RSI=restructuring and shaping interactions)

on the basis of these emotional experiences. Present and changing positions were also heightened as partners enter into new cycles of engagement related to the injury. The EFT therapist further supported the offending partner to express responsibility, and invited the offending partner to offer some type of response to the injured partner, including an apology.

In step 7 of this study, the injured partner expressed empathy for the offending partner, asserted attachment needs related to the injury and within the relationship in the aftermath of the injury. The EFT therapist continued to focus on reflecting and heightening primary vulnerable emotions to facilitate expression of attachment needs. Restructuring and shaping interventions were used to create enactments based on deeper emotional expressions and needs. New positions in the cycle were also heightened as partners engage in attachment interactions based on emotional accessibility and responsiveness. With step 8, the offending partner responds to the expression of need and was guided to interact in an affiliative manner with the injured partner through restructuring and shaping interventions.

Discussion

Process of Forgiveness and Reconciliation

The steps of the AIRM were validated in this psychotherapy process study. The active ingredients of therapy presumed by EFT and attachment theory are the injury softening process that occurs in steps 5 through 8. Successful clients completed the process steps in the expected manner. The injury specific softening process involves emotional processing of attachment-related emotion and needs for care and support and offending partner responsiveness to these core signals. This process facilitates emotional

accessibility and responsiveness, which is crucial to restore the offending partner as a potential safe haven and to revise attachment representations of the wounded partner and the relationship (Davila, Karney, &Bradbury, 1999; Johnson, 2008). In attachment theory, these interactions are believed to be the building blocks of more secure attachment bonds (Bowlby, 1988). Resolved partners responsiveness to the injured partner's emotional pain and attachment distress appears to serve as an antidote to the rupture in the bond. These new cycles of emotional engagement related to the incident promoted greater trust, dyadic adjustment and forgiveness in resolved partners (Makinen & Johnson, 2006).

In this study, resolved partners were able to complete the empirically defined performance tasks involved in this injury specific softening process in steps 5 through 8. Process measures captured the critical shifts in clients' manner of engagement that was required to complete this process. Process research findings affirm the presumed effective ingredients in EFT couple therapy. By completing an injury-specific softening process, partners are able to expand constricted emotional responses and rigid interaction cycles and create new patterns of interpersonal responding. In steps 5 to 8, partners processed primary emotions related to an injurious incident in a highly emotionally involved (ES: Klein et al., 1986), reflective, differentiating, integrating (LCPP: Toukmanian & Gordon, 2006), and affiliative (SASB: Benjamin et al., 1986) manner. Increased experiential involvement and more affiliative responding are critical shifts in client engagement that have been associated with a softening process and successful positive outcomes, including marital satisfaction, in previous EFT research (Greenberg et al., 1993; Johnson & Greenberg, 1993). Forgiveness and reconciliation

was clearly associated with completion of an injury specific softening process. Resolved partners were able to express and interact on the basis of core emotional signals related to the injurious incident in manner that promoted forgiveness and reconciliation.

Non-resolved partners were unable to engage in therapy in a manner that enabled them to complete the performance tasks required for injury resolution. The active ingredients associated with client change were not found in these cases. Contrary to study hypotheses that assumed that de-escalation would not occur (i.e., steps 3 and 4 would not be completed in non-resolved partners), some unresolved partners were able to de-escalate their injury-specific cycle. They were able to gain awareness of the impact of the cycle on each other's responses, but were unable to move through to step 5, the beginning of the injury specific softening process. Instead, they moved back into their injury-specific negative, rigid interaction cycle fuelled by secondary emotional responding. Unresolved couple partners' manner of engagement was mostly emotionally detached and reactive as measured by the ES (Klein et al., 1986). They processed external information about the incident in an automatic, habitual mode of processing (LCPP: Toukmanian & Gordon, 2004), and interpersonal responses were non-affiliative (SASB: Benjamin et al., 1986). They were unable to engage in a manner that would allow them to expand their constricted secondary reactive emotional responses and enact new more open responses on the basis of more vulnerable emotional experience. The primary emotional engagement required for resolution was impeded and the injury remained unresolved.

In the AIRM outcome study, many non-resolvers were found to have multiple attachment injuries (Makinen & Johnson, 2006). More sessions may have been required

to resolve injuries in these cases. Typically, these clients had lower levels of trust at study onset and would require longer treatment. Multiple injuries may have also impeded the injury-specific softening process. Repeated transgressions may have contributed to the injured partner's fears in processing more vulnerable primary, attachment related emotions. Transgressors who repeatedly injure their partners may also been unable to become emotionally accessible. Low experiential involvement and an automatic mode of processing promote a more rigid manner of construing experience about the incident and so block access to, exploration and expansion of primary emotional signals. As such, critical shifts in client's manner of engagement required to complete performance tasks could not be achieved.

Current forgiveness-specific couple models do not appear to promote attachment-caregiving interactions involving emotional accessibility and responsiveness (Baucom, Gordon, Snyder, Atkins, & Christensen, 2006; DiBlasio, 1998, 2000; DiBlasio & Benda, 2008; Gordon et al., 2005; Hargrave & Sells, 1997). This study affirms the significance of these types of interactions as the active ingredients underlying client change that promoted forgiveness and reconciliation in resolved couples. Forgiveness and reconciliation require that injured partners experience an internal experiential shift toward the offending partner (Enright & Coyle, 1998). An injury specific softening process promoted such a shift in resolved partners. Without these interactions, couples are vulnerable to ongoing attachment distress when lingering unprocessed hurts and fears continue to seep into the relationship. With the AIRM, deep, emotional experiencing and confiding leading to congruent apologies focused on the injurious incident is the primary means by which the injured partner's emotional pain related to

the ruptured bond is healed. Without this engagement, emotional regulation strategies, such as anxious protest and blaming, or numbed avoidance, may continue to be opted for as a self-protective strategy to manage these emotional residues. Attachment oriented responsive interactions further promoted reconciliation, a restoration of an emotional connection (Rusbult, Hannon, Stocker, & Finkel, 2005) and relational trust (Haaken, 2002; Scobie & Scobie, 1998).

AIRM EFT Interventions

Process research was employed to link therapist foci at each step of the AIRM to EFT interventions. EFT experiential interventions support internal experiential searching, and help injured and offending partners to reflect upon, differentiate and integrate attachment-related emotional experience and needs. EFT systemic interventions allow partners to reflect upon emotional experience within the context of couple interactions. These interactions were also employed to restructure attachment interactions and bring partner's attention to new cycles of engagement based on primary emotion and need. Identifying clinical interventions associated with successful task resolution supports clinicians in promoting forgiveness and reconciliation in couples beleaguered by an attachment injury. This study suggests that EFT can be implemented in a systematic manner by linking client performance tasks with therapist interventions in the steps to forgiveness and reconciliation. Linking client process and therapist interventions in process research provides a systematic blueprint for clinicians to resolve cognitive-affective problems, such as an attachment injury (Hawley & Geske, 2000; Johnson, 2003a; Johnson & Lebow, 2000; Pinsof & Wynne, 2000).

Interventions used to initiate and complete the injury-specific softening process were similar to those found in Bradley & Furrow (2004). Prior to entering into the softening process, in steps 3 and 4, the EFT therapist employed a wider range of interventions to de-escalate the injury specific cycle and support partners to begin to access more primary vulnerable emotions related to the incident. Reflection of primary emotion, evocative responding and heightening were employed to initiate and enter into the injury-specific softening process in step 5 onward. These interventions may facilitate attentional allocation to deeper emotions while promoting a more controlled mode of processing key elements of primary emotional signals, including attachment needs. Restructuring interactions were used to facilitate new cycles of engagement involving primary, emotional responses. New emerging positions in the couples interactions were also heightened. In steps 7 and 8, partners were invited to interact at a primary emotional level and respond to attachment needs and concerns about the injury. Primary underlying attachment-related emotion and need was reflected and interactions structured so that needs are expressed in such a way as to elicit responsiveness. These interventions promoted new cycles of positive engagement and facilitated completion of the injury-specific softening.

General Discussion

A systematic clinical blueprint to resolve attachment injuries is set out in this process study. EFT and attachment theory suggest new attachment focused interactions that involve the sharing of softer primary emotions are crucial to heal these injuries. The injury-specific softening process in steps 5 to 8 captures the process of change that leads to forgiveness and reconciliation. Therapist interventions that facilitate these change

events and help resolved couples to complete performance tasks are identified. As such, research findings in this study supports EFT therapist training by setting out the client change process and the interventions that seem to facilitate this process.

Process research findings in this study may further expand current knowledge about the softening process and how this process contributes to attachment security in resolved clients. A controlled mode of processing primary, attachment-related emotions during the injury-specific softening process may facilitate a more deliberate, focused exploration of primary inner emotional experience and needs that may then facilitate self and other schematic change (Toukmanian, 1992; Toukmanian & Gordon, 2004). This manner of emotional processing may support deeper exploration of core attachment-related emotional signals that are adaptive in close relationships and promote greater security. Recent research suggests that primary emotional processing and controlled modes of processing are associated with positive EFT therapy outcomes and reduced depression symptoms (Missirlian et al., 2005).

Process research findings in this study contributes to an understanding of how clients engage in-session when they are insecurely attached and when an injury has taken place and remains unhealed. Together, the ES (Klein et al., 1986), the LCPP (Toukmanian & Gordon, 2004) and SASB (Benjamin et al., 1986). Steps 1 through 4 are associated with attempting to reduce secondary reactive processing and client self-protectiveness, anxious pre-occupation and emotional avoidance related to the injury. When clients were self-protective, they showed lower experiential involvement, were habitually processing information about the injurious incident in an externally focused manner, and were non-affiliative in their responses. Theoretically, insecure attachment

resulting from a number of attachment injuries may impede access, and exploration of internal experience that involves high degrees of self-vulnerability. Internal exploration may require sufficient emotional safety so that the injured partner can turn his or her attention away from the source of danger (i.e., the partner's unavailability and inappropriate behaviors) and inward toward core adaptive attachment-related emotional signals. In a successful injury specific softening process, an EFT therapist is able to create emotional safety between partners and guides an injured client to tolerate and deepen their experience of an injury.

Process research findings further suggest that clients who initiated and completed an injury specific softening process were engaging in-session in a manner associated with attachment security (Kobak & Cole, 1991; Main, 1991; Mikulincer, 1997; Neumann & Tress, 2007). A shift from secondary reactive to deeper emotional processing of the incident requires a broadening of information processing beyond the injured and offending partners' rigid construal of the incident. Clients who completed steps 5 through 8 became increasingly flexible in their processing of a wide range of internal information, particularly attachment emotions and needs. In this study, increased cognitive flexibility during this process was captured by the LCPP (Toukmanian & Gordon, 2004). Attachment security has been associated with cognitive flexibility (Main, 1991), a greater ability to attend to and integrate new information, and with greater empathy (Kobak & Cole, 1991; Mikulincer, 1997). Finally, the more affiliative responding captured in the latter steps of the softening process suggest that resolved partners became increasingly nurturing, comforting, trusting and relying as measured by the SASB (Benjamin et al., 1986). These types of interpersonal responses

on the SASB have also been associated with greater attachment security (Neumann & Tress, 2007).

Limitations and next steps

This process study has several limitations. By virtue of the intensive and lengthy nature of task analysis, smaller sample sizes are typically used. Smaller sample sizes yield possible difficulties with under-representation of particular types of injury events. Any nuances in the process of change between different types of attachment injuries were not noted in this study, but this warrants further investigation. In therapy, EFT therapists often returned to various performance tasks to support resolution. A therapist may have repeated a particular task numerous times before clients engaged in a manner that suggested they resolved the task. The therapist's perseverance in re-focusing clients to complete a task may have been a significant factor in completion of a performance task. Where there were multiple transgressions, a therapist's perseverance would have been particularly warranted. Therapists of non-resolvers may have lacked such perseverance. There may also be additional components that were overlooked in reviewing audiotapes. This may have affected how often the therapist had to re-focus therapy sessions on negative models and secondary emotion reactions that may have been steeped in earlier self and attachment experience.

The external validity of these findings is limited on the basis that most study couples were Caucasian and heterosexual, and most injured partners were female (79%). Gender and attachment seem to interact so that women's positive models of self and other and men's positive model's of self seem to predict forgiveness (Kachadourian, Fincham, & Davila, 2005). These gender differences suggest that the process of change

may be slightly altered as a result of social identity differences. The psychotherapy change process may also differ on the basis of whether stable, long-term negative models of self and other were reinforced by the attachment injury as opposed to formed only on the basis of the specific injury addressed in the outcome study sessions and in this process study. Finally, examining patterns of change related to specific injuries may elucidate some differences in the change process.

Finally, the client change process outlined in this study warrants further investigation. From a task analytic methodology, further studies may be warranted to continue to empirically define performance tasks using other process measures. Further review of audio tapes of couple therapy sessions may uncover further components in the resolution path. Investigating non-resolved cases in terms of in-session therapist behaviours that may have contributed to difficulties in performance task completion is also an important next step in EFT research. Further research into the AIRM from a task analytic research paradigm could be also be conducted to continue to empirically delineate potentially different components and resolution paths with diverse populations (e.g., gender, race, gays and lesbians), and to explore whether anxiously attached versus avoidantly attached couple partners show variations in their process.

Study findings related to EFT interventions are also limited. Findings highlight frequency of use of interventions within each category across numerous cases. Other interventions used in EFT were used to support the resolution of an attachment injury and to support client change; however, the infrequency of these interventions means they were not included. For example, self-disclosures, or disquisitions were also used in some cases. Also, between cases, therapists used interventions in different frequencies to

engage clients in a manner that would lead to performance task resolution. The interventions identified can still, however, provide a systematic framework for clinical training. Finally, interventions within a component cannot be said to be the cause of processing shifts, but appears to facilitate a particular manner of processing that promotes resolution of the task at hand.

Conclusion

Couple partners beleaguered by an attachment injury often experience intense emotional reactions that are not easily relinquished. Supporting partners to engage emotionally on the basis of the anger and hurts in the aftermath of injurious incidents is essential in resolving the deep emotional pain associated with ruptures to the attachment bond. EFT appears to promote partner accessibility and responsiveness to deeper emotions and needs related to injurious incidents. An injury softening process within the AIRM is essential to healing these painful emotional injuries and moving couples toward forgiveness and reconciliation. Interventions that facilitate deepening of emotional experience and processing of core emotional signals, including attachment needs, were also identified and provide a guide to healing these injuries.

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General Discussion

The role of emotions and how to work with emotions has largely been ignored in the forgiveness literature, as has the attachment implications of interpersonal injuries. EFT and attachment theory provide a frame to understand the intense, emotion reactions in the aftermath of interpersonal injuries in close, adult relationships. In the first article of this dissertation, the significant transforming role of emotions and corrective emotional experiences in promoting forgiveness and reconciliation in couples was explicated. Deepening partner emotional engagement on the basis of attachment-related emotions appears to be particularly significant to healing interpersonal injuries, known as attachment injuries.

Consistent with attachment and EFT theory, in Article 1 it was suggested that creating attachment-caregiving interactions involving partner emotional accessibility and offending partner responsiveness is crucial to healing these injuries. With the AIRM, these attachment focused interactions are facilitated in an injury-specific softening process in steps 5 through 8. Without new levels of partner accessibility and responsiveness, injured couple partners may continue to be self-protective in their engagement about an injurious incident. Continual disconnection and unresolved hurt contributes to an ongoing lack of emotional safety and relational distrust. Offending partner accessibility and responsiveness to an injured partner's attachment-related emotions and needs for care and support is an antidote to the traumatic wounding that has ruptured the bond and rendered this partner untrustworthy (Johnson et al., 2001).

In the EFT forgiveness and reconciliation model facilitating the injured and offending partners' deeper, emotional processing of the injurious incident is a significant

component of therapy that is presumed to facilitate client change toward forgiveness and reconciliation. AIRM outcome and process research suggests that attachment injuries associated with an inability to trust and rely on a partner may be best healed by a corrective emotional experience of deeper, emotional engagement and increased understanding of these injuries in terms of attachment fears and needs. This fosters the same open 'softening' dialogues with more accessible and responsive partners that are the royal route to forgiveness and reconciliation and to the creation of more secure bonds between partners.

In Article 2, psychotherapy process research findings substantiate that softening types of interactions related to a significant emotional injury distinguish whether couples are able to resolve an injury. Study findings suggest that resolved injured and offending partners completed an injury-specific softening event in steps 5 through 8. Interventions that facilitated this softening change event mirrored interventions commonly used in Phase II change events in traditional EFT treatment (Johnson, 2004; Bradley & Furrow, 2004). The study also outlined interventions that were used during the injury-specific softening. Reflections, reframing, heightening, and evocative responding seem to facilitate a deepening and more deliberate processing of injurious events. These interventions may be crucial to facilitate the client manner of engagement that is associated with successful completion of AIRM performance tasks.

Process findings in Article 2 contribute to the further development of EFT for couples by advancing knowledge about the resolution path of an attachment injury and the clinical interventions that are likely to facilitate this process. EFT for couples can be strengthened and training in the practice of EFT improved when the client change

process and interventions used during change events can be elaborated (Johnson 2003a,b; Johnson et al., 1999). A systematic framework to support training of EFT clinicians in healing these injuries, the AIRM, is set out in this dissertation. EFT theory and training may be expanded to further stress the significance of these interventions.

Conclusion

In this dissertation, two articles, one theoretical and the other empirical, were presented on the subject of forgiveness and reconciliation in couples. Interest in the area of forgiveness and couples has grown exponentially in the past twenty years. Various couple therapy models have emerged to promote forgiveness and reconciliation in couples in the aftermath of an interpersonal injury. A review of the forgiveness literatures was conducted to place the development and empirical investigation of the AIRM, a clinical forgiveness and reconciliation model, in context. Previous studies guided by a task analytic research methodology in the development and empirical substantiation of the AIRM were also reviewed to provide a rationale for the empirical studies in this dissertation.

In the first theoretical article, a focus on emotion and the experiential way of working with emotion was viewed as transformative in terms of promoting forgiveness and reconciliation in couples beleaguered by an injury. These injuries are construed as a rupture to an attachment bond. Attachment theory was employed to explain the significance of partner emotional engagement and responsiveness upon the rupture of an attachment bond. Emotion responses associated with separation distress are predictable and must be addressed in the clinical repair process. Existing forgiveness and reconciliation models do not facilitate emotional communication related to injuries and

do not address the attachment-related emotions (i.e., attachment fears, sadness) related to these injuries. The AIRM was further placed and integrated in the clinical language of EFT and the EFT understanding of change events. Three AIRM phases were identified: cycle de-escalation related to the injury, new cycles of engagement related to the injury, and reconsolidation of the frayed bond. Attachment injury resolution was paralleled to a softening process in EFT, a significant change event within EFT that is associated with successful outcomes (Johnson et al., 1999).

In the second article, empirical findings from a psychotherapy process research study were reported. Three research objectives were outlined within the context of task analytic research methodology, including further empirical specification of performance tasks using the LCPP (Toukmanian, 1992; Toukmanian & Gordon, 2004), model validation through discrimination of components in resolved versus non-resolved cases, and identification of therapist interventions employed in task resolution. Depth of experiential involvement, more controlled models of perceptual processing, and more affiliative interpersonal responding, were associated with attachment injury resolution. The process of change reflects a softening process related to an injury. Study results suggest that deeper emotional processing of the incident is a common feature of resolved versus unresolved couples. Accessibility and responsiveness to the primary emotional experience associated with the original rupturing of the attachment bond in the aftermath of an injury is a significant in-session event that promotes forgiveness and reconciliation in couples. Finally, therapist interventions at each stage of the model were identified based on their frequency of use. Therapist interventions, in Phase I, supported the identification of a rigid, negative interaction cycle, and the unpacking of secondary

emotion reactions in the context of the cycle. In Phase II and III, interventions were employed to facilitate a softening process related to the injury.

The AIRM is a clinical forgiveness and reconciliation model within EFT for couples that promotes healing of injured partner emotional pain and fears in the aftermath of attachment injuries. This dissertation has clarified the client change process as clients resolve an attachment injury. EFT and attachment theory suggest that emotional processing of attachment-related emotions associated with the rupture to the attachment bond is essential to the clinical process of repair. Without processing these emotional experiences, partners continue to experience hurts and fears. Attachment fears prime autobiographical memories of incidents of partner unavailability and inaccessibility, including secondary reactions and associated models of self and other related to the incident. AIRM implementation provides clients with an opportunity to heal these ruptures by restoring partner accessibility and availability to assuage the deep attachment fears, sadness and grief associated with the injury.

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