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POSTDOCTORAL STUDIES

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**Resolving Attachment Injuries in Couples:
Relating Process to Outcome**

Judy A. Makinen

Dissertation submitted to the School of Graduate and Postdoctoral Studies
of the University of Ottawa
in partial fulfillment of the requirements
for the degree of Doctor of Philosophy
(Clinical Psychology)

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Abstract

An attachment injury has been defined as a perceived betrayal, violation of trust, or abandonment in a critical moment of need. The injurious event is then used as a standard for the dependability of the other partner. Some events are obvious but other may appear trivial or exaggerated to an observer. Such events, if not resolved, can have a deleterious effect on the relationship bond and create impasses to relationship repair. Couples are often stuck in an attack-defend pattern and experience marital distress. A rational-empirical model of attachment injury resolution has been developed.

The goal of this study was two-fold: First, task analysis was used to measure in-session performances to confirm that the model discriminates resolved from non-resolved couples. Second, the goal was to relate the process of change model to outcome.

Twenty-four couples received 13 weeks of Emotionally Focused Therapy to work on resolving an attachment injury. At the end of treatment, couples were identified as either resolved or non-resolved. Couples were identified as resolved only if they met three criteria: (1) couples' perspective, (2) therapist perspective, and (3) a clinical judge.

Segments of first and best sessions were transcribed and rated on depth of experiencing and the structural analysis of social behavior. Resolved couples were found to be significantly more affiliative and achieved deeper levels of experiencing than non-resolved couples. In addition, dyadic satisfaction, relationship trust, forgiveness and pain were good predictors of attachment injury resolution. An important finding was that the non-resolved couples had more than one attachment injury. Both groups benefited from therapy in that they experienced significantly less anxiety from pre- to post treatment.

Introduction

Many couples encounter situations or life events that may lead to emotional distress. While some couples successfully resolve these conflicts or may tolerate them for an indefinite period of time, others may seek out marital therapy or some other form of intervention. Occasionally, however, specific incidents have a particularly deleterious effect on or injure the relationship bond. These incidents result in what has recently been called an attachment injury (Johnson, 1998; Johnson, Johnson & Whiffen, 1999). An attachment injury has been characterized as a perceived abandonment, betrayal, or a breach of trust in a critical moment of need, and it is continually used as a standard for the dependability of the other partner (Johnson, Makinen, & Millikin, 2000). The incident becomes a clinically recurring theme and creates an impasse that blocks relationship repair. As such, the couple becomes stuck in rigid, negative interactional cycles (e.g., attack-defend, pursue-distance), which may then escalate into severe marital distress.

Although the attachment injury concept is rooted in attachment theory, the concept itself and the resolution model emanated from the theory and practice of emotionally focused couples therapy and the task analytic research paradigm, respectively. EFT is an empirically validated approach to marital therapy (Johnson & Greenberg, 1985a, 1985b, 1987, 1988), and is recognized as one of the most effective approaches in resolving relationship distress (Alexander, Holtzworth-Munroe, & Jameson, 1994; Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998). EFT interventions and change processes are rooted in a clear theoretical base arising from a synthesis of experiential (intrapsychic) and systemic (interpersonal) therapeutic interventions. It is

also grounded in attachment theory, which includes a theory of romantic relationships, and this approach is congruent with empirical studies on the nature of relationship distress (Gottman, 1994). The premise of EFT is that the failure of the couple to express and deal with their underlying emotions, insecurities and attachment needs impedes communication and the couples' ability to resolve relationship conflicts. The essence of the change process, therefore, involves accessing emotional experiences that underlie rigid, interactional positions and reorganizing such experiences to create new interactions that involve accessibility, concern, trust, and safety in the relationship.

Task analysis is a research paradigm that facilitates the identification, description and analysis of change processes that lead to successful outcomes in psychotherapy (Greenberg, 1984, 1986; Greenberg & Newman, 1996). The advantage of the task analytic method is that it assists in determining whether the delivery of a particular treatment actually sets in motion the anticipated change. Task analysis of change processes in EFT (Johnson & Greenberg, 1988; Greenberg, Ford, Alden, & Johnson, 1993), retrospective studies (Greenberg, James, & Conry, 1988), and clinical practice (Johnson, 1996) have all aided in the construction of a conceptual model of the process by which couples resolve attachment injuries. Following the development of the conceptual model, a rational-empirical analysis of attachment injuries was conducted (Millikin, 2000).

The following review provides the theoretical underpinnings for the attachment injury concept, as well as the rationale for this study. To understand the development of attachment injury as a concept, attachment theory and its pertinence to adult romantic relationships will be reviewed. Second, attachment injury as a theoretical construct and

its utility in understanding impasses and change processes is delineated. Third, a summary of the EFT literature is provided and the attachment injury resolution model is included. Finally, the rationale for the present study is presented and the hypotheses stated.

Attachment Theory

Attachment theory evolved out of the seminal work of John Bowlby, a renowned British psychiatrist (Bowlby, 1944, 1969, 1973, 1980). He observed extreme emotional distress in boys placed in a home for maladjusted children, war orphans, and hospitalized infants. All of these children experienced disruptions in their relationship with their caregivers, particularly their mothers. The infant-mother relationship was considered crucial for psychosocial functioning, and disruptions in this relationship led to later problems.

While traditional drive theorists proposed that the child's attachment to his/her primary caregiver emerged because of associations with the mother as the source of nourishment, Bowlby (1973, 1980) sought out alternate explanations for child attachment. Systematic observations of animals and humans made it abundantly clear that the offspring's need for comfort, especially in times of stress, overrode physiological needs. Drawing on diverse fields, such as evolutionary biology and ethology, he formulated his own ideas and postulated that the mechanisms governing the child's attachment to the mother originated from biological and evolutionary factors. The attachment behavioral system evolved to enhance survival against threats. When a child is hurt, ill, or afraid, the attachment system is activated and specific attachment behaviors produced by the child (e.g., clinging, crying, seeking) serve to increase proximity to the

caregiver. The caregiver's responsiveness to the child's needs provides a sense of security, which in turn deactivates the attachment behavioral system (Sroufe & Waters, 1977).

Bowlby (1969, 1973, 1980) discovered that prolonged physical or emotional separations from the mother produced a predictable sequence of responses or phases: protest, despair, and detachment. The initial response of protest typically began the moment the caregiver left the child. During this phase the child exhibited emotional distress by crying. The dominant emotions were fear, anger, and distress. While fear and distress signaled the child's appraisal of danger at being separated from his/her attachment figure, anger served to reestablish maternal contact. Angry protest was often followed by despair, which is the second phase of the behavioral sequence. Reduced activity, sadness, withdrawal, and increased hopelessness about reestablishing contact marked this phase. Bowlby (1973) likened the reaction to prolonged maternal separation to that observed in grieving adults. The final phase is detachment. In this phase, the child returns his/her attention to the environment and no longer rejects alternative caregivers. A child who has reached the detachment phase displays indifference toward the mother upon her return.

An important component of attachment theory is the concept of internal working models, which are viewed as the backdrop of personality (Bowlby, 1988). Beginning at birth, infants develop mental structures to organize and process affective and cognitive events. In particular, they construct attachment-related models according to their day-to-day experiences with their caregivers. These relationship models are comprised of knowledge about self and knowledge about others. The model of self (e.g., lovable vs.

unlovable) not only reflects self-perceptions, it also reflects images conveyed by caregivers. The child also develops a model of others (responsive and accessible vs. unresponsive and inaccessible) in relation to how he/she has been treated. In essence, the child internalizes the dyadic attachment experience. This experience governs thoughts, feelings, expectations, and behavior toward others (Bowlby, 1973, 1988).

Attachment in Childhood

The theory of attachment began as a framework for describing the significance of child-mother bonds. Although most children develop an affective tie with a caregiver, who typically is the child's source of comfort in the face of future challenges and threats, the quality of the attachment bond seems to vary across child-caregiver dyads (Weinfield, Sroufe, Egeland, & Carlson, 1999). Individual differences in attachment are purportedly tied to individual expectations, which are incorporated into internal working models. Expectations are based on whether the other (caregiver) is deemed to be one who is responsive to the child's needs for comfort and protection, and whether the self (child) is judged to be someone to whom others are likely to respond (Feeney & Noller, 1996).

Most of the empirical research on child attachment stemmed from Ainsworth's observations of mother-infant interactions. In an early attempt to describe the nature of the individual differences in the quality of the attachment bond, infant-mother dyads were categorized as secure and insecure (Ainsworth, 1972; Bowlby, 1973). Later, with the development of a research paradigm referred to as the "strange situation", Ainsworth and colleagues (Ainsworth, Blehar, Waters, & Wall, 1978) provided support for attachment theory. Based on her observations of infants' responses to separation from their mothers

and interactions with a stranger, she identified and described three distinct attachment patterns (i.e., secure, ambivalent, and avoidant).

Infants classified as secure (group “B”) are able to use the caregiver as a secure base for exploration in a novel environment. Despite a preference for the caregiver, upon separation secure infants may become distressed but are receptive to being comforted by strangers. When reunited with the caregiver, a secure infant will seek proximity, maintain contact for as long as necessary, and then resume play. Secure infants appear to be confident that their caregiver will be available, offer comfort and protection (Ainsworth et al., 1978).

Infants classified as resistant (group “C”) do not appear confident about the responsiveness and accessibility of their caregiver. They exhibit intense distress upon separation and are unable to be comforted. Upon the caregiver’s return, these infants show ambivalence by simultaneously seeking and resisting physical contact. Because they tend to be preoccupied with their caregiver’s availability, they are unable to use the caregiver as a secure base to explore the environment. As a result of uncertainty, they tend to cling to the caregiver and anxiously explore their world (Ainsworth et al., 1978). This pattern develops when the caregiver inconsistently avails himself or herself to the child (Bowlby, 1988).

Infants classified as avoidant (group “A”) are also uncertain whether their caregiver will be there for them if called upon. However, they exhibit little distress when separated from the caregiver and do not seek comfort in the reunion episodes. Upon reunion they divert their attention elsewhere in order to avoid anxiety from the rejection

should they seek comfort. This attachment pattern develops when caregivers constantly reject or rebuff their infant's needs for proximity (Ainsworth et al., 1978).

Main and Solomon (1986, 1990) became increasingly aware of a fourth pattern, referred to as disorganized, for infants who could not be classified according to the three primary patterns. Infants classified as disorganized (group "D") fail to show a coherent system for dealing with separation and reunion episodes. They often show signs of disorganized and contradictory behaviors (e.g., proximity-seeking followed by avoidance, awaiting the caregiver with trepidation, etc.). Some children appear to be disoriented, apathetic, and even depressed (Main & Solomon, 1986, 1990). This pattern of attachment is often seen in children who are severely maltreated. Crittenden (1985) noted that this pattern, which she referred to as avoidant/ambivalent (A/C), originates when the primary caregiver is neglectful, physically or sexually abusive, or suffering from psychiatric illness.

It is clear that the child attachment theorists and researchers delineated a specific type of bond that is distinguishable from other types of social ties. Despite the individual differences in attachment patterns, the child-caregiver attachment bond is unique in that it arises from the operation of an innate behavioral system designed to serve three functions. First, the infant wants to maintain contact with or closeness to the attachment figure, especially in times of stress (proximity seeking). Second, they derive comfort and security from the attachment figure in order to make exploration possible (safe base). Third, the child protests to keep the caregiver close when the attachment figure becomes or threatens to become unavailable (separation protest).

Several researchers have also demonstrated that the attachment patterns originally assessed in infancy are remarkably stable in later childhood (e.g., Arend, Gove, & Sroufe, 1979; Grossmann & Grossmann, 1991). Attachment patterns that originate in childhood are purported to continue throughout the life span. Bowlby (1979) stated that attachment extends from “the cradle to the grave” and that “there is nothing intrinsically childish or pathological about it” (pp. 129, 131). Rothbard and Shaver (1994) more recently concurred that it is “plausible that adult attachment patterns are developmental successors of childhood attachment patterns” (p. 51). Early experience influences how adults seek and maintain proximity to siblings, friends, and intimates.

Attachment in Adulthood

In the last decade the interest in and the investigations of adult attachment have proliferated at a remarkably high rate. Adult attachment theory essentially developed out of two main lines of research. The first line of research relied on adults’ memories of childhood experiences with their parents (Main & Goldwyn, 1984). This research attempted to show that attachment patterns established in the early years continue into adulthood. However, the notion that childhood attachment patterns are progenitors to adult attachment bonds may not be entirely accurate. The impact of other close relationships appears to influence these early attachment patterns. The second line of research focused on self-reports of attachments to peers and romantic partners, which resulted in the development of various models of adult romantic attachment.

Three Category Model of Adult Attachment. Hazan and Shaver (1987) were the first researchers to provide empirical support for attachment theory as a theory for romantic love. They developed a three-category model of attachment by extrapolating

from the infant attachment literature (Ainsworth et al., 1978) and translating the three attachment patterns or styles into descriptions relevant to adult romantic relationships. Subjects were asked to choose one of three paragraph descriptions that best described the way they felt in romantic relationships. Secure subjects are described as being comfortable with intimacy and able to trust and depend on the other. Avoidant subjects are described as experiencing discomfort with closeness and difficulty in depending on others. Anxious-ambivalent subjects are described as seeking extreme levels of closeness and fearing abandonment.

Hazan and Shaver (1987) tested the three-category measure of attachment in two studies, one consisting of a large community sample and the other consisting of university students. Both samples completed the attachment measure, and adjective checklist as well as other measures that tapped into relationship experiences with their most important romantic partner. The results indicated that the frequencies of the three attachment patterns (56% secure, 25% avoidant, and 19% anxious/ambivalent) showed a remarkable resemblance to those observed in infant-caregiver attachment studies.

Many researchers have adopted Hazan and Shaver's forced-choice, three-category model of romantic attachment because of its brevity, ease of administration, and scoring. However, the measure assumes that there is no variation among adults within a particular category. As Baldwin and Fehr (1995) noted, test-retest reliability was only .40. The original measure was then revised so subjects can rate the degree to which each paragraph description fits their general approach to romantic relationships. Test-retest reliability estimates for one to eight week intervals increased to .60 (Levy & Davis, 1988).

To obtain a more complete understanding of the nature of adult romantic attachment, some researchers have decomposed the three descriptions of attachment into several items and had subjects rate the degree to which each item accurately describes them. These brief multi-item measures not only made it easier for subjects who found it difficult to choose one of three original descriptions, they increased reliability estimates to .70 (e.g., Collins & Read, 1990; Simpson, 1990). In addition, from a researcher's perspective, multiple items facilitate a more precise analysis of a subject's attachment pattern and assist in the investigation of the underlying structure of attachment using statistical procedures, such as factor analysis (Feeney & Noller, 1996).

Four-Category Model of Adult Attachment. While researchers were assessing the utility of the three-category model, Bartholomew (1990; Bartholomew & Horowitz, 1991) noted that the avoidant category in the Hazan and Shaver's model may conceal some important differences between two types of avoidant adults (i.e., fearful and dismissing). Therefore, she provided an interpretation of adult attachment based on the Bowlby's notion of internal working models. She argued that the two orthogonal dimensions underlying adult attachment could be conceptualized as positive versus negative model of self, and positive versus negative model of other. Combinations of these two orthogonal dimensions produce four categorical attachment patterns (i.e., secure, preoccupied, dismissing, and fearful).

Although categorical models of adult romantic attachment have provided a system from which hypotheses about relationship dynamics could be derived, others have argued that the categorical approach is not optimal from a psychometric point of view (Fraley & Waller, 1998; Simpson, 1990). Meehl (1992) argued that behaviors or traits may actually

reflect differences in degree rather than true differences in type. Fraley and Waller's (1998) taxometric analysis of individual differences in attachment organization revealed no evidence of taxonomy. Rather, they found continuous latent variables associated with individual differences in adult attachment organization by challenging current measurement models of adult attachment

Two-Dimensional Approach to Adult and Romantic Attachment. To address the methodological concerns associated with the typological approach to attachment, a greater emphasis has been placed on the dimensional structure underlying adult attachment. Recently, the results of an integrative overview of adult attachment indicated that the construct of attachment is best construed as a product of two orthogonal dimensions: anxiety and avoidance (Brennan, Clark, & Shaver, 1998). Similar to Bartholomew's underlying structure of attachment, anxiety about abandonment is associated with a negative model of self and avoidant behavior is associated with a negative model of others. Two continuous attachment-dimension scales were derived from the extant self-report attachment scales (e.g., Bartholomew & Horowitz, 1991; Hazan & Shaver, 1987; Simpson, 1990). Unlike other measures, the use of two continuous scales provides researchers with more "power and precision" than the categorical approach (Brennan et al., 1998, p. 68). Avoidance and anxiety dimensions can also be used to classify individuals into one of four adult romantic attachment categories: secure (low in anxiety and avoidance), preoccupied (high in anxiety, low in avoidance), dismissing (high in avoidance, low in anxiety) and fearful (high in avoidance and anxiety).

Attachment Security and Relationship Satisfaction. Attachment patterns have been conceptualized as being relatively stable over time. More recently, some researchers have argued that adult romantic attachment may be a reflection of the current relationship dynamic (e.g., Feeney, 1999). Personality traits and relationship dynamics are not mutually exclusive events; however, relationship security is often associated with relationship satisfaction. A responsive secure individual paired with an equally responsive secure individual tends to confirm each partner's expectations of the other. Moreover, Kobak and Hazan (1991) found that secure partners tend to be less rejecting and more supportive during conflicts. Couples reported high levels of dyadic satisfaction when they were able to rely on available and supportive partners. Secure attachment has not only been linked to relationship satisfaction, it has been linked to high levels of trust, commitment, and interdependence (Levy & Davis, 1988; Simpson, 1990).

Conversely, insecurity is associated with decreases in relationship satisfaction. A dynamic that likely leads to distress and confirms models of self and other is the pairing of an avoidant individual with a preoccupied individual (Kirkpatrick & Davis, 1994; Levy & Davis, 1988). Findings also showed that anxious/ambivalent attachment was linked to low levels of trust and satisfaction. Avoidant attachment was linked to low levels of interdependence and commitment to the relationship. Attachment insecurity, in general, has been associated with reactivity and destructive tracking of recent partner behaviors perceived as threatening (Feeney, 2002).

Several studies have highlighted the importance of gender differences when examining attachment and relationship satisfaction (Collins & Read, 1990; Feeney, Noller, & Callan, 1994; Kirkpatrick & Davis, 1994). Anxiety over relationships was

strongly negatively related to relationship quality for women. In particular, fear of abandonment was linked with jealousy, communication problems, lack of closeness, and lack of partner responsiveness. In contrast, men's degree of comfort with closeness was a crucial link with most indices of relationship quality. For men, comfort with closeness was linked to more reported satisfaction, better communication, and self-disclosure. Men liked their partner more, were more trusting, felt closer, had more faith in her, and described her as dependable. Kirkpatrick and Davis (1994) found that ambivalent women and avoidant men rated their relationships negatively. Avoidant men rated their relationships least favorably. They scored significantly lower on commitment, satisfaction, relationship viability, intimacy, and caring than secure men. Anxiously attached women reported low relationship satisfaction, caring, and greater conflict-ambivalence than securely attached women. However, despite the negative ratings of relationship satisfaction, the relationship of ambivalent women and avoidant men were quite stable over a three-year period. Feeney, Noller, and Callan (1994) found that the quality of marital interaction predicted later attachment security. Pairing an insecure individual with a secure individual may result in a revision of internal working models. This supports the notion that attachment styles or internal working models may be revised on the basis of relationship experience.

Mikulincer (1998) explored adult attachment styles and relationship satisfaction by focusing on each individual partner's sense of trust. Trust, which is the "most desired quality" and "a necessary condition" for the development of relationship satisfaction, is "an integral part of secure attachment" (Mikulincer, 1998, p. 1209). It has been argued that the lack of trust not only produces relationship distress, it may lead to relationship

dissolution (Holmes & Rempel, 1989). The results of Mikulincer's (1998) research revealed an association between attachment security and constructive coping following a trust-violation episode. Secure individuals have the tendency to openly talk with their partners about the event. Insecure individuals relied on strategies that were maladaptive for relationship maintenance. Avoidant individuals tended to distance themselves from their partners and preoccupied individuals engaged in ruminative worry and reacted to violations of trust with strong affect. Although attachment styles may influence the way in which individuals respond to such events, a violation of trust could be an assault on perceptions of his/her partner, thus influencing coping strategies employed.

In summary, attachment theory, which is now one of the most promising theories of adult romantic relationships, emphasized the propensity for human beings to make and maintain powerful affectional bonds. Research on the various conceptualizations of attachment has tried to bridge the gap between infant attachment theory and theories of romantic relationships. Most of the studies on romantic relationships highlight the importance of attachment security and the profound effect it has on psychological well being. For instance, self-reports of a secure attachment are linked with positive aspects of relationship functioning including high levels of trust, commitment, interdependence and higher dyadic satisfaction. Supportive relationships encourage the creation of optimal experiences that enhance both self and other.

Attachment Injury

Couple distress may be traced to a specific incident when one partner fails to respond at times of urgent need. These incidents seem to disproportionately alter the quality of an attachment relationship. Such negative attachment-related events (e.g.,

abandonment, betrayals) often cause seemingly irreparable damage to close relationships. When couples enter therapy they are not only in general distress, they come with the goal of bringing closure to such events and so restoring lost intimacy and trust. During the therapy process, these events, which have recently been termed “attachment injuries,” often reemerge in a vivified and markedly emotional manner, much like a traumatic flashback (Johnson et al., 2000). Consequently, the injured partner perceives the current interactions with his/her partner in light of the past event. The more significant these events are, the more the present relationship is hostage to them.

Attachment Injury Defined

An attachment injury, therefore, is a specific type of betrayal experienced in couple relationships. It has been characterized as an abandonment or violation of trust (Johnson & Whiffen, 1999). However, it is not simply a trust issue; it is usually about an incident where one partner is inaccessible and unresponsive in the face of the other partner’s urgent need for the kind of caring and support we expect of attachment figures. The injurious incident not only defines the relationship as nonviable for the injured partner, it is continually used as a standard for the dependability of the other. These events not only damage the attachment bond between the couple, they are obstacles to repair, and perpetuate negative interactional cycles.

The actual incident that precipitates an attachment injury is not necessarily the primary causal factor in couple distress. Some partners may have endured insecure or frayed attachment bonds over a period of years and that one incident acts as a symbolic marker of insecure attachment. Other couples may have a relatively secure bond and this

type of incident marks the beginning of their relational distress.

Types of Attachment Injuries

Different types of attachment injuries experienced by couples also need to be considered. Some may appear trivial or exaggerated to an outsider, or they may be more obvious betrayals of trust, such as infidelity (Johnson & Whiffen, 1999). Although infidelity, for most couples, constitutes a prototype of betrayal, feelings of abandonment may emerge when one partner fails to respond to the other during times of transition, threat, danger, and uncertainty. Classic times when attachment needs are particularly salient are during the birth of a child, at times of a physical illness (e.g., cancer diagnosis), life transitions (e.g., retirement, immigration), and at times of loss (e.g., miscarriage or death of a child). Furthermore, what may be a momentous interpersonal cataclysm for one couple may be inconsequential for another. For example, being inadvertently left out of a family photo after immigration to a new country may dramatically alter the way one couple's relationship is defined, whereas another couple would be able to deal with such an incident and their relationship would remain untouched.

These damaging incidents are highly subjective and conceivably idiosyncratic judgments made by the injured partner. As Jones and Burkette (1994) suggest, injurious events are "embedded in perceptions, beliefs, and expectations...or the unique interpersonal perspective of the person" who has been wounded (p. 260). Much depends on how the injured partner interprets the event in question, although the other partner's response to expressions of hurt by the injured party also seems to play a role. When this partner discounts, denies or dismisses the injury, this response prevents the processing of

the event in the relationship and in a sense confirms the injury, retraumatizing the injured partner. The unresolved injurious event may be the topic of constant bickering or it may lay dormant for years, but it eventually reemerges with a vengeance, especially when a small current incident evokes a powerful emotional response related to the initial injury.

For example, a couple may be referred because the husband's retirement has precipitated depression and marital distress. When the couple comes in, however, the main problem seems to be the wife's detachment and unwillingness to engage in activities with her husband. When he is encouraged by the therapist to ask his wife for hugs and physical affection, his wife explodes. She then asks him if he remembered fifteen years ago, on a particular winter afternoon when he returned from work, when she was ill and depressed and had four children under five to care for, she had desperately begged him to hold her. He had gone to his study to make a series of long phone calls. She had sobbed on the kitchen floor and then decided never to ask again. He did not recall this incident and she had never discussed it with him. As she describes it in the session, however, she flushes, wrings her hands and weeps (Johnson et al., 2000).

Attachment Injury as Trauma

Attachment injuries must be distinguished from the ordinary highs and lows of an ongoing relationship. It may be useful to view them as relationship traumas. Indeed a number of authors have begun to examine betrayals in relationships as a form of trauma (Glass & Wright, 1997; Gordon & Baucom, 1998; Johnson, 2002; Spring, 1997). Traumatic experience shatters assumptions and changes the way we see others and ourselves. It induces helplessness and a sense of existential vulnerability.

Betrayals, such as attachment injuries, call into question basic beliefs about the relationship, the other, and the self. Expectations are one of the most fundamental aspects of any relationship (Bar-Tal, Bar-Tal, & Yarkin-Levin, 1991). When partners commit to an intimate relationship, they have an internal model of what the relationship will look like and how they expect to be treated. Couples typically expect their partner to be attentive, responsive, and supportive. More specific expectations (i.e., time spent together, socializing, division of domestic labor, etc.) evolve out of the everyday relationship experiences. Under normal circumstances, the violation of expectations would not harm the attachment bond; however, when the person is most vulnerable and comfort is essential, such violations can rupture the relational bond in significant ways.

Jones and Burdette (1994) emphasize that one of the dangers of becoming intimately involved with another is the “potential for rejection” (p. 245). When a partner cries out for help and there is no response, the sense of basic trust, which is the “bedrock upon which the welfare of their bond depends,” is shattered (Baxter et al., 1997, p. 656). The most basic assumption of attachment relationships, that my partner will be there for me when I need him/her, is suddenly destroyed. This shattering of basic assumptions is, in and of itself, disorienting and disorganizing and is part of the sense of helplessness that is one of the most salient features of traumatic experience.

Furthermore, the extent to which each partner’s identity and self-esteem are derived from or are connected to the relationship constitutes a serious threat to the injured partner. Jones and Burdette (1994) stated that events such as these have the “potential for psychological damage...because as the relationship progresses, typically each participant has an increasing commitment to and dependence on the relationship” (p. 246). When

one partner fails to invest in the relationship, it threatens the other partner's sense of self-worth, entitlement, and safety.

Attachment theory has been referred to as a "theory of trauma" (Atkinson, 1997, p. 3). When people are without physical or emotional support, they are most vulnerable, and have difficulty regulating their emotions. Disturbances of affect are central to all descriptions of traumatic stress and its sequelae (Stone, 1996). Johnson (2002) argued that wounds to attachment relationships resulting from emotional inaccessibility by one partner may be equated to trauma with a small "t". In therapy, couples often talk about injurious events in terms of life and death (e.g., "I was so sick I could have died", "You let me drown", " You didn't care that I crashed and burned after that argument", "I was left to fight the fire alone"). Following traumatic abandonment the entire relationship gets organized around eliciting or defending against the lack of emotional responsiveness from the other partner. Moreover, the injured partner may exhibit symptoms characteristic of post-traumatic stress disorder (PTSD), such as re-experiencing, numbness and hypervigilance.

Re-experiencing traumatic events may emanate from the "indelible imprint" of the traumatic moment (Herman, 1992, p. 35). Memories and emotions connected to the event linger and manifest themselves in the form of dreams, flashbacks, and intrusive memories. Spring (1997) pointed out that after a betrayal, disturbing memories, vivid images, and sensations puncture the injured person's concentration and sleep. As a result, they are likely to engage in excessive ruminating. Much energy is spent in attempts to examine every minute detail of the event. Although the offending partner may have apologized for the transgression, the injured partner cannot let the matter go

(Gordon & Baucom, 1998). These events are momentous, pivotal moments in the ongoing definition of the relationship that constantly come up and color present realities. The injured partner's apparent refusal to allow the event to recede into the past often evokes resentment and distance from the offending partner. This then exacerbates the wound to the attachment bond.

Avoidance and numbing are both natural, self-protective responses to the barrage of intrusive symptoms (van der Kolk & McFarlane, 1996). This self-protective strategy can be very costly for the couple's relationship. In obvious ways, numbing interferes with emotional engagement and emotional attunement between partners. Although avoidance may help the injured party cope with his/her pain, it actually interferes with the resolution of the attachment injury. Alternative sequences of numbing, intrusive images and hyperarousal, the third primary symptom of PTSD, are a response to the paralyzing attachment paradox that the injured party experiences. As attachment theorists (Main & Hesse, 1990) have pointed out, situations where the primary attachment figure is both the source of and a solution to pain are inherently difficult to tolerate and result in a fundamental disorganization of the attachment system. The injured partner tends to swing between hypo- and hyper-arousal, between accusing and protesting, clinging and reaching and numbing and withdrawing. This, then, becomes chaotic and aversive to the other partner. Even in moments when the injured spouse can evoke from his/her partner the comforting touch that "tranquilizes the nervous system," he/she does not trust it. (Schoore, 1994, p. 244). The open confiding that allows us to give meaning and structure to difficult experiences is also almost impossible (Pennebaker, 1985). In short, the

couple's way of coping with the attachment injury becomes aversive and perpetuates the alienation between partners.

Finally, physiological hyperarousal, which is the cardinal symptom of PTSD, reflects the persistent expectation of impending danger. Difficulty regulating affective states is recognized as one of the most obvious and significant results of exposure to trauma and loss and results in fight, flight and freeze responses to innocuous stimuli (van der Kolk, 1996). Couples dealing with trauma incurred by one of the partners tend to express more intense negative affect than typical distressed couples (Johnson & Williams-Keeler, 1998), and clinical experience shows that this is also true for couples dealing with relationship trauma or attachment injuries. Exaggerated sensitivities and hypervigilance for further signs of betrayal become the norm. Normally positive interactions become tentative and doubts about the security of the bond result in the couple being caught in a drama where the injured partner tests and the offending partner is always found guilty. If an attachment injury is viewed as traumatic, what does this imply about the process of resolution? Recovery from trauma generally involves the following elements: the ability to construct an integrated narrative of the event, its meaning and its consequences, the ability to regulate and integrate the emotion associated with the event, and the ability to create secure connections with others that offer restitutive emotional experiences. In general, most trauma theorists view a relationship that offers a safe haven and a secure base as the most basic condition for addressing such experiences. The therapist creates the safety that the injured partner expected at the time of the event so the couple can work through the attachment injury.

The Role of Forgiveness

Forgiveness, a cornerstone of the Judeo-Christian tradition, has recently emerged as an important concept in psychotherapy in general and couple and family therapy in particular. Successful couples, who have recovered from the impact of a relationship betrayal, often allude to the role of forgiveness in the resolution process (Gordon, Baucom & Snyder, 2000). The concept of forgiveness, however, is as difficult to define as the concept of love. It is extremely personal and not always possible to create at will. Part of the difficulty may reside with the different conceptualizations of forgiveness within and across theological and psychological domains.

Psychological definitions of forgiveness have focused on the benefits of forgiveness for the injured. Forgiveness has often been understood as a voluntary act in which the injured party relinquishes the right to retaliate (Pingleton, 1989). It has been further described as a prosocial change in the injured person's motivations toward the offending party (McCullough, Worthington, & Rachel, 1997), the releasing of bitterness and resentment (Fitzgibbons, 1986), and the letting go of a record of wrongdoings (DeBlasio, 1992). More recently, Enright and Coyle (1998) defined forgiveness as the ability to overcome negative affect, judgment, and indifferent behavior toward the offender and foster compassion, benevolence, and love. This conceptualization emphasizes how the injured party feels, thinks, and behaves toward the offender.

The literature has also emphasized the positive impact forgiveness has on both the injured and the offending parties. Rowe and colleagues (Rowe, Halling, Davies, Leifer, Powers & van Bronkhorst, 1989) were among the first researchers to acknowledge that the experience of forgiveness is both intra- and interpersonal. Gordon and Baucom

(1998) concur that forgiveness involves a “complex interaction including the person who is forgiving, the person who is being forgiven, and the dyadic interaction between these two people” (p. 426). It occurs in response to an interpersonal violation and involves mending inner emotional wounds as well as restoring relationships.

Although numerous models of forgiveness exist, McCullough and Worthington (1994) note that there are only four categories of adequate models of forgiveness. There are models based on established psychological theories, models based on a moral development framework, typologies of forgiveness, and models that describe the process of forgiveness. They argue that models based on psychological theories may be strong in internal consistency but they have generated little empirical research. Similarly, models based on moral development have not been studied empirically, and typologies of forgiveness lack theoretical value to support a program of research. Process models appear to be among the most prominent; however, because forgiveness is an arduous and painful process that can take a lifetime to achieve, the number of steps in the process, composition of the actions involved, and sequence of forgiveness are varied.

The ambiguous definitions and diverse models of forgiveness has created a conundrum for the development of assessment tools. To date there are very few psychometrically valid and reliable forgiveness measures available. There is only one measure that assesses the process of forgiveness at the dyadic level (McCullough, Hoyt, & Rachal, 2000). The theoretical model and measure of forgiveness, Interpersonal Relationship Resolution Scale (IRRS), set forth by Hargrave and Sells (1997) was developed in response to the void in the literature on the process of forgiveness in interpersonal relationships. This process model focuses on relational ethics, which is the

subjective balance of justice, trustworthiness and entitlement. When one partner betrays the other partner, there is a violation in relational ethics. The revelation that the person on whom they are most dependent cannot be trusted results in emotional pain. As a result, they are likely to experience either rage toward the offender or the shame of self-blame. Violated people are also likely to become over-controlling or likely experience chaos from a deep sense of helplessness.

In addition, Hargrave and Sells (1997) stated that the process of forgiveness involves two categories: exonerating and forgiving. Exonerating has two components: insight and understanding. Exoneration occurs when the injured person gains insight into the motive behind the injury and is able to understand or empathize with the offending partner. The injured acknowledging the fallibility of the offending partner does not remove the offending partner's responsibility. Forgiving also has two components: giving the opportunity for compensation and an overt act of forgiving. By giving an opportunity for compensation, the injured partner provides a chance for the offending partner to rebuild trust. The overt act of forgiveness includes openly discussing the injurious event and demonstrating alternate relational patterns. This model does not imply that people move through the forgiveness process in a sequential manner. Rather, in a progressive effort to forgive and restore relational trust, people often oscillate among the four components.

The interpersonal relationship resolution model is also consistent with McCullough and colleagues' (1997) notion of forgiveness. It is not a statement of "I forgive you" but rather a "concept that people invoke to describe the transformation that occurs when their motivations to seek revenge and to maintain estrangement from an

offending relationship partner diminish, and their motivation to pursue conciliatory courses of action increases” (p. 322). As the injured partner goes through the process of expressing his/her hurt and empathizing with the offending partner, the responses from the offending partner are crucial as they may either exacerbate the injury or facilitate restoration. Key to this process is the offending partner’s ability to take responsibility. The overt act of forgiving involves positive interactions, which eventually lead to reestablishing relational love and trust (Gordon et al., 2000; Hargrave & Sells, 1997)

Overall, a substantial number of therapists from various therapeutic orientations support the clinical utility of forgiveness. It has been used as a powerful therapeutic intervention for the treatment of intra- and interpersonal problems. Specifically, it has been shown to be effective in repairing intimate relationships following a betrayal (e.g., Abrahms Spring, 1996). Although forgiveness for an emotional injury is related to decreases in the level of relational distress, some therapeutic approaches (e.g., cognitive-behavioral marital therapy, solution-focused) are less effective for emotionally laden issues such as betrayal, jealousy, and so forth (Gordon et al., 2000). An emotionally focused approach to resolving injuries in couples would be optimal for those whom forgiveness is a major issue.

Emotionally Focused Couples Therapy

Emotionally Focused Couple Therapy (EFT) is a short-term, structured approach to couples therapy (Johnson, 1996; Greenberg & Johnson, 1988). This approach has demonstrated clinical effectiveness (Alexander, Holtzworth-Munroe, & Jameson, 1994; Baucom et al., 1998), relatively high treatment effects (Johnson, Hunsley, Greenberg, & Schlindler, 1999), and stable recovery rates (Gordon-Walker & Manion, 1998).

Furthermore, it has been successful in treating a wide range of distressed relationships that co-occur with extreme stress due to chronic illness (Gordon-Walker, Johnson, Manion, & Cloutier, 1996). It has also been used extensively with couples whose relationship distress has been exacerbated by symptoms of PTSD (Johnson & Williams-Keeler, 1998).

Interventions and change processes in EFT are rooted in a clear theoretical base arising from a synthesis of humanistic, experiential and systems perspectives. Experiential therapy is a discovery-oriented approach that regards the couple as experts about their own experience. It emphasizes the importance of affect and focuses on the subjective experience of the here-and-now. Systems theory emphasizes the role of communication sequences and the power of interactional patterns. This approach encourages the examination of all the elements in the system, rather than looking at a single element in isolation. Integrating the intrapsychic and interpersonal approaches provides the therapist with a new model of how couples process and construct emotional experience and how they organize patterns of interactions (Johnson, 1996).

The EFT perspective on close relationships is embedded in attachment theory, which is one of the most cogent theories of romantic relationships (Hazan & Shaver, 1987; Cassidy & Shaver, 1999). Intimate relationships are considered as affectively charged attachment bonds in which each partner is viewed as the primary source of basic security, contact, and affection (Johnson, 1996). Berman, Marcus, and Berman (1994) noted that, like parent-infant relationships, intimate adult relationships require a reciprocal process that comprises both care-giving and care-seeking (attachment)

functions. When one partner is inaccessible or unresponsive to the physical and emotional needs of the other, relationship distress ensues.

The Role of Emotion in EFT

In EFT, emotion is understood as a central part of human functioning (Johnson, 1996). It is an adaptive force that serves to signal and communicate inner states to others. Emotions provide feedback about the physical environment, influence perceptions about self and other, and prime and organize attachment-related responses. For example, the expression of affection and tenderness organizes attachment responses that draw partners toward each other. On the other hand, anger and disgust pull for a different set of responses such as attack, defend, and distance.

Gottman's (e.g., Gottman, Coan, Carrere, & Swanson, 1998; Gottman & Levenson, 1999, 1985; Levenson & Gottman, 1984) research on couple distress has provided some insight as to how negative affect serves to maintain distress. Couple distress is the result of one or both partners experiencing emotional withdrawal in the relationship. These relationships are marked by a tendency for partners to get locked in absorbing states of negative affect (e.g., diffuse, undifferentiated, negative emotion) and rigid, negative interaction patterns (e.g., critical attacks followed by distance). Even nonverbal emotion such as facial expression and gestures are predictive of relationship stability and satisfaction. The furrowing of a brow coupled with a harsh tone can immediately define a relationship as threatening and the gestures and tone evoke corresponding attachment-related responses in the other partner. Focusing on affect fosters the reprocessing of experience, the construction of new meaning, and a new way of being with the other partner. Awareness of emotion is central as it serves to organize

experiences of self and responses to others. The focus is on cycles of interaction or how one partner's behavior (e.g., hostile criticism) pulls for a particular response (e.g., withdrawal) from the other, which in turn incites more hostility.

EFT places a premium on emotion as a powerful force in altering negative interactions (Johnson, 1998). One of the major tasks of EFT is to focus on, expand, and reprocess key emotional experiences that underlie negative interactional positions through interventions such as reflection, evocative responding and empathic conjecture. The goal is to move beyond secondary emotions (e.g., anger, criticism, blame) that obscure awareness of the here-and-now to more primary responses (e.g., fear, hurt, shame). Although an EFT therapist may begin by validating secondary responses, the aim is to access the often ignored, disowned, or undifferentiated primary emotions. As these emotions are expressed, each partner begins to perceive the other in light of these new emotional experiences. This creates new levels of emotional engagement that engender the growth of safety and trust, which are essential for the creation of healthier, flexible interactional patterns.

EFT Perspective on Relationship Distress

Although partners may provide each other with safety and comfort, paradoxically, they also may be the source of a substantial amount of stress (Jones & Burdette, 1994). According to EFT theory, the single most important cause of distress is attachment insecurity and how the couple deals with such insecurity (Johnson, 1999). Attachment insecurity complicates the process of emotional engagement and responsiveness and so creates a pathway to absorbing states of negative affect and constricted patterns of

interaction. These patterned interactions that typify a distressed couple are attack, blame, or criticize by one partner followed by defend, stonewall, or withdraw by the other.

The three well-known characteristics of relationship distress are ineffective communication, reciprocal negativity, and a negative relationship schema (Halford, Kelly & Markman, 1997). First, needs are expressed and conflicts are negotiated through communication (Feeney, 1999). Distressed couples have difficulty expressing their underlying emotions and attachment needs, which impedes their ability to resolve conflicts. As a result, one partner tends to criticize and complain while the other takes a defensive and distancing stance. Overwhelming negative affect coupled with rigid interactional patterns obstructs the process of working through recurring issues and bringing closure to negative events.

Second, distressed couples selectively interpret each other's behavior and responses in ways that perpetuate their distress. Distressed couples tend to make stable, blameworthy, and global attributions for their partner's ostensibly negative behavior (Halford et al., 1997; Johnson & Sims, 2000). From an attachment framework negative working models of self as undeserving of love and of the other as undependable pull for and guide interpretations of the other partner's behavior. Small disappointments may, for an insecure spouse, echo back to major wounds and disproportionately reinforce relationship distress.

Finally, unhappy couples also develop a negative schema about the entire relationship history (Halford et al., 1997). Negative working models of self and other influence the way in which the couple experiences the relationship in general. Distressed partners not only have negative views of self and their partner, they remember

relationship events in ways that are consistent with their schema. They perceive their current interactions and past interactions in a negative light.

Prolonged marital conflict is the most frequently reported event preceding the onset of depression and anxiety disorders in women (Halford, Bouma, Kelly, & Young, 1990). Depression is also a natural part of the process of separation distress as outlined by Bowlby. It can be considered an expression of loss of the attachment figure and also of the sense of efficacy that arises from secure attachment. As might be expected from an attachment point of view, the quality of marital interactions may be associated with heightened vulnerability to stressful events and poor individual health (Johnson, 1999; Rust, Golombok, & Collier, 1989).

Therapeutic Tasks and the Process of Change

In EFT, the therapeutic tasks have been clearly specified and the process of change delineated in nine steps designed to be implemented in approximately 10 to 15 sessions (Johnson, 1996). The standard nine steps are mapped out as follows:

Stages	Steps & Descriptions
I Assessment & Delineation of Problematic Cycles	1. Create an alliance and delineate conflict issues in the struggle. 2. Identify the negative interactional cycle. 3. Access unacknowledged feelings and attachment needs. 4. Reframe problem in terms of underlying emotions and needs.
II Re-engagement	5. Promote identification with disowned needs and aspects of self. 6. Promote acceptance of partner's experience. 7. Facilitate the expression of unmet needs and wants.
III Consolidation	8. Facilitate the emergence of new solutions. 9. Consolidate new positions.

The first four steps involve assessment and the delineation of problematic cycles, such as demand/withdraw and the absorbing states of emotion that are associated with them. At the end of this stage of therapy the couple is able to dislodge from negative cycles and have stabilized their relationship. They tend to view the cycle as the enemy

rather than each other. This shift constitutes de-escalation or first order change. Although the couple appears less distressed, the overall organization of the interactions remains the same and they are susceptible to relapse should therapy terminate at this stage.

In the second stage (steps 5 to 7), both partners are able to use their emotional experience as a guide to their needs and communicate these needs in a way that maximizes their partner's responsiveness. Usually the more withdrawn partner is able to express the emotional experience that evoked the withdrawal and asks his/her partner for the responses that will make emotional engagement possible. For example, a withdrawn husband states that he will not tolerate sarcasm and hostile criticism but needs his wife's acceptance. The more hostile partner will then begin to explore the emotional realities that evoke the relationship stance. This usually involves expressing hurts, fears and disappointments, and taking new risks with the partner. It is at this point, as this partner is invited into a new dance, that the particular incidents that are the subject of this study come alive. If there have been no attachment injuries or if these injuries are resolved in the process of therapy this partner is able to explore insecurities and ask for comfort, caring and reassurance. This final interaction constitutes a second order change event associated with success in EFT, a "softening" (Johnson & Greenberg, 1988). These change events are powerful as they have the ability "to heal past injuries and wounds in the relationship" and create powerful new bonding events and the construction of a new positive cycle (Johnson, 1999, p. 21).

The final stage (steps 8-9) is concerned with the integration and consolidation of the positive changes that occurred during therapy. By reflecting on the process of therapy and validating new emotions and new interaction patterns that have replaced the

former negative interactional cycle, couples can construct clear models and narratives of their relationship. With this new ability to communicate clearly about crucial issues they can solve ongoing problems in the relationship.

Empirical Research on the Process of Change

The empirical investigation of change processes is a young field that spans only three decades. This research is complex and labor-intensive. Although numerous advances have been made, several methodological problems and issues have been raised. Three fundamental methodological issues are worthy of note.

The first issue concerns the process variables or clinically useful units of analysis (Marmar, 1990). In an attempt to generate an optimal set of process variables, either discrete or abstract variables have been used. Discrete variables may be easier to quantify and may be more reliable, but they lack sophistication. On the other hand, abstract variables tend to be difficult to operationalize and rate by clinical judges, hence yielding lower inter-rater reliabilities. One solution offered is to study variables at the middle level of abstraction.

Second, traditional process researchers have not represented multiple viewpoints regarding the therapeutic process (Elliot & Anderson, 1994; Garfield, 1990). Most researchers have had the option of utilizing the phenomenological perspective (e.g., client, therapist), behavioral perspective (e.g., trained non-participant raters), or multiple perspectives (e.g., client, therapist, and raters). Since objectivity is paramount in scientific research, previous investigators have often employed trained non-participant raters.

A third issue that has been a concern of late is the deficiencies with some of the process measures. Developing a good measure of the psychotherapeutic process is a complex, multi-step procedure that encompasses the generation of an item pool, dimensional structure, scoring formats, training manuals, and an assessment of inter-rater reliabilities (Marmar, 1990). Recently, efforts have been made to better classify the dimensions of process measures, such as direct versus indirect, focus (i.e., self, other), types of scaling, and pragmatic or classical coding schemes (Hill, 1990).

Two of the best process measures of client behavior are the Structural Analysis of Social Behavior (SASB; Benjamin, 1974) and the Experiencing Scale (Kline, Mathieu, Kiesler, & Gendlin, 1969). The SASB is a complex coding system designed to analyze and rate interpersonal processes. Statements of transcribed segments of therapy sessions are coded by trained raters as belonging to one of four quadrants (i.e., affiliative, distant, hostile, and friendly) on one of two grids (i.e., self and other). Statements may also be coded as belonging to one of 8 clusters and one of 36 tracks. The Experiencing Scale is designed to measure the quality of client involvement in psychotherapy. Trained raters code client statements on a 7-point scale ranging from superficial or detached (level 1) to deeper levels of feelings and internal processes (level 7). Both of these measures have been developed and are extensively used to capture client involvement and behavior (Greenberg & Pinsof, 1986).

Task Analysis Research Paradigm. One of the major shifts in process research is the development of an exploratory, investigative approach to study change processes. Task analysis, a research paradigm proposed by Greenberg (1984, 1986a, 1986b), is a rational-empirical methodology for discovering change episodes based on an intensive

analysis of recurring patterns of in-session client performance. The emphasis is on identifying, describing, explaining, and predicting therapeutic change processes in context throughout therapy. Studying the process of change requires the measurement of change over the course of therapy, and the measurement of change would be in vain unless change is linked to some kind of outcome.

Specifying the immediate outcomes is less complex than reliably measuring the type and size of variables for process ratings. Greenberg (1986a, 1986b) proposed that the variables be organized in a hierarchical fashion progressing from small observable units to broader contexts of meaning to describe in-session process. The levels most relevant to process research are content, speech act, episode, and relationship.

The *content level* refers to the specific words being used in discourse but without any reference to the message. The *speech act level* refers to the pragmatics of discourse, which includes the context of the discourse. The *episode level* refers to the sequence of interactions between the client and the therapist. Finally, the *relationship level* refers to the “sense of we” or the “particular qualities that people attribute to the ongoing relationship,” such as the therapeutic alliance (Greenberg, 1986b, p. 715).

Each of these levels, therefore, provides a context for the meaning and understanding of communicative acts in psychotherapy. In this new paradigm, “the segments of interest are not random samples that often fail to capture the salient phenomena in the change process and are not frequency counts, but rather they are change episodes or change events studied in context” (Marmar, 1990, p. 266). The episode is the most important level in the study of change, yet it has been given the least

attention (Greenberg, 1984). As a result, an events-based approach to studying change processes has been proposed.

Greenberg (1984) has defined a change event or therapeutic episode as “an interactional sequence between client and therapist” (p. 138). The sequence consists of the client problem marker (a client in-therapy state or condition), the therapist operation (intervention), the client performance (client’s response to the intervention that leads to change), and the immediate in-session outcome (Greenberg, 1986b). An event can be a diminutive three-statement interchange (i.e., client-therapist-client), encompass an entire therapy session, or occupy multiple sessions.

To study change events, Greenberg (1984) proposed using task analysis, which promotes the tracking and description of complex human performance. Task analysis has been used in the behavioral sciences, information processing, and educational psychology, for the purpose of analyzing successful performances.

The process analysis approach incorporates the analysis of performance and the analysis of information-processing competencies. This type of investigation strategy enables researchers to specify a sequence of recurring patterns (events) of client performances, to delineate the components of successful performance, and to develop models of change. The development of a change process model occurs through a series of single case analyses. The model is then tested by distinguishing between the event and the non-event state (Greenberg, 1984).

The task analytic approach to studying the process of change involves eight steps. The first six steps are discovery oriented and begin with the task selection and proceed to

a model of change. The final two steps are considered the verification phase

(Greenberg, 1984; Greenberg & Foerster, 1996; Greenberg & Newman, 1996).

Task Analysis

Phases	Steps
Discovery	1. Explicating the implicit map of experts 2. Selection and description of a task and task environment 3. Verification of task significance 4. The rational analysis: Constructing performance diagrams 5. Empirical Analysis: Description of actual performances 6. Comparison of actual with possible performances
Verification	7. Validation of the model 8. Relating process to outcome

Drawing on Greenberg and colleagues' (Greenberg & Foerster, 1996; Greenberg & Newman, 1996) description of the methodology, task analysis can be summarized as follows: Guided by EFT and clinical experience, the clinician/investigator maps out how change takes place. The task that is a recurrent problem across clients (e.g., attachment injury) is selected and the investigator operationalizes the distinctive features that 'mark' the beginning of the event. In order to verify the significance of the task, measures of the markers are then constructed after which a rationally derived set of possible performance strategies is clarified in order to facilitate task resolution. Rational analysis is followed by an empirical task analysis of actual in-therapy performances involving successful resolutions. A refined model is then constructed by comparing actual with possible performances. This requires successive repetitions or a progressive recycling between the rational model and empirical observation. The end product, which is the construction of a specific resolution model, sets the stage for the verification phase. This is achieved by comparing resolution and non-resolution performances to verify that the specified components of the model discriminate between the successful and unsuccessful

performances. This also enables the investigator to relate in-session change to intermediate and ultimate outcomes.

In summary, task analysis has been used to identify major clinical in-session change events, to build models of therapy, to refine models of change, and to predict complex therapy outcomes from in-session change processes (Greenberg & Newman, 1996). As a result of its utility, a number of researchers from diverse therapeutic orientations have used this approach to study change (e.g., Clark, 1996; Friedlander, Heatherington, Johnson & Skowron, 1994; Safran & Muran, 1996).

The Application of Task Analysis to EFT. Given the considerable amount of research on change processes, little attention has been paid to addressing the process of change in couples. Only recently has task analysis been used to identify and specify mechanisms of change in EFT. The basic premise of EFT is that when couples access their underlying emotions and needs, this process leads to changes in perceptions of self and other. To isolate the active ingredient of change, a number of studies were conducted.

Greenberg and Johnson (1985) developed a number of notions about the process of change and used these notions to develop a rational model of change. Their ideas about how change occurs were as follows.

- (1) One partner perceives him or herself differently by bringing into awareness experiences that are not congruent with his/her self-view;
- (2) As a result, the spouse begins to perceive his/her partner in a new way;
- (3) This reorganization leads to different behaviors and interactions;
- (4) The spouse's new perceptions of the partner lead to different responses; and

(5) Partner comes to see himself or herself in a new way.

These change processes provided the framework for subsequent empirical investigations. By employing the task analytic approach, Greenberg and colleagues (Greenberg, James & Conry, 1988) developed a more refined model of change. Twenty-one couples were interviewed four months after receiving EFT. They were asked to describe incidents in therapy that were particularly helpful or not helpful for them. Fifty-two incident descriptions were hand-sorted into categories according to similarities and computer analyzed to reveal latent categories. The five change process categories found were: changes in interpersonal perception following expressed feelings, expressing feelings and needs, acquiring understanding, taking responsibility (softening instead of blaming), and receiving validation from partner. These empirically derived findings were then compared to the rational model of change, which supported the notion that emotional expression is an important component in changing perceptions of self, other and the relationship.

To address how change processes are related to outcome, Johnson and Greenberg (1988) analyzed change processes in best sessions of EFT. Six couples were selected on the basis of extreme scores on the Dyadic Adjustment Scale (DAS; Spanier, 1976). Three couples with the greatest amount of change and three couples with the least amount of change in their marital satisfaction scores were selected. Client performance in therapy was rated on depth of experiencing measured by the Experiencing Scale (ES; Klein, Mathieu-Coughlin, & Kiesler, 1986) and the quality of interpersonal interactions measured by the Structural Analysis of Social Behavior (SASB; Benjamin, 1974). A comparison of successful and unsuccessful couples revealed that deep levels of

experiencing and autonomous/affiliative interactions characterized those couples that were successful in therapy.

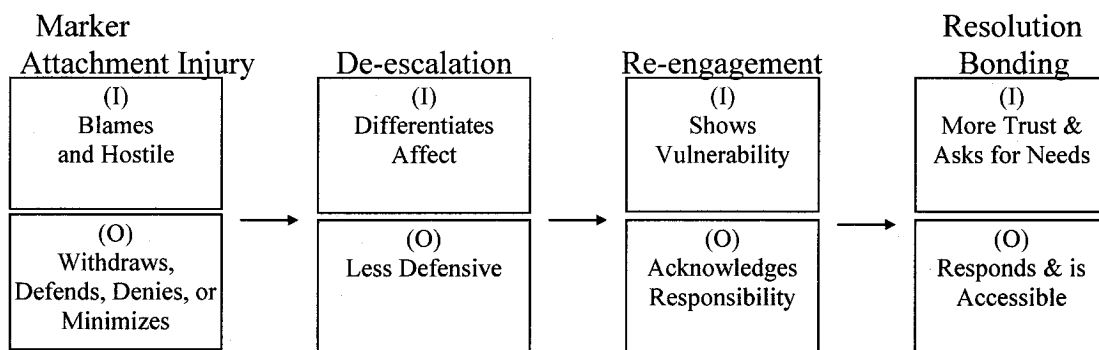
Greenberg, Ford, Alden, and Johnson (1993) also presented three event-based studies that compared change and no-change performances. In the first study, the investigators analyzed audio taped data of 22 couples (11 moderately distressed couples from a treatment group and 11 couples from a wait list group) at session 2 and session 7. The SASB-rated episodes showed that couples manifested a greater proportion of hostile behaviors at the beginning than at the end of therapy. In the second study, the investigators examined the depth of experience (measured by the ES) and degree of affiliation (measured by the SASB) in peak sessions (i.e., viewed by the couples as highly productive) and poor sessions (i.e., unproductive). The results of the chi square analysis revealed significantly more affiliative responses and depth of experiencing in peak than in poor sessions. The final study examined the role of affective self-disclosure. Using the SASB, five talk turns following self-disclosure were rated and compared to five-response control segments following a randomly selected talk turn. The results showed that responses from partners were more affiliative following intimate self-disclosures than the control segments.

These studies demonstrate several steps in the task-analytic research paradigm that are relevant to couples therapy. An in-depth analysis of change in EFT strongly suggests that the expression of underlying feelings and associated needs are helpful in couple therapy. Affective self-disclosure is associated with changes in perceptions of self and other, which is related to a shift in negative interactional patterns. Ultimately,

studies relating these processes to more distal outcomes are needed to further validate the model.

The Application of Task Analysis to Attachment Injuries. Recently, task analysis has been used to study a particular type of impasse in EFT referred to as attachment injuries. The understanding of key change events begins with a conceptual map of the conjectured process of change (Greenberg, 1986a). Drawing on previous EFT research and clinical experience has facilitated the development of a conceptual map about the process of resolving attachment injuries (Millikin, 2000). The conceptual attachment injury resolution model and process ratings were as follows (Note: “I” represents the injured partner and “O” represents the offending partner):

Conceptual Model of Attachment Injury Resolution



Marker

A marker denotes the beginning of the event. In this case, an attachment injury is typically “marked” by a highly emotional response (e.g., anger, hostility, blame) by the injured spouse, who describes a specific incident in which he/she felt abandoned and helpless, and experiencing a violation of trust that damaged his/her belief in the

relationship as a secure bond. The offending partner denies, discounts, or minimizes the incident and takes a defensive stance.

Process ratings:

SASB = Quadrant 2 or 3 (1-7 attacking and rejecting; 1-8 belittling and blaming; 2-7 protesting and withdrawing; 2-8 walling off and avoiding),

ES < Level 4 (1-avoids personal involvement; 2-superficial involvement; 3-emotionally reactive)

De-escalation

With the therapist's help, the injured partner stays in touch with the injury and begins to articulate its impact and attachment significance. New emotions frequently emerge at this point. Anger evolves into hurt, helplessness, fear, and shame. The connection of the injury to present negative cycles in the relationship becomes clear. The offending partner begins to hear and understand the significance of the event in attachment terms as a reflection of his/her importance to the injured partner, rather than as a reflection of personal inadequacy. Supported by the therapist, he/she acknowledges the injured partner's pain and suffering.

Process ratings:

SASB = Quadrant 3 (1-7 attacking and rejecting; 1-6 belittling and blaming; 2-7 protesting and withdrawing),

ES < Level 3 (feelings and personal reactions are clear but limited perspective)

Expression of Vulnerability/Emotional Engagement

The injured partner then tentatively moves toward a more integrated and complete articulation of the injury and expresses grief at the loss involved and fear concerning the

specific loss of the attachment bond. This partner allows the other to see his/her vulnerability. The offending partner becomes more emotionally engaged and acknowledges responsibility for his/her part in the attachment injury and expresses empathy, regret and/or remorse.

Process ratings:

SASB = Quadrant 1 (1-2 affirming and understanding; 2-2 disclosing and expressing)

ES = Level 4 (subjective felt flow of experience but not the focus of examination)

Risking/Bonding

The injured spouse then risks asking for comfort and caring from the partner, which was unavailable at the time of the injurious event. This event is similar to a change event in EFT entitled a “softening” (Johnson, 1996). The offending partner responds with caring and is able to reciprocally share his/her needs, fears, and hopes for the relationship. This marks the beginning of a positive cycle of bonding and connection that offers the antidote to the traumatic experience of the attachment injury. The entire process defines the relationship as a safe haven, fostering the resolution of other difficulties and entry into the final stage of therapy (i.e., consolidation).

Process ratings:

SASB = Quadrant 1 (1-2 affirming and understanding; 2-2 disclosing and expressing)

ES ≥ Level 4 (4-self-descriptive feelings; 5-purposeful elaboration and exploration of feelings and experiencing; 6-felt sense of an inner referent; 7-expanding awareness of present feelings and internal processes).

Rational-Empirical Model of Attachment Injury Resolution. Recently, a preliminary investigation of the process of attachment injury resolution was carried out in order to develop a rational-empirical model (Millikin, 2000). The investigator collected data from three mildly to moderately distressed couples who had undergone 15 sessions of EFT and successfully resolved the attachment injury. Successfully resolved couples were those who initially reported an attachment injury, showed improvements based on comparing pre- and post-treatment measures, and reported having resolved the attachment injury at the end of therapy. The SASB and ES measured the process of change for each partner at each of the steps of the model.

The rational model assumes that the attachment injury would be a workable model from the beginning of EFT and continue thematically throughout therapy until resolution. By comparing actual to possible performances, the results showed that the attachment injury typically emerges at the end of Stage 1, after de-escalation. Although couples may mention the attachment injury in assessment sessions, it was not successfully dealt with until after de-escalation. It was also noted that over the course of therapy, couples did not progress through this process in a linear fashion. Successful couples tended to vacillate between periods of closeness (re-engagement) and angry distance several times before experiencing a resolution/bonding event. The attachment injury model was revised to reflect the findings.

The following is a step-by-step description of the rational-empirical model of attachment injury resolution. Millikin (2000) provided clinical examples of the therapeutic process of a couple that successfully resolved their attachment injury.

Initially, this couple came to therapy because of communication problems. The attachment injury did not surface until the fifth session of EFT. An attack/distance relational cycle with the wife critically attacking and the husband defending and distancing was evident at assessment.

Assessment

- Injured partner shows secondary affect such as *blaming, hostility, critical anger and contempt*.
- Offending partner shows secondary affect such as *defensiveness, minimizing, withdrawal and avoidance*.

Example:

Injured Partner: I'm fed up...he does nothing. I was left to clean up the mess. I have a short fuse, especially when I have a bad day or a headache. He should just know. It takes a lot for me to get really angry and sometimes I have to get really angry just to get a reaction.

Offending Partner: I don't want her ranting and raving about everything that comes up. She does it all the time. If she has a problem, go find someone...one of your friends to talk to. I mean, I don't mind if she has a problem and needs to say something, but she gets upset all the time and tries to make me feel stupid...so I just stay out of her way.

De-escalation

- Injured partner shows less anger and more secondary affect such as fear, hurt, and helplessness.
- Offending partner becomes more engaged, listens more, less defensive.

Example:

Injured Partner: I am glad to hear that I am important to you. Sometimes, I just don't know how you feel about me or how you feel about anything.

Offending Partner: Well...I have never been a very expressive person, never talked a lot, but she knows that I do have feelings but I just don't talk a lot about them.

Steps Toward Attachment Injury Resolution: Marker

1. The marker denotes the beginning of the event. In this case, as the therapist encourages the injured spouse to begin to risk connecting with her now accessible partner, she begins to describe the incident in which she felt abandoned and helpless, experiencing a violation of trust that damaged her belief in the

relationship as a secure bond. She speaks of this incident in a highly emotional manner. The incident is alive and present rather than a calm recollection.

2. The offending partner discounts, denies or minimized the incident and her partner's pain and moves into a defensive stance.

Example:

Injured Partner: You are the same as always...never there when I really need you. Just like when I had the miscarriage, I remember blood was all over the place and I realized that I had just lost this baby. I called out and he came but then he shut down and went away. I just remember feeling so abandoned. My sister came in and gathered us up and we all got into the car and drove to the hospital. As we drove away, I was feeling totally alone staring down at the butter container that held my baby.

Offending Partner: I did everything I could. I felt so bad about losing our baby but I had to keep cool because somebody had to take care of things. I called her family on the phone, made arrangements for our son to be looked after, and called the hospital. I was there for her...she just doesn't remember that.

Differentiation of Affect

3. With the therapist's help, the injured spouse stays in touch with the injury and begins to articulate its impact and its attachment significance. New emotions frequently emerge at this point. Anger evolves into clear expressions of hurt, helplessness, fear, and shame. The connection of the injury to present negative cycles in the relationship becomes clear.
4. The offending partner supported by the therapist begins to hear and understand the significance of the injurious event

Example:

Injured Partner: I was so afraid. I thought that I did not matter...the baby didn't matter...we were insignificant in your life. At times, I feel so scared and alone that I want to just smack you just so you know that you cannot discount me and my feelings like that.

Offending Partner: I didn't realize that you felt abandoned then and so alone.

(Reengagement) Shows Vulnerability and Acknowledges Responsibility

5. The injured partner then tentatively moves toward a more integrated and complete articulation of the injury and expresses grief at the loss involved in it and fear concerning the specific loss of the attachment bond. This partner allows the other to witness her vulnerability.
6. The offending partner becomes more emotionally engaged and acknowledges responsibility for his part in the attachment injury and expresses empathy, regret and/or remorse.

Example:

Injured Partner: I not only lost the baby, I thought I lost you too. We have never talked about this miscarriage or the others. Our babies died and there was no burial...nothing but silence. I needed you to hold me, say that everything will be ok, and to show that you were sad too.

Offending Partner: I am so sorry. I felt so bad about losing another baby and scared that I might lose you too. I guess I'm just not very good at expressing my feelings all the time. After I called for help I should have stayed with you. I was so wrapped up in making sure everything was taken care of but I realize that I didn't really take care of you. I really messed up.

Resolution (Risking and Responding)

7. The injured partner then risks asking for the comfort and caring from the partner that were unavailable at the time of the injurious event.
8. The offending partner responds in a caring manner that acts as an antidote to the traumatic experience of the attachment injury.

Injured Partner: I did not know that you were grieving the loss of our baby too. I was afraid that you did not care...that you did not really love me. That was more than I could bear. I need to know that you care and that you feel the same as I do about our babies. I don't have closure on that. I would like to do something in memory of them...just the two of us...to say good-bye...so, so we can move on.

Offending Partner: I do care (he reaches out to her and takes her hand and in a soft voice says). Yes, why don't we do something...something private...just you and me. Let's do that.

According to Millikin (2000), the ratings on the SASB and ES fell within the predicted ranges for each component of the model. At the resolution phase, the couples were much more affiliative and expressed feelings at a much deeper level. Specifically, the injured partners continued to differentiate affect, express vulnerability and were able to describe the event in terms of attachment significance. The offending partners became more engaged. They listened more, acknowledged their partner's pain, and took responsibility for their part in the attachment injury. Consequently, the injured partner risked asking for comfort and caring that was absent at the time of the injurious event.

This resolution element is similar to a softening event, which is a key change event in EFT (Johnson, 1996).

In terms of the psychotherapy outcome, a qualitative analysis of marital satisfaction and level of trust showed overall improvements for all three couples. The couples also reported a change in attachment style from pre- to post-therapy. As a result of working through the attachment injury, the couples shifted from preoccupied and dismissive attachment styles to more a secure pattern of attachment. At the end of therapy, all couples reported that the attachment injury was only a slight problem for them.

Rationale for this Study

The current investigation is designed to build on research regarding the process of resolving attachment injuries. As in previous research, the focus of this investigation is on client performances rather than client-therapist processes. A strict adherence to the EFT treatment manual assists in treating the therapist's behavior as a controlled variable (Johnson & Greenberg, 1988). This allows the investigator to examine client processes and to analyze how change occurs within the couple system.

Given that task analysis was used in previous attachment injury research and the goal of this study is to build on earlier findings, task analysis is the research methodology used in this study. The task analytic approach to model building is divided into the discovery and verification phases (Greenberg & Foerster, 1996). The rational and empirical aspects of the discovery phase have already been carried out and a revised model has been clearly delineated. This model has provided the groundwork for the second phase of research, the verification phase.

The verification phase has two stages. The first stage, which is particularly germane to this study, involves ratings based on the various process measures to compare resolution and non-resolution performances to confirm that the steps of the model actually discriminate between the two groups. If the observed patterns and steps of the model are found to discriminate between resolution and non-resolution performances, then the attachment injury resolution model will be deemed credible (Greenberg & Newman, 1996). In this study, two psychometrically valid process measures of client responses that will be used are the Experiencing Scale (ES; Klein et al., 1986) and the Structural Analysis of Social Behavior (SASB; Benjamin, 1974).

The second stage of the verification phase involves relating the process of change to distal outcomes. As such, various outcome measures will be administered pre- and post-therapy. The measures pertinent to this investigation are the Dyadic Adjustment Scale (DAS; Spanier, 1976), Relationship Trust Scale (RTS; Holmes, Boon & Adams, 1990), Experiences in Close Relationships (ECR; Brennan, Clark, & Shaver, 1998), and the Interpersonal Relationship Resolution Scale (IRRS; Hargrave & Sells, 1997).

Hypotheses

1. The first set of hypotheses ensures that differences between groups are not related to other variables. It is predicted that post-treatment group differences will not be attributed to:
 - (a) treatment implementation,
 - (b) the therapeutic alliance,
 - (c) demographic characteristics (e.g., SES, education, age, number of years together), and

(d) scores on the outcome measures at pre-treatment.

In the event that the tests are significant, these variables will be used as covariates in subsequent analyses.

2. The second set of hypotheses is designed to examine pre-treatment differences on the process measures. Using clinical and theoretically meaningful process measures, it is predicted that:

(a) best session group differences in the ratings of the Structural Analysis of Social Behavior (SASB) will not be attributed to differences at pre-treatment, and

(b) best session group differences in the ratings of the Experiencing Scale (ES) will not be attributed to differences at pre-treatment.

3. The third set of hypotheses is designed to verify the recently developed attachment injury resolution model. Using clinical and theoretically meaningful process measures, it is predicted that resolved couples will exhibit:

(a) more affiliative responses (i.e., disclosing and expressing needs, affirm and understanding) and less hostile/distant responses (i.e., attack and blame, defend and withdraw) in best sessions than non-resolved couples.

(b) deeper levels of experiencing in best sessions than non-resolved couples.

4. The fourth set of hypotheses is designed to test whether the process of change model is related to treatment effects. It is predicted that resolved couples will show:

(a) significant decreases in marital distress at post-treatment, as measured by the Dyadic Adjustment Scale,

- (b) significant gains in the level of relationship trust, as measured by the Relationship Trust Scale,
- (c) significantly less avoidant and anxious attachment, as measured by the Experiences in Close Relationships Scale, and
- (d) significant increases in the level of forgiveness and decreases in emotional pain, as measured by the Interpersonal Relationship Resolution Scale than non-resolved couples.

Method

Participants

The 24 couples in this study were recruited through advertisements in local media and mental health facilities that described the research project. All respondents were screened using a standardized telephone screening procedure (See Appendix A for media advertisement and the telephone screening procedure). In selecting the pool of participants for this study, couples had to meet the following inclusion criteria:

- The couples had been living together for at least one year.
- Neither partner had a drug or alcohol problem.
- Neither partner was receiving psychiatric treatment.
- Neither partner had a history of sexual abuse.
- There was no physical violence in the relationship.
- One partner had to have identified an incident of betrayal or loss of trust in the relationship.
- Scores on the Dyadic Adjustment Scale (DAS) had to be in the mild to moderate distress range for at least one partner (i.e., scores between 80 and 97).

The rationale for the final criterion was that scores lower than 97 are indicative of marital distress. Scores lower than 80 are indicative of severe distress and scores 70 or below correspond to those couples seeking divorce (Spanier, 1976).

Therapists and Setting

A total of 13 therapists with prior training in EFT were involved in the research project. Five therapists were Ph.D. clinical psychology interns at the Centre for Psychological Services (CPS) at the University of Ottawa. The remaining nine therapists

were team members of the Marital and Family Therapy Clinic. All of the therapists offered services on a voluntary basis. Therapy was carried out at CPS, the Ottawa Couples and Family Institute (OCFI), or at private practice facilities. Throughout the study, therapists received weekly group and/or individual supervision by Dr. Sue Johnson, who is an academic faculty member at the University of Ottawa, the director of the Ottawa Couple & Family Institute, and the originator of EFT for couples.

Measures

Process Measures

These frequently used process measures were selected for their ability to capture client processes (e.g., Greenberg & Foerster 1996; Johnson & Greenberg, 1988).

The Experiencing Scale (ES). The ES (Klein, Mathieu-Coughlin, & Kiesler, 1986), is a 7-point rating scale that measures in-session level of experiencing and is very sensitive to changes in the couple's involvement in therapy. Moving up the scale, there is a gradual progression from superficial, interpersonal self-references to simple, limited, or externalized self-references, to a synthesis of newly emerged feelings and new awareness that leads to problem solving and better self-understanding.

The validity of the scale has been supported by its correlation with client variables such as introspection and cognitive complexity (Klein et al., 1986). The scale has been used to predict client change, especially in client-centered therapy (Orlinsky & Howard, 1986). The scale has been shown to be reliable in terms of measuring client involvement or "experiencing" in therapy with early studies showing inter-rater reliability coefficients ranging from .75 to .92. (Klein et al., 1969). More recently, researchers have reported inter-rater reliability coefficients between .84 and .90 ($p < .001$) (e.g., Greenberg &

Foerster, 1996; Johnson & Greenberg, 1988). General descriptions of the seven scale stages as well as short form descriptors are provided in Appendix B.

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

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

This coding system has shown to be a valid and reliable instrument. The validity of this instrument has been established by factor analysis, circumplex analysis, and dimensional ratings (Benjamin, 1977). The SASB behavioral ratings show significant correlations ($r > .71$) with average cluster scores from self-rating questionnaires completed by family members of the identified patient (Benjamin, Foster, Roberto, & Estroff, 1986). Inter-clinician reliability for difficult material containing multiple and complex messages yielded kappas between .70 and .85 (Benjamin et al., 1986). By using trained undergraduate students, kappas ranged from .61 to .79. However, by using group

consensual judgments (two independent coders followed by two additional coders and then group consensus) kappa coefficients ranged from .80 to .84 with a mean of .81 for process codes (Benjamin et al., 1986). A copy of the SASB model and the levels of increasing complexity are in Appendix B.

Rater Selection and Training. Two graduate students from the department of psychology were selected to rate the process data. They received training on the process measures. For the ES and the SASB, training consisted of four two-hour sessions, which involved the rating of practice segments. They were trained to .70 level of reliability with each other on both the ES and the SASB.

Self-Report Measures

The following self-report instruments have been selected on the basis of their theoretical relevance to EFT, their ability to detect changes in couples with an attachment injury, and their ability to predict outcome in distressed couples (Greenberg & Webster 1982; Johnson & Talitman, 1997; Millikin, 2000).

Post-Session Resolution Questionnaire (PSRQ). The PSRQ is designed to measure the amount of in-session change perceived by the couple. The questionnaire, which is adapted from Orlinsky and Howard's (1975) Therapy Session Report Questionnaire, consists of three 5-point and one 7-point session evaluation scales. The PSRQ evaluates how resolved the couples feel they are in relation to the issues that brought them into therapy. The first scale asks the couple to identify whether the issue dealt with in the session was related to the issue identified at the beginning of therapy. The remaining three scales are grouped together to derive a single PSRQ change score. The two scales are showed high correlations (Greenberg & Webster, 1982) and can be

grouped together to form a single score. High scores are indicative of no change and low scores are indicative of much change. This instrument has only face validity but has been used in previous studies to successfully identify best sessions (Greenberg & Foerster, 1996; Greenberg & Webster, 1982; Greenberg et al., 1993). A copy of this scale is in Appendix C.

Attachment Injury Measure (AIM). The AIM (Millikin, 2000) is a modification of the Target Complaints Discomfort Box Scale (TCDBS; Battle, Imber, Hoehn-Saric, Stone, Nash, & Frank, 1966). This single-item scale was developed to obtain a written description of the injury as well as a measure of its severity (Millikin, 2000). Each partner is asked to describe the nature of the attachment injury from his or her point of view. It also asks the couple to rate the severity of the attachment injury on a 7-point scale from 1 (Not at all Severe) to 7 (Extremely Severe). For the purpose of this study, the measure was expanded by adding 3 additional severity items and 2 hope items, thus yielding a total of 6 items.

To obtain a score for the AIM, individuals are asked to rate the first 4 items on a 5-point severity scale ranging from severe (1) to negligible (5). The remaining two items are rated on a 5-point scale ranging from very much (1) not at all (5). The theoretical range of scores is 5 to 30. High scores are indicative of a greater resolution of the attachment injury than low scores. A couple's mean score is obtained by averaging the sum of each partner's score. In this study, internal consistency ranged from .66 to .90. See Appendix C for a copy of this scale.

The Dyadic Adjustment Scale (DAS). The DAS (Spanier, 1976) is a 32-item self-report rating scale designed to measure the quality of adjustment between married or

cohabiting couples. It is currently considered the instrument of choice for the assessment of relationship adjustment. The scale yields a total adjustment score, as well as scores on four subscales: Satisfaction (10 items), Consensus (13 items), Cohesion (5 items), and Affectional Expression (4 items). The DAS was used in this study to select mild to moderately distressed couples, and to ensure that resolving attachment injuries in these couples actually made a difference in their relationship.

There is evidence that the DAS is a valid and reliable measure of dyadic adjustment (Spanier, 1976). Internal consistency has been determined for each of the subscales and for the total measure using Cronbach's Coefficient Alpha (Cronbach, 1960). Reliability coefficients ranged from .73 to .94 for the subscales, and .96 for the total dyadic adjustment scale. Content validity was determined by evaluating the relevance of each item to contemporary relationships, its consistency with nominal definitions of adjustment and the components (i.e., satisfaction, cohesion, and consensus), and its wording with the fixed choice responses (Spanier and Cole, 1974, as cited in Spanier, 1976). Criterion-related validity was established by assessing the difference of each item with the external criterion of marital status (divorce vs. married couples). On the total scale score, divorced and married couples differed significantly ($p < .001$). Construct validity was established by factor analysis and by correlating this scale with the Locke-Wallace Marital Adjustment Scale, which is a frequently used scale. Correlations between these scales were .86 for married and .89 for divorced respondents.

The DAS is scored by summing the weights of each fixed response. The scale score has a theoretical range of 0-151. High scores are indicative of less distress and better adjustment. Mean total scale scores of 114.8 are indicative of happily married

couples and 70.7 for divorced couples. The distress cut-off point of 97 has been set at one standard deviation (17.8 below the mean for the married sample). Any couple scoring below 97 is considered distressed. The average of each partner's score yields the couple's mean total score. See Appendix C for a copy of the DAS.

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

Reliability for this scale was established for each of the component subscales, as well as for the total scale using Cronbach's Coefficient Alpha (Holmes et al., 1990). The standardized reliabilities for the above subscales were .89, .83, .84, .84, and .83, respectively. Reliability for the entire scale was .89. Test-retest reliability over a three-year period was approximately .72. Construct validity was obtained by assessing the relationship between this scale and other measures that assess comfort being close to her/his partner and the availability and responsiveness of the partner (Boon & Holmes, 1990). This sample consisted of 70 married couples and the results showed a strong relationship between scores on the trust scale and the couples' experiences in their relationship. This revised scale also has demonstrated discriminant validity by contrasts

with measures of self-disclosure, ambivalence, and anger, for both partners (Holmes et al., 1990).

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

Experiences in Close Relationships (ECR). The ECR (Brennan, Clark & Shaver, 1998) is a 36-item measure of adult attachment consisting of two 18-item self-report scales: anxiety and avoidance. The measure was developed in response to the lack of convergence on a common and reliable method for assessing adult attachment patterns. The construction of this scale involved the incorporation of attachment measures involving single-item prototype descriptions of attachment (e.g., Bartholomew & Howowitz, 1991) and every extant multi-item self-report adult attachment measure in the literature (e.g., Brennan & Shaver, 1995; Collins & Read, 1990).

There is evidence that this scale is a valid and reliable measure of adult attachment (Brennan et al., 1998). Construct validity based on factor analysis with oblique rotation was established by administering the preliminary 323 items to 1,086 participants. Sixty constructs loaded onto two factors. The correlation between the two factors was only .12, suggesting the underlying attachment dimensions are orthogonal. Two 18-item scales were constructed by selecting 36 items with the highest absolute-value correlations with the two higher-order factors. The two scales were orthogonal ($r =$

.11). The correlation between the revised version and the original scale was .95. This measure is able to discriminate among Bartholomew's (1990) four types of attachment ($p = .0001$). Internal consistency has been determined for both scales using Cronbach's Coefficient Alpha (Cronbach, 1960). Reliability coefficients for the avoidance and anxiety scales were .94 and .91, respectively. This measure can also be used to classify individuals into one of four adult romantic attachment categories: Secure, Fearful, Preoccupied, and Dismissing (Brennan et al., 1998).

To obtain a score for this scale, individuals are asked to respond to the 36 items on a 7-point scale ranging from "Disagree Strongly" (1) to "Agree Strongly" (5). The two scales are individually summed with a total score ranging from 18 to 126. High scores are indicative of avoidance and anxiety. This scale is included because of its psychometric properties, its ability to analyze attachment patterns in terms of a two-dimensional space, and its ability to classify individuals into one of four attachment styles. See Appendix C for a copy of this scale.

Interpersonal Relationship Resolution Scale (IRRS). The IRRS (Hargrave & Sells, 1997) is a 44-item self-report rating scale designed to assess the extent to which a person who has been hurt by a significant other continues to feel pain as a result of the offence and has forgiven that person for the offence. This instrument consists of two scales and eight subscales that measure individual work in forgiveness along four constructs: Insight (5 items), Understanding (5 items), Giving the Opportunity for Compensation (7 items), and Overt Act of Forgiveness (5 items). The second scale, which measures the manifestations of pain resulting from violations of trust and love,

consists of four constructs: Shame (6 items), Rage (6 items), Control (4 items), and Chaos (6 items).

Reliability for this instrument was established by using Cronbach's alpha analysis on the two scales and the corresponding subscales. Reliability for the Forgiveness and the Pain Scale was .92 and .95, respectively. Internal consistency for the four Forgiveness subscales ranged from .63 to .86. Internal consistency for the four Pain subscales ranged from .74 to .87 (Hargrave & Sells, 1997).

Construct validity based on factor analysis with varimax rotation was established by administering the preliminary scale items to 164 participants. Items that loaded on a construct at or above the .45 level were included in the final version of the IRRS. Concurrent validity of the revised IRRS was determined by correlating it with the Personal Authority in the Family System Questionnaire (PAFS-Q; Bray, Williamson, & Malone, 1984), the Relational Ethics Scale (RES; Hargrave & Bomba, 1993), the Fundamental Interpersonal Relations Orientation – Behavior Scale (FIRO-B; Fisher, Macrosson, & Walker, 1995), and the Burns Depression Checklist (BDC; Burns, 1994). The forgiveness scale had significant correlations with subscales on the PAFS-Q (.37), RES (-.45), and the FIRO-B (-.39). The pain scale had significant correlation coefficients with all the measures ranging from -.40 to .72. Finally, predictive validity of this instrument was obtained by its ability to discriminate between clinical and nonclinical samples (Hargrave & Sells, 1997).

To obtain a score for this scale, individuals are asked to respond "Yes" or "No" to each of the 44 items. Summing the weights of each response yields a score for the eight subscales. High scores on the Forgiveness Scale indicate that the individual has made

little progress in the work toward forgiveness and low scores are indicative of considerable progress. High scores on the Pain Scale indicate that the individual has made considerable progress, whereas low scores indicate that they are experiencing a wide range of feelings and actions as they vacillate between shame/rage and control/chaotic cycles. See Appendix C for a copy of this scale.

Couples Therapy Alliance Scale (AS). The AS (Pinsof & Catherall, 1986) is a 28-item measure designed to assess the couple's perception of the therapeutic alliance. This instrument is often used to control for client-therapist relationship variables that have been shown to be important in predicting therapeutic outcomes (e.g., Bergin & Garfield, 1986). The instrument was used in this study to ensure that differences between resolved and non-resolved couples could not be attributed to a poor therapeutic alliance. The scale was administered privately to each partner after the third session to detect any differences in the alliance, which appears to occur earlier rather than later in the treatment process.

The scale was developed to assess the alliance on two theoretical dimensions: Content and Interpersonal System. The content dimension, which is based on the work of Bordin (1979), consists of three components: bond between the therapist and client, the degree of agreement as to the therapeutic goals, and engagement in tasks relevant to the process of therapy. The Interpersonal System dimension consists of viewing these key components in relationship to Self (11 items), Other (11 items), and the Relationship (6 items).

This instrument has been shown to be reliable and valid. Internal consistency for the total test was calculated at .96 (Johnson & Greenberg, 1985b). For each of the

subscales (i.e., self, other, the relationship) coefficients were .88, .92, and .85, respectively. Test-retest reliability at one week was .84 ($p < .005$) for an earlier 5-point version of the test and .79 ($p < .005$) for the most recent 7-point version (Pinsof & Catherall, 1986). Preliminary results regarding predictive validity have shown a significant positive correlation ($p < .05$) between the overall alliance score and patient progress (Pinsof & Catherall, 1986).

To obtain a score for this instrument, each partner individually rates the extent to which he or she agrees or disagrees with each statement. The ratings are made on a 7-point scale, ranging from “Completely Agree” (7) to “Completely Disagree” (1), with a “Neutral” (4) as a midpoint. The theoretical range of scores is 28-196. Higher scores reflect a higher quality of the alliance between the couple and therapist. The overall mean couple score is determined by averaging the sum of each partner’s overall score.

Implementation Check

A concern for this study is that the therapy condition is implemented faithfully. In order to ascertain whether the interventions stipulated in the treatment manual have taken place, two procedures were carried out. First, the supervisor audited segments of therapy sessions played during group supervision to ensure the therapist implemented the approach faithfully. Second, the principal investigator audited tapes of sessions picked at random. Third, a checklist of therapist interventions used in previous studies was also used (Dandeneau & Johnson, 1994; Johnson & Greenberg, 1985a; Johnson & Talitman, 1997). The checklist consists of 16 interventions. Eight interventions selected from the EFT manual are considered EFT interventions. Eight interventions considered to be non-EFT interventions were also included. Interventions considered to be specific to EFT are

1,3,5,7,9,11,13, and 15 (See Appendix A for a copy of the checklist). For each couple, 10 minutes of the first and best sessions were transcribed and rated by two independent raters (doctoral students with two years experience in EFT). Raters were provided with three hours of training in order to obtain an acceptable level of inter-rater reliability of .80.

Clinical Procedures

Telephone Screening

The initial contact with couples, who responded to an announcement in local media and mental health facilities, began with a description of a free, brief program of therapy for couples wishing to improve trust and security in their relationship following an injurious incident. The principal investigator then conducted telephone screening interviews. Using a structured format, callers were first asked how they heard about the study. Then callers were asked to provide verbal consent before proceeding with questions to assess their suitability for the study. Those couples that met the inclusion criteria were invited to come to the University for an intake interview and an appointment date and time was set.

Intake Interview

The principal investigator conducted all of the intake interviews, which took approximately 30 minutes. During this phase, procedures were described, the couple was assured of confidentiality of information, and each partner was asked to sign a consent form (see Appendix A). Couples were also notified that the therapy sessions would be either audio or videotaped. During the intake interview, the researcher had the opportunity to ask additional questions to ensure suitability. A statement of a specific or

prototypical incident of betrayal or rejection in the relationship was considered the attachment injury marker. Those couples that met the inclusion criteria and expressed their interest in participating proceeded to the assessment phase.

Assessment

At the end of the intake session, both partners were asked to complete a questionnaire package consisting of demographic information, the Attachment Injury Measure (AIM), the Dyadic Adjustment Scale (DAS), the Relationship Trust Scale (RTS), the Experiences in Close Relationships (ECR), and the Interpersonal Relationship Resolution Scale (IRRS). The DAS was scored immediately in order to identify prospective couples. To be included in the study, the injured partner's score on the DAS ideally should have been between 80 and 97. Couples that had scores below 70 (divorce range) and indicated low commitment to their relationship (DAS item # 32) were advised that they did not meet the requirements of the study. They were informed that if they wished, they could be referred either to the Centre for Psychological Services or to another provider of psychological services. Couples meeting all the requirements for the study were informed that they would be contacted by a therapist, who would offer them 12 sessions of EFT.

Treatment

The couples that participated in the study received on average 13 sessions of therapy that focused on the resolution of the attachment injury. At the end of each of the sessions, therapists asked both partners to complete the Post-Session Resolution Questionnaire (PSRQ). At the end of the third session, therapists asked each partner to complete the Couples Therapy Alliance Scale. At the final session, each partner

completed the PSRQ, the AIM, the DAS, the RTS, the ECR, and the IRRS. An implementation check was also conducted to ensure that the therapy condition was implemented faithfully.

Selection of Resolved and Non-resolved Couples

At the end of the program of therapy, couples were assigned to the resolved or non-resolved groups. To be identified as resolved, three criteria had to be met (i.e., a judgment of resolution from the perspective of the couple, the therapist, and a clinical judge). For couple identification, both partners had to have a mean score greater than 10 on the AIM. Therapist identification required each therapist to identify best sessions by using the PSRQ. A post-session rating of 5 or above on the 7-point resolution subscale of the PSRQ in couples who expressed responsibility and risked asking for comfort were considered potential resolution sessions. Therapists queued up audiotapes of best sessions to the most advanced step of the resolution model for each couple. These tapes were used as a midpoint for a ten-minute segment that was transcribed for process ratings. Finally, a clinical judge trained in EFT and familiar with the model, made a judgment based on listening to the tapes consisting of ten-minutes of dialogue. The non-resolved group consisted of couples that had a rating of 10 or less on the AIM, were not selected by the therapist and/or clinical judge as having resolved the attachment injury. There was no difficulty identifying resolved and non-resolved couples.

Selection of Transcripts for Rating

Ten-minute taped segments of best sessions were transcribed for rating on the process measures (i.e., SASB and ES). These transcripts were randomly presented to two

graduate students, who were unaware of the hypotheses of the study. The two raters had received sufficient training on the process measures and the model of resolving attachment injuries. The units for the ratings are statements from the couples. Dialogue between the client and the therapist were not rated. Cohen's kappa (Cohen, 1960) that yields a coefficient of agreement for nominal scales was used to determine the extent of agreement between the two raters. Kappas for the ES, SASB quadrant, and SASB cluster were .83, .84 and .73, respectively.

Data Analyses

All statistical analyses were carried out using the SPSS 11 statistical package. The preliminary analyses are presented as follows: demographic characteristics, clinical characteristics, data screening, and the psychometric properties of the measures. Descriptive statistics were provided for all variables and reliability analyses were conducted using Cronbach's (1960) coefficient alpha.

In order to test for pre-treatment group differences the following analyses were carried out. To verify that treatment was properly implemented, inter-rater reliability analysis was conducted on ratings of therapist statements by two independent raters. Scores on the Couples Therapy Alliance Scale were analyzed using one-way analysis of variance to check for group differences for the injured partners, offending partners, and couples. For the continuous demographic variables, univariate analyses of variance were carried out comparing the resolved and non-resolved groups. Chi-square tests were performed for categorical variables. Pre-treatment comparisons of the dependent variables were carried out using between-groups multivariate analyses of variance.

To test the set of hypotheses related to the process of change, a series of 2 (presence vs. absence of response) by 2 (resolved vs. non-resolved) chi-square tests of significance were performed for each response type at pre-treatment and post-treatment. In cases where the minimum expected frequency requirements were not fulfilled, Fisher's exact probability values were provided.

To test the hypotheses that link the process of change to outcome, repeated measures analyses were conducted with resolved and non-resolved groups as the between-subjects independent variable and partner type (i.e., injured vs. offending) and time (i.e., pre-treatment vs. post-treatment) as the within-subjects independent variables. Separate analyses were conducted on each of the dependent variables (i.e., DAS, RTS, ECR avoidance, ECR anxiety). Given that the IRRS scores were only available for the injured partners, a doubly multivariate analysis (i.e., MANOVA with a repeated measures component) was performed on the dependent variables: emotional pain and forgiveness. To control for Type I error rate, Bonferroni correction was used to reduce the likelihood of spurious results.

Finally, to measure the resolution process for the entire sample, separate regression analyses were conducted to determine if the variables (i.e., dyadic adjustment, relationship trust, avoidance and anxiety attachment dimensions, emotional pain and forgiveness) are good predictors of attachment injury resolution, as measured by the Attachment Injury Measure (AIM).

Results

The results are organized into five stages. The first stage involves preliminary analyses including descriptive characteristics, data screening, and the psychometric properties of the measures (internal consistency). The second stage tested the hypotheses related to group differences on treatment implementation, the therapeutic alliance, and the demographic variables. The third stage examined the hypotheses related to statistical differences between resolved and non-resolved couples on the process variables at pre- and post-treatment. The fourth stage examined the hypotheses related to statistical differences between resolved and non-resolved couples at pre- and post-treatment. Finally, regression analyses were carried out to test the association between the predictor variables and level of resolution for the total sample.

Stage One: Preliminary Analyses

Descriptive Characteristics

A total of 107 couples responded to media advertisements. Thirty couples met the inclusion criteria. Of these participants, 3 couples declined participation prior to the onset of therapy. One couple dropped out of the study after the initial session. Two couples expressed their decision to terminate their relationship once therapy commenced. In total, 24 couples completed the course of therapy and the pre- and post-treatment questionnaire packages. Based on clinical observation and self-report, the mean couple dyadic adjustment was 84 (range 67 to 100). Each couple identified an event that altered the quality of their relationship bond and expressed a desire for closure. These injurious events were the primary focus of therapy. However, over the course of treatment, therapists discovered that many of the non-resolved couples had multiple or compound

attachment injuries. For example, while helping a couple attain closure on a recent event involving infidelity, the withdrawn offending partner disclosed feelings of anger dating back to the first year of their common-law relationship when his wife decided to separate and took their newborn child with her. Table 1 summarizes the types of attachment injuries reported at intake by couples that participated in the study.

Table 1

Summary of Types and Frequencies of Attachment Injuries in the Resolved and Non-resolved Groups

Type of Attachment Injury	Resolved ^a	Non-Resolved ^b
Abandonment	3	0
Derogatory Remark	1	0
Exotic Message	0	1
Financial Investment/Loss	0	1
Flirtation	1	3
Friendship with Opposite Sex	1	1
Infidelity	7	3
Miscarriage	2	0

^a n = 15 couples

^b n = 9 couples

At the end of treatment, 15 couples were identified as having resolved the attachment injury and 9 couples were identified as unresolved. For the resolved group, the onset of the events reported dates back from 1 to 11 years. They received an average of 14 sessions of emotionally focused therapy (EFT). For the non-resolved couples,

onset ranged from 1 to 12 years. They received, on average, 12 sessions of emotionally focused therapy.

Data Screening

Prior to computerized analyses, the data file was visually examined to ensure the accuracy of data entry. For 6 of the 24 couples, each item of the questionnaires (pre- and post-treatment) was compared to the computerized data file. There were only two occurrences out of 3984 where the value differed from the value on the questionnaire. This suggests a very high degree of accuracy was maintained during the transformation from the hard copy questionnaire scores to electronic data.

Data were missing for three couples on two of the measures (i.e., ECR and IRRS) at pre- and post-treatment. In addition, two couples did not complete the Couples Therapy Alliance Scale. After careful consideration, the group mean was used in order to maximize sample size. It is important to note that although the IRRS was administered to both partners, 9 offending partners commented that many of the items were not relevant to them and consequently the items were left blank. Therefore, analyses were conducted only for the injured partners.

Descriptive statistics were calculated for all variables to identify the presence of univariate outliers. An inspection of standardized scores (z scores) and histograms was undertaken on all dependent and independent variables. Standardized scores exceeding the recommended maximum of ± 3.29 ($p = .001$) are potential univariate outliers (Tabachnick & Fidel, 2001). The results revealed that all cases were within the acceptable limits. Mahalanobis distance probability estimate of $p = .001$ was used to

identify multivariate outliers. No multivariate outliers were found for the pre- and post-treatment data.

Univariate normality was assessed by an examination of skewness, as well as an examination of the histograms for the variables to be included in the study. Standard scores were obtained by dividing the values for skewness by their respective standard errors. Standardized scores exceeding ± 3.29 ($p = .001$) were considered to represent significant departures from normality (Tabachnick & Fidell, 2001). The scores were within reasonable limits.

Multicollinearity and singularity were assessed using SPSS collinearity diagnostic and by examining correlation coefficients of the dependent variables. No multicollinearity or singularity was evident. However, some of the dependent variables were significantly correlated with each other. Table 2 has the Pearson correlation coefficients for the dependent variables.

Finally, analysis of Box's M test of homogeneity of variance-covariance matrices within each cell for the two groups at pre- and post-treatment for the injured and offending partners using a significance level of .001 showed no violation of the assumption with the DAS, $F(10, 1411) = 1.447, p > .001$, the RTS, $F(10, 1311) = 1.243, p > .001$ and the forgiveness subscale of the IRRS, $F(10, 1311) = 2.107, p > .001$. The Box's M test for the two continuous attachment dimensions (i.e., anxiety and avoidance) showed no violation at pre- and post-treatment for the injured and offending partners, $F(36, 962) = 1.1, p > .001$. Levene's test of equality of error variances for the univariate between group analyses showed no violation at $p = .001$.

Table 2

Pearson Correlations between the Dependent Variables at Pre-treatment

Variables	DAS	RTS	ERC		IRRS	
			Anxiety	Avoidance	Forgiveness	Pain
DAS	1.00	.69**	.09	-.25	-.38	.23
RTS		1.00	-.03	-.11	-.33	.23
ERC						
Anxiety			1.00	-.17	.07	-.46*
Avoidance				1.00	.26	-.40
IRRS						
Forgiveness					1.00	-.37
Pain						1.00

Note. DAS = Dyadic Adjustment Scale, RTS = Relationship Trust Scale, ERC Anxiety = Experiences in Close Relationships Anxiety dimension, ERC Avoidance = Experiences in Close Relationships Avoidance dimension, IRRS Forgiveness = Interpersonal Relationship Resolution Scale Forgiveness subscale, IRRS Pain = Interpersonal Relationship Resolution Scale Pain subscale.

* $p < .05$. ** $p < .01$.

Psychometric Properties of the Measures

Preliminary analyses were also conducted to test the assumptions regarding the reliability of the self-report measures. Cronbach's Coefficient Alpha, a conservative estimate of internal consistency, was used to calculate the reliability of the total scales and the relevant subscales. The sample consisted of the 48 individuals (24 couples) who completed the study. The analysis was conducted on pre-treatment and post-treatment scores for the following self-report measures: Attachment Injury Measure (AIM),

Couples Therapy Alliance Scale (CTAS), Dyadic Adjustment Scale (DAS), Experiences in Close Relationships (ECR), Interpersonal Relationship Resolution Scale (IRRS), Relationship Trust Scale (RTS). The reliability coefficients for the IRRS are reported only for the injured partners.

As seen in Table 3, the reliability coefficients for the self-report measures ranged from .58 to .90 for the subscales and .66 to .96 for the total scale. It is important to note that the AIM, a six-item measure that was developed for this study, yielded a coefficient of .23 at pre-treatment using all six items. An examination of the item-total statistics revealed that Cronbach's Alpha would increase to .66 if the last two hope items were deleted. This led to the decision to remove these two items. In an attempt to understand the source of the low reliability, analyses were conducted separately for the injured and offending partners. Using the 4 items, Cronbach's Alpha was .74 for the injured partners and .51 for the offending partners, suggesting that the offending partners responded inconsistently on this measure at pre-treatment. With the exception of the low reliability for the AIM and the Pain subscale at pretreatment, the reliability coefficients are comparable to the reported findings for these measures in the research literature.

Table 3

Reliability Statistics for Self-Report Measures at Pre-treatment and Post-treatment

Measure	Pre-treatment	Post-treatment
AIM ($\underline{n} = 48$)	.66	.90
RTS ($\underline{n} = 48$)	.92	.96
DAS ($\underline{n} = 48$)	.73	.94
ECR ($\underline{n} = 42$)		
Avoidance	.89	.90
Anxiety	.87	.89
IRRS ($\underline{n} = 21$)		
Forgive	.76	.87
Pain	.58	.73
CTAS ($\underline{n} = 48$)	NA	.96†

Note. DAS = Dyadic Adjustment Scale, RTS = Relationship Trust Scale, ERC Anxiety = Experiences in Close Relationships Anxiety dimension, ERC Avoidance = Experiences in Close Relationships Avoidance dimension, IRRS Forgiveness = Interpersonal Relationship Resolution Scale Forgiveness subscale, IRRS Pain = Interpersonal Relationship Resolution Scale Pain subscale.

†The CTAS (Couple Therapy Alliance Scale) was administered after the third session.

Stage Two: Pre-Treatment Group Comparisons

Hypothesis 1

It is predicted that post-treatment group differences will not be attributed to (1a) treatment implementation, (1b) the therapeutic alliance, (1c) demographic characteristics, and (1d) scores on the measures at pre-treatment.

To test for differences in treatment implementation, inter-rater reliability was calculated on the coding of therapist statements by two independent raters. To test for differences in therapeutic alliance, independent-samples t-tests were carried out for injured partner, offending partner, and the mean couple score. Finally, to test for group differences on demographic variables, independent samples t-tests were carried out for the continuous variables and chi-square tests of independence were performed for the categorical variables

(1a) Group Comparison of Treatment Implementation. To verify that the treatment was implemented according to the EFT manual, several verification checks were carried out. First, segments of therapy sessions were played during group supervision and the supervisor did not report improper implementation. Second, the researcher audited therapy sessions, randomly selected during the course of the study, and judged that treatment was more than adequate. Third, two independent raters conducted an implementation check by coding therapists' statements in the 24 transcribed first sessions and 24 transcribed best sessions. In order to obtain an acceptable level of inter-rater reliability ($Kappa \geq .70$; Cohen, 1960), the raters had to have training in EFT and be familiar with the Implementation Checklist.

Inter-rater reliability was calculated on the total 451 therapist statements, 290 therapist statements for the resolved group, and 161 therapist statements for the non-resolved group. Cohen's (1960) Kappa coefficients were .80, .79 and .84, respectively. In total, the mean rater percentage of statements found to be EFT interventions was 94%. The mean rater percentage of EFT statements was 96% for the resolved group and 90% for the non-resolved group, which is not significant $t(22) = -1.6, p > .05$.

For each therapist, EFT statements ranged from 66% to 100%. The therapist who received the lowest rating had non-EFT statements that occurred primarily in the first session where the couple was asked to disclose relevant background information. It is important to note that the couple followed by the therapist with the most non-EFT statements resolved their attachment injury. Other therapists' statements coded as non-EFT interventions were mainly interjections (e.g., hmm, oh) or questions asking the couple what they thought. Overall, inter-rater reliability coefficients and the small percentage of inappropriate interventions suggest that the therapists were faithful at implementing EFT equally across both groups.

(1b) Group Comparison of the Therapeutic Alliance. Scores on the Couples Therapy Alliance Scale were analyzed using independent-samples t-tests to test for group differences. No significant differences in therapeutic alliance were found between groups for the injured partner, $t(22) = -.84, p > .05$, offending partner, $t(22) = -1.47, p > .05$, or for the couple, $t(22) = -1.31, p > .05$. The couples' mean score was 6.3 for the resolved group and 6.0 for the non-resolved group. The maximum possible score is 7 (Completely Agree) and all couples scored above 4 (Neutral). This suggests a high degree of mutual

collaboration between therapists and couples in both groups on the tasks and goals of treatment.

(1c) Group Comparison of Demographic Variables at Pre-treatment. Analyses were carried out to test for group differences on the demographic variables: age of both partners, number of years together, number of children, family income, level of education for both partners, previous marriage for both partners, and previous couples counselling. For the continuous variables, independent-samples *t* tests were carried out comparing the resolved and non-resolved groups. Chi-square tests of independence were performed for the categorical variables. Despite the number of tests performed, an alpha level of $p < .05$ was maintained in order to maximize the likelihood of detecting pre-treatment differences.

As shown in Table 4, there were no significant group differences for the number of years together $t(22) = .37, p = .72$, number of children $t(22) = 1.45, p = .16$, age of the injured partner $t(22) = 1.3, p = .22$, age of offending partner $t(22) = .89, p = .38$, level of education for the injured partner $t(22) = -.18, p = .86$, level of education for the offending partner $t(22) = .47, p = .64$, and total family income $t(22) = -.065, p = .95$.

Table 4

Means and Standard Deviations for the Resolved and Non-Resolved Couples on
Demographic Variables at Pre-treatment

Variable	Resolved ^a		Non-Resolved ^b	
	Mean	SD	Mean	SD
Age of Injured Partner	38.13	7.17	42.11	7.93
Age of Offending Partner	38.73	8.87	42.00	8.29
Years Together	12.80	9.73	14.22	8.09
Number of Children	1.60	1.24	2.33	1.12
Family Income	4.40	2.44	4.33	2.45
Level of Education (Injured)	4.00	1.56	3.89	1.17
Level of Education (Offending)	3.80	1.74	4.11	1.17

^a $\underline{n}$ = 15 couples

^b $\underline{n}$ = 9 couples

The chi-square tests revealed that there were no significant dependency between resolution and previous couple counselling $\chi^2 = (1, N = 24) = .011, p = .92$, previous marriage for the injured partner $\chi^2 = (1, \underline{n} = 24) = .32, p = .57$, and previous marriage for the offending partner $\chi^2 = (1, \underline{n} = 24) = .017, p = .90$. An analysis by gender for both groups also was not significant $\chi^2 = (1, \underline{n} = 24) = 1.36, p = .24$ (See table 5). These analyses indicate that the frequencies of the aforementioned variables do not vary as a function of resolution.

Table 5

Frequency in Resolved and Non-Resolved Groups for Demographic Variables at Pre-treatment

Variable	Resolved ^a	Non-Resolved ^b
Gender		
Injured Males	2	3
Injured Females	13	6
Injured Previously Married		
Yes	2	2
No	13	7
Offending Previously Married		
Yes	3	2
No	12	7
Previous Marital Counselling		
Yes	8	5
No	7	4

^a $\underline{n}$ = 15 couples

^b $\underline{n}$ = 9 couples

(1d) Group Comparison of Dependent Variables at Pre-treatment. Pre-treatment comparisons of the dependent variables were also carried out. Given the small sample size, separate univariate analysis of variance tests were performed on the following dependent variables for the injured and offending partners: (DAS) dyadic adjustment, (RTS) relationship trust, (ECR) avoidance, and (ECR) anxiety (see Table 6). The independent variable was resolved vs. non-resolved groups. The alpha level of $p < .05$ was maintained in order to maximize the likelihood of detecting pre-treatment

differences. Univariate analysis of variance carried out for the variable dyadic adjustment showed no significant group differences for the injured partner, $F(1, 22) = 2.12, p = .16, \eta_p^2 = .08$, but there was significant group differences for the offending partner, $F(1, 22) = 2.12, p = .03, \eta_p^2 = .21$. The resolved offending partners were significantly less distressed than the non-resolved offending partners.

Univariate analysis of variance carried out for the relationship trust variable revealed significant group differences for both the injured partners' level of trust, $F(1, 22) = 9.29, p = .006, \eta_p^2 = .30$ and the offending partners' level of trust, $F(1, 22) = 5.16, p = .03, \eta_p^2 = .19$. The non-resolved group reported significantly lower levels of trust at pre-treatment than the resolved group.

In terms of the two attachment dimensions, univariate analyses revealed no significant group differences for the injured partners' level of anxiety, $F(1, 22) = .82, p = .38, \eta_p^2 = .04$, but significant group difference were found for the offending partners level of anxiety, $F(1, 22) = 4.35, p = .05, \eta_p^2 = .17$. The resolved offending partners reported significantly more anxiety at pre-treatment than their counterparts. There were also significant group differences for the offending partners' level of avoidance, $F(1, 22) = 6.74, p = .02, \eta_p^2 = .24$, but not for the injured partner, $F(1, 22) = 1.18, p = .29, \eta_p^2 = .05$. The non-resolved offending partners reported significantly more avoidance behavior at pre-treatment than the offending partners that resolved the attachment injury.

Finally, univariate analysis of variance was performed on the injured partners' levels of emotional pain, $F(1, 22) = .90, p = .35, \eta_p^2 = .04$ and forgiveness, $F(1, 22) = .02, p = .90, \eta_p^2 = .001$. No significant pre-treatment group differences were found.

Table 6

Means and Standard Deviations for Resolved and Non-Resolved Groups on the
Dependent Variables at Pre-treatment

Variables		Resolved ^a		Non-Resolved ^b	
		Injured	Offending	Injured	Offending
DAS	M	85.47	90.07*	78.89	80.89*
	SD	(8.82)	(10.19)	(13.38)	(6.70)
RTS	M	109.73**	135.33*	81.56**	108.33*
	SD	(22.27)	(30.99)	(21.31)	(22.52)
ECR Anxiety	M	71.38	78.31*	78.11	63.89*
	SD	(17.93)	(14.51)	(17.19)	(19.28)
Avoidance	M	49.03	40.91*	56.44	57.67*
	SD	(17.38)	(10.32)	(13.80)	(21.41)
IRRS Forgiveness	M	33.98	--	33.78	--
	SD	(3.32)		(4.79)	
Pain	M	36.72	--	35.56	--
	SD	(2.88)		(3.01)	

^a $\underline{n} = 15$ couples

^b $\underline{n} = 9$ couples

* = $p < .05$, ** = $p < .01$

At the end of this stage, it was established that for the purposes of this investigation that both groups were not statistically different in terms of treatment implementation, the therapeutic alliance, or demographic variables. Thus, it can be concluded that any differences found in subsequent analysis of the process and outcome variables are not the result of group differences in treatment implementation, therapeutic alliance, and demographics found at the outset of the study. Given that pre-treatment group differences were found for the injured partners' level of trust and for the offending partners on all of the four measures, it was decided to use these variables as covariates in subsequent analyses.

Stage Three: Testing the Hypotheses Related to Change Processes

Hypothesis 2

It is predicted that best session group differences in the ratings of (a) the Structural Analysis of Social Behavior (SASB), and (b) the Experiencing Scale (ES) will not be attributed to differences at pre-treatment.

To test the hypotheses related to the process of change, the Structural Analysis of Social Behavior (SASB) and the Experiencing Scales (ES) were used. Every utterance in a ten-minute segment of the "first" and "best" sessions was rated on the ES and the 4 quadrants and 8 clusters of the SASB scale. Two trained independent raters coded a total of 700 utterances of the injured and offending partners. Inter-rater reliability was high with only minor discrepancies between the two raters. Coding on the ES was analyzed for convergence and yielded a kappa of .83 ($p < .001$). Kappas for the SASB quadrant and cluster were .84 ($p < .001$) and .73 ($p < .001$), respectively.

To arrive at a single rating for each partner for each session, the mode rating was used for the SASB (Benjamin et al., 1981) and the peak rating for the ES (Klein et al., 1969). The 15 resolved and 9 non-resolved events were tested pre-treatment and post-treatment on the presence and absence of the following responses: attack and blame (1-6, 1-7), defend and withdraw (2-7, 2-8), disclose and express needs (1-2), affirm and understand (2-2). They were also tested on the injured and offending partners' depth of experiencing (i.e., ≤ 3 = low; ≥ 4 = high).

First Session Group Differences. To test hypothesis 2a, a series of two (resolved and non-resolved) by two (presence or absence of a response) chi-square analyses were conducted for each response type. To test hypothesis 2b, chi-square analyses were conducted for the injured and offending partners. In analyses where the expected frequency was less than 5 in a cell, Fisher's exact test was used. The frequencies of the response categories are presented in Table 7. As predicted, there were no significant pre-treatment differences in response frequencies for the resolved and non-resolved groups on the process measures.

Table 7

Pre-treatment Response Frequencies for the Resolved and Non-Resolved Groups on the Process Measures

Response Categories	Resolved	Non-Resolved	p
Disclose & Express Needs			
Present	2	0	.38
Absent	13	9	
Affirm & Understand			
Present	1	1	.62
Absent	14	8	
Attack & Blame			
Present	13	8	.69
Absent	2	1	
Defend & Withdraw			
Present	12	8	.51
Absent	3	1	
Injured High Experiencing			
Present	8	3	.30
Absent	7	6	
Offender High Experiencing			
Present	3	2	.64
Absent	12	7	

Note. Disclose & Express Needs (1-2), Affirm & Understand (2-2), Attack & Blame = (1-6, 1-7), Defend & Withdraw = (2-7, 2-8), ES High Experiencing ≥ 4 .

Hypothesis 3:

It is predicted that resolved couples will exhibit (a) more affiliative/friendly responses (i.e., disclosing and expressing needs, affirm and understanding), less hostile/distant responses (i.e., attack and blame, defend and withdraw), and (b) deeper levels of experiencing in best sessions than non-resolved couples.

The Process of Change in Best Sessions. To test hypothesis 3a, two (resolved and non-resolved) by two (presence or absence of a response) chi-square tests were conducted for each type of response. To test hypothesis 3b, a two (resolved and non-resolved) by two (presence or absence) chi-square tests were conducted for the injured and offending

partners. Fisher's exact test was used for analyses where the expected frequency was less than 5 per cell. The frequencies of the response categories are presented in Table 8.

As predicted, couples that resolved the attachment injury had significantly more affiliative/friendly responses (i.e., Disclose & Express Needs, Affirm & Understand) than hostile/distant responses (i.e., Attack & Blame, Defend & Withdraw). Resolved partners openly disclosed and expressed their needs and were affirming and understanding, whereas non-resolved couples remained in the attack/blame and defend/withdraw stance. In terms of level of experiencing, both partners had significantly deeper levels of experiencing than the non-resolved group. All of the resolved couples exhibited deeper levels of experiencing ranging from a self-description of feelings (level 4) to expanding awareness of feelings (level 7). All but one of the non-resolved couples had significantly lower levels of experiencing ranging from totally detached/superficial (level 1) to reactive responding (level 3).

Table 8

Response Frequencies in Best Sessions for the Resolved and Non-Resolved Groups on the Process Measures

Response Categories	Resolved	Non-Resolved	p
Disclose & Express Needs			
Present	14	1	.000
Absent	1	8	
Affirm & Understand			
Present	15	0	.000
Absent	0	9	
Attack & Blame			
Present	0	7	.000
Absent	15	2	
Defend & Withdraw			
Present	0	7	.000
Absent	15	2	
Injured High Experiencing			
Present	15	0	.000
Absent	0	9	
Offender High Experiencing			
Present	15	1	.000
Absent	0	8	

Note. Disclose & Express Needs (1-2), Affirm & Understand (2-2), Attack & Blame = (1-6, 1-7), Defend & Withdraw (2-7, 2-8), ES High Experiencing ≥ 4 .

Stage Four: Testing the Relationship Between Process and Outcome

Hypothesis 4

It was predicted that at post-treatment resolved couples will show (a) significant decreases in marital distress, (b) significant gains in the level of relationship trust, (c) significant less avoidant and anxious attachment (d) significant increases in the level of forgiveness, and (e) significant decreases in the level of emotional pain than non-resolved couples.

To investigate the relationship between process and outcome, SPSS GLM statistical program with repeated measures was used with group (i.e., resolved vs. non-resolved) as the between-subjects independent variable and partner type (i.e., injured vs. offending) and time (i.e., pre-treatment vs. post-treatment) as the within-subjects independent variables. Due to the small sample size and to ensure that the statistical assumptions were not violated, a separate repeated measures analysis was performed for each of the dependent variables (i.e., dyadic adjustment, relationship trust, avoidant attachment, and anxious attachment). Given that the IRRS was administered only to the injured partners, a doubly multivariate analysis of variance with one between-subjects (group) and one within-subjects (time) was performed on emotional pain and forgiveness. Bonferroni corrected alpha of .01 (.05/5) was used to account for multiple analyses performed and to take into account that pre-treatment group differences on the dependent variables could not be controlled for in the repeated measures analyses.

Dyadic Adjustment. The first set of repeated measures analyses involved the dependent variable dyadic adjustment. With the use of Wilks' criterion, there was no three-way interaction for partner type by time by group $F(1, 22) = 4.40, p > .01, \eta_p^2 =$

.16. There were no two-way interaction effects for partner type by group, $F(1, 22) = .22$, $p > .01$, $\eta_p^2 = .01$ or partner type by time, $F(1, 22) = .40$, $p > .01$, $\eta_p^2 = .02$. However, there was a significant two-way interaction for time by group, $F(1, 22) = 24.82$, $p < .001$, $\eta_p^2 = .53$. There was no main effect for partner type, $F(1, 22) = 1.22$, $p > .01$, $\eta_p^2 = .05$. There was a main effect for group, $F(1, 22) = 47.62$, $p < .001$, $\eta_p^2 = .68$, and for time, $F(1, 22) = 18.59$, $p < .001$, $\eta_p^2 = .46$, which can be attributed to the interaction.

See Table 9 for means and standard deviations.

Table 9

Means and Standard Deviations for Resolved and Non-Resolved Groups on Dyadic Adjustment at Pre- and Post-treatment for Injured and Offending Partners

Group	Pre-treatment		Post-treatment	
	Injured	Offending	Injured	Offending
Resolved ^a	85.47	90.07	110.13	108.53
	(8.23)	(10.19)	(12.32)	(10.93)
Non-Resolved ^b	78.89	80.89	75.67	81.00
	(13.38)	(6.70)	(9.98)	(11.20)

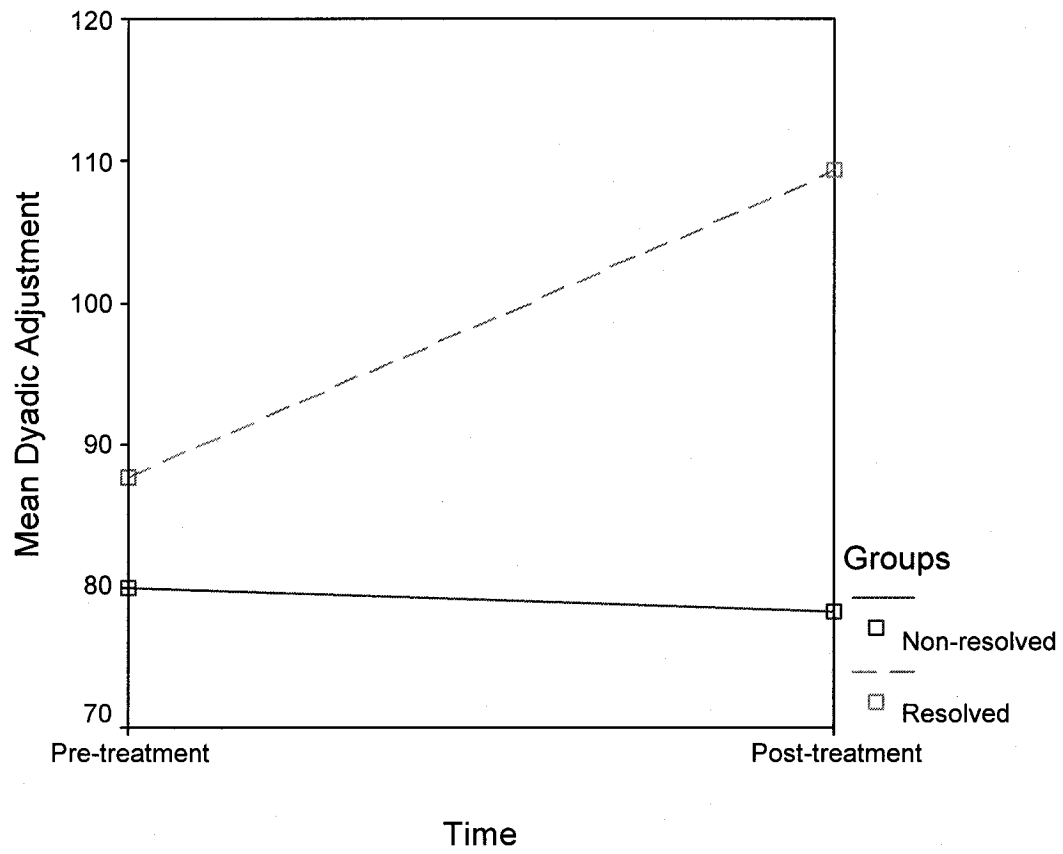
Note. Values in parentheses represent standard deviations.

^a $n = 15$ couples

^b $n = 9$ couples

The main effect for group and the main effect for time are best interpreted in terms of their interaction. Figure 1 shows the mean dyadic adjustment scores for the resolved and non-resolved couples at pre- and post-treatment. Paired-samples t-tests showed no significant improvement in dyadic adjustment over time $t(8) = .58, p > .05$ for the non-resolved group. However, the resolved group showed a significant improvement in dyadic adjustment from pre- to post-treatment, $t(14) = -6.76, p = .000$.

Figure 1. Mean dyadic adjustment as a function of time.



Relationship Trust. The second repeated measures analysis involved the dependent variable relationship trust. Using Wilks' criterion, there was no three-way interaction for partner type by time by group, $F(1, 22) = .35, p > .01, \eta_p^2 = .02$. There were no two-way interaction for partner type by group, $F(1, 22) = .16, p > .01, \eta_p^2 = .01$ or for partner type by time, $F(1, 22) = 4.32, p > .01, \eta_p^2 = .16$. However, there was a two-way interaction for time by group, $F(1, 22) = 19.15, p < .001, \eta_p^2 = .47$. There was a main effect for partner type, $F(1, 22) = 12.39, p = .002, \eta_p^2 = .36$. Injured partners' level of relationship trust was significantly lower than for the offending partners' level of relationship trust at both times. See Table 10 for means and standard deviations.

Table 10

Means and Standard Deviations for Resolved and Non-Resolved Groups on Relationship Trust at Pre- and Post-treatment for Injured and Offending Partners

Groups	Pre-treatment		Post-treatment	
	Injured	Offending	Injured	Offending
Resolved ^a	109.73	135.33	152.07	162.27
	(22.27)	(30.99)	(24.75)	(23.17)
Non-Resolved ^b	81.56	108.33	92.56	110.78
	(21.31)	(22.52)	(23.95)	(20.90)

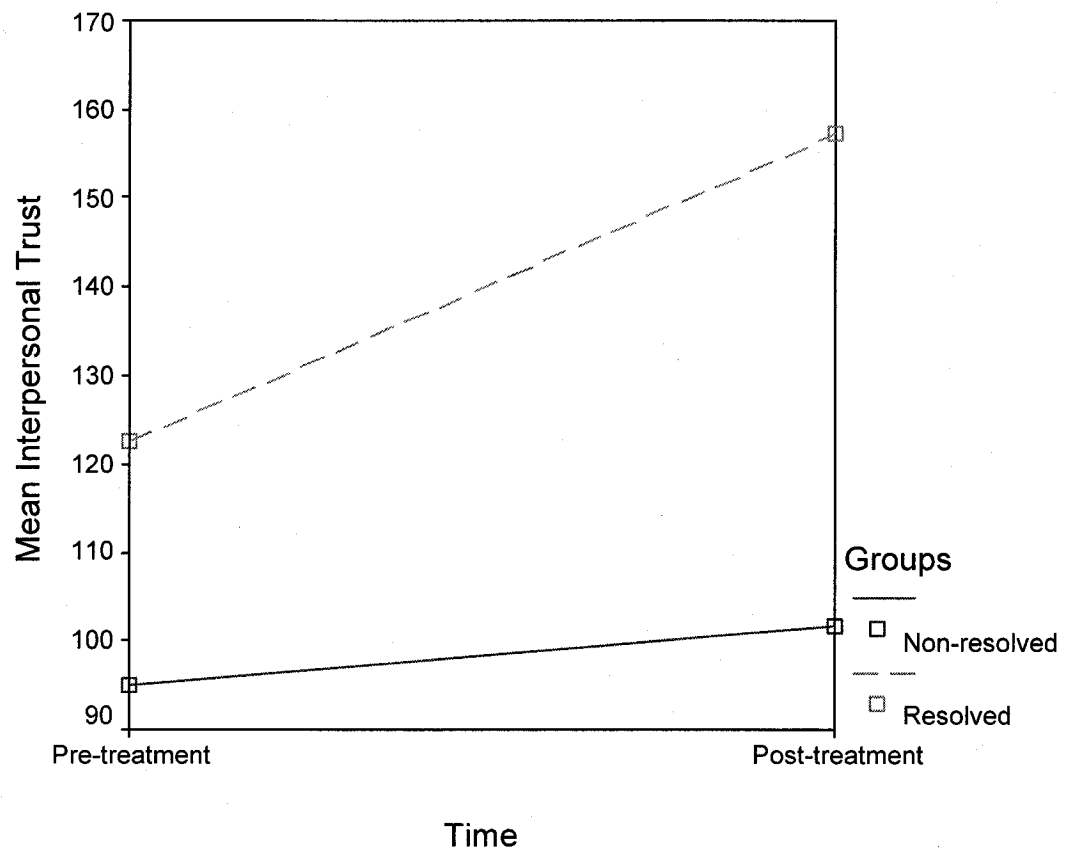
Note. Values in parentheses represent standard deviations.

^a $n = 15$ couples

^b $n = 9$ couples

The main effect for groups, $F(1, 22) = 31.88$, $p < .001$, $\eta_p^2 = .60$, and the main effect for time, $F(1, 22) = 42.04$, $p < .001$, $\eta_p^2 = .66$, are interpreted in terms of their interaction. Figure 2 shows the mean relationship trust scores for the resolved and non-resolved couples at pre- and post-treatment. Paired-samples t-test showed no significant improvement in the level trust over time for the non-resolved group, $t(8) = -1.62$, $p > .05$. The resolved group, however, showed a significant improvement in trust from pre- to post-treatment, $t(14) = -8.15$, $p = .000$. Although there were pre-treatment group differences for the injured and offending partners, the interaction in Figure 2 shows a significant improvement over time for the resolved group but the non-resolved group showed no change.

Figure 2. Mean relationship trust as a function of time.



Anxiety and Avoidance Dimensions of Attachment. The third repeated measures analysis involved the anxiety attachment dimension as the dependent variable. With the use of Wilks' criterion, there was no partner type by time by group interaction $F(1, 22) = .77, p > .01, \eta_p^2 = .03$. There were no two-way interaction effects for partner type by group, $F(1, 22) = 2.60, p > .01, \eta_p^2 = .11$, for partner type by time, $F(1, 22) = .93, p > .01, \eta_p^2 = .04$, or for time by group, $F(1, 22) = .009, p > .01, \eta_p^2 = .00$. There were no main effects for group, $F(1, 22) = .336, p > .01, \eta_p^2 = .04$, partner type, $F(1, 22) = .089, p > .01, \eta_p^2 = .004$, but there was a significant main effect for time, $F(1, 22) = 11.05, p = .003, \eta_p^2 = .33$. The pre-treatment mean level of anxiety (72.94, SE = 2.05) for the entire sample was significantly greater than the post-treatment mean (64.70, SE = 2.38), suggesting a significant decrease in anxiety for both groups at the end of treatment. See Table 11 for means and standard deviations.

Table 11

Means and Standard Deviations for Resolved and Non-Resolved Groups on Anxiety at Pre- and Post-treatment for Injured and Offending Partners

Groups	Pre-treatment		Post-treatment	
	Injured	Offending	Injured	Offending
Resolved ^a	71.38	78.31	62.74	70.04
	(17.93)	(14.51)	(13.82)	(18.35)
Non-Resolved ^b	78.11	63.89	66.22	59.78
	(17.19)	(19.28)	(19.70)	(19.76)

Note. Values in parentheses represent standard deviations.

^a $n = 15$ couples

^b $n = 9$ couples

The avoidance of closeness dimension of attachment was used as the dependent variable for the following repeated measures analysis. Using Wilks' criterion, there was no three-way interaction for partner type by time by group $F(1, 22) = 4.68, p > .01, \eta_p^2 = .17$. Similarly, there were no two-way interaction effects for partner type by group, $F(1, 22) = 2.66, p > .01, \eta_p^2 = .11$, for partner type by time, $F(1, 22) = 6.6, p > .01, \eta_p^2 = .23$, or for time by group, $F(1, 22) = .88, p > .01, \eta_p^2 = .04$. There were no main effects for group, $F(1, 22) = 6.57, p > .01, \eta_p^2 = .23$, partner type, $F(1, 22) = .005, p > .01, \eta_p^2 = .00$, or time, $F(1, 22) = 1.97, p > .01, \eta_p^2 = .08$. Despite the finding in stage two of significant group differences on the avoidance dimension for the offending partners at pre-treatment (i.e., offending partners in the non-resolved group reported greater avoidance than the offending partners in the resolved group), no significant interaction was found, indicating that the group differences were maintained over time. Table 12 shows the means and standard deviations for the avoidance attachment dimension.

Table 12

Means and Standard Deviations for Resolved and Non-Resolved Groups on Avoidance at Pre- and Post-treatment for Injured and Offending Partners

Groups	Pre-treatment		Post-treatment	
	Injured	Offending	Injured	Offending
Resolved ^a	49.03	40.91	51.87	44.73
	(17.38)	(10.32)	(15.34)	(11.74)
Non-Resolved ^b	56.44	57.67	51.33	64.11
	(13.80)	(21.41)	(18.33)	(14.17)

Note. Values in parentheses represent standard deviations.

^a $n = 15$ couples

^b $n = 9$ couples

Emotional Pain and Forgiveness. In order to investigate if scores on the IRRS differed for the resolved and non-resolved groups over time, a doubly multivariate analysis (i.e., MANOVA with a repeated measures component) was performed on the dependent variables emotional pain and forgiveness. With the use of Wilks' criterion, the combined dependent variables were significantly affected by group, $F(2, 21) = 5.42$, $p = .01$, $\eta_p^2 = .34$, by time, $F(2, 21) = 11.54$, $p = .000$, $\eta_p^2 = .52$., and by their interaction, $F(2, 21) = 6.30$, $p = .007$, $\eta_p^2 = .38$. Univariate analyses of the pain scores revealed no group by time interaction effects, $F(1, 22) = 1.26$, $p > .01$, $\eta_p^2 = .05$. There was no main effect for group, $F(1, 22) = 2.86$, $p > .01$, $\eta_p^2 = .12$; however, there was a main effect for time, $F(1, 22) = 13.09$, $p = .002$, $\eta_p^2 = .37$. Both resolved and non-resolved injured partners showed a significant decrease in their reported level of emotional pain over the course of treatment.

In terms of forgiveness, univariate analyses revealed a significant group by time interaction, $F(1, 22) = 11.93$, $p = .002$, $\eta_p^2 = .35$ with significant main effects for both time, $F(1, 22) = 23.29$, $p = .000$, $\eta_p^2 = .51$, and group, $F(1, 22) = 11.30$, $p = .003$, $\eta_p^2 = .34$. Figure 3 shows the interaction for the resolved and non-resolved groups at pre-and post-treatment. At pre-treatment the non-resolved group's mean of 33.78 (SE mean = 1.3) was the same as the resolved group's mean of for 33.91 (SE mean = 1.01). Paired-samples t-test revealed no significant improvement in the work toward forgiveness over time for the non-resolved couples, $t(8) = .62$, $p > .05$. However, the resolved group showed a significant improvement in forgiveness from pre to post-treatment, $t(14) = -9.92$, $p = .000$. See Table 13 for the means and standard deviations for the resolved and non-resolved groups on emotional pain and forgiveness at pre- and post-treatment.

Table 13

Means and Standard Deviations for the Resolved and Non-Resolved Groups on Emotional Pain and Forgiveness at Pre- and Post-treatment for Injured Partners

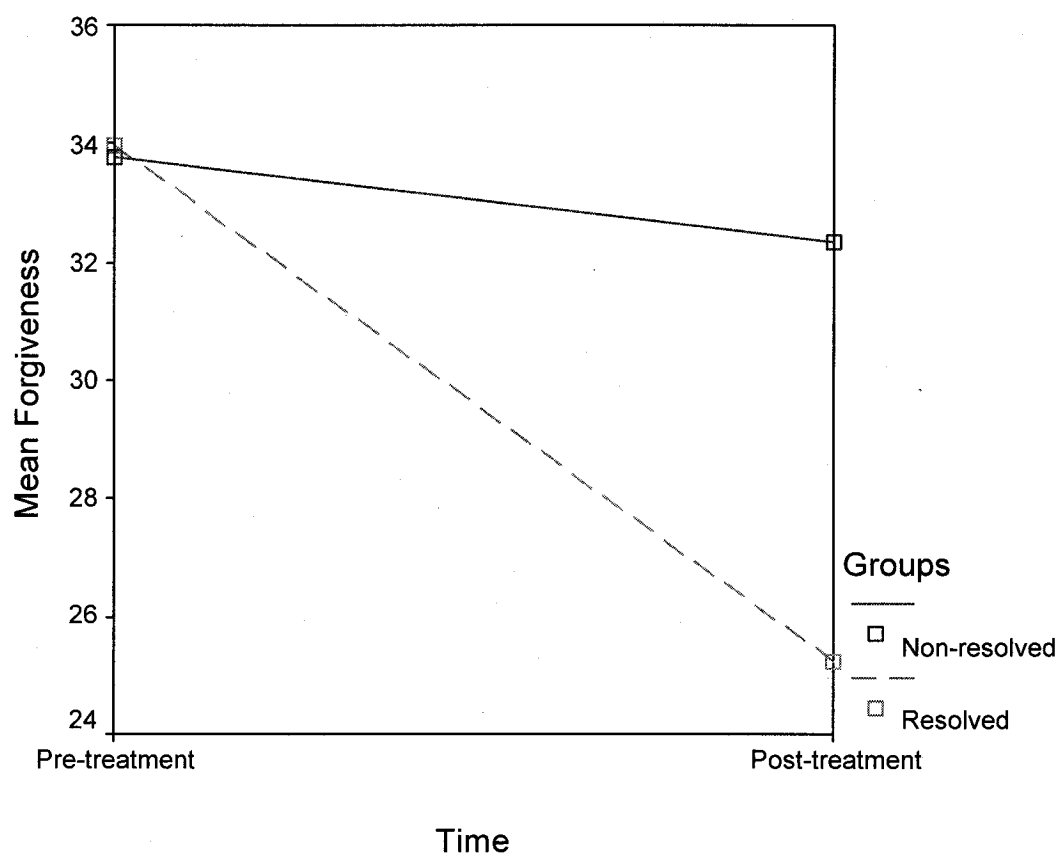
Groups	Pre-treatment		Post-treatment	
	Pain	Forgiveness	Pain	Forgiveness
Resolved ^a	36.72 (2.88)	33.98 (3.32)	39.68 (1.32)	25.25 (1.84)
Non-Resolved ^b	35.56 (3.01)	33.77 (4.79)	37.11 (4.81)	32.33 (4.33)

Note. Values in parentheses represent standard deviations.

^a $n = 15$ couples

^b $n = 9$ couples

Figure 3. Mean forgiveness as a function of time.



Given that the pre-treatment group differences on the dependent variables could not be used as covariates in the repeated measures analyses, a MANCOVA was conducted in order to test if the differences found at post-treatment can be attributed to differences at pre-treatments. Separate analyses were carried out for the injured and offending partners because the variables used as covariates differed for the injured and offending partners.

For the injured partners, a between-subjects multivariate analysis of covariance was performed on six dependent variables: dyadic adjustment, trust, anxiety, avoidance, forgiveness, and pain. Pre-treatment level of trust was used as the covariate. The independent variable was group (resolved and non-resolved). Using the Pillia's criterion, which is recommended for small groups of unequal size (Tabachnick & Fidel, 2001), there was a multivariate effect for group, $F(6, 16) = 8.22, p = .000, \eta_p^2 = .76$. Univariate analyses showed a significant effect for dyadic adjustment, $F(1, 21) = 29.45, p = .000, \eta_p^2 = .58$, forgiveness, $F(1, 21) = 24.80, p = .000, \eta_p^2 = .54$, trust, $F(1, 21) = 16.16, p = .001, \eta_p^2 = .44$, and pain, $F(1, 21) = 4.72, p = .04, \eta_p^2 = .18$. There were no effects for anxiety, $F(1, 21) = 1.49, p > .05, \eta_p^2 = .07$, or avoidance, $F(1, 21) = .04, p > .05, \eta_p^2 = .002$.

For the offending partners, a between-subjects multivariate analysis of covariance was performed on four dependent variables: dyadic adjustment, trust, anxiety, and avoidance with pre-treatment scores used as covariates. The independent variable was group (resolved and non-resolved). With the use of Pillia's criterion, there was a multivariate effect for group, $F(4, 15) = 5.8, p = .005, \eta_p^2 = .61$. Univariate analyses showed a significant effect for trust, $F(1, 18) = 24.49, p = .000, \eta_p^2 = .58$, and dyadic

adjustment, $F(1, 18) = 11.48$, $p = .003$, $\eta_p^2 = .39$. There were no effects for anxiety, $F(1, 18) = 2.35$, $p > .05$, $\eta_p^2 = .12$, or avoidance, $F(1, 18) = 3.73$, $p > .05$, $\eta_p^2 = .17$.

Stage Five: Regression Analyses

In view of the exploratory nature of this study, it was not known at the outset how many couples would be assigned to each group. Although the data did lend themselves to dichotomizing the sample into two groups, it can be argued that it may not accurately reflect the process of resolving attachment injuries. Therefore, in order to analyze resolution process for the entire sample, separate multiple regression analyses were carried out for injured and offending partners to determine whether dyadic adjustment, relationship trust, avoidance, anxiety, emotional pain and forgiveness were good predictors of attachment injury resolution, as measured by the Attachment Injury Measure (AIM).

Predictors of Resolution for the Injured Partners

In order to determine what variables predict attachment injury resolution for the injured partners after controlling for pre-treatment attachment injury score and trust, separate hierarchical regression analyses were carried out for each of the predictor variables: dyadic adjustment, trust, forgiveness, pain, avoidance, and anxiety. In the first step pre-treatment AIM and trust were entered as a block. The results showed that pre-treatment AIM and trust accounted for 50% of the variance in outcome, $F(2, 21) = 10.41$, $p = .001$. Dyadic adjustment was entered next, which accounted for 13% of the variance, $F(1, 20) = 7.14$, $p = .02$. The F values presented represent incremental F change. Separate analyses were carried out for each predictor variable. The results showed that trust accounted for 19% of the variance, $F(1, 20) = 11.86$, $p = .003$, forgiveness 16% of

the variance, $F(1,20) = 9.09$, $p = .007$, and pain 11% of the variance in outcome, $F(1,20) = 5.36$, $p = .03$. In terms of the attachment dimensions, anxiety and avoidance were not good predictors of attachment injury resolution. Anxiety accounted for only 2% of the variance, $F(1,20) = .78$, $p > .05$, and avoidance accounted for 0% of the variance in attachment injury resolution, $F(1,20) = .08$, $p > .05$. A summary of these analyses is presented in Table 14.

Table 14

Summary of Hierarchical Regression Analyses for Variables Predicting AttachmentInjury Resolution for the Injured Partners (N = 24)

Variable	B	SE B	β
Step 1			
Ipraim	-.96	.39	-.41
Iprrts	.13	.03	.75
Step 2			
Ipodas	.10	.04	.47*
Iports	.08	.02	.70**
Ipoforg	-.43	.14	-.46**
Ipopain	.46	.20	.35*
Ipoanx	.03	.04	.14
Ipoavoi	.01	.05	.05

Note. ipraim = injured partners' pre-treatment Attachment Injury, iprrts = injured partners' pre-treatment Trust, ipodas = injured partners' post-treatment Dyadic Adjustment, iports = injured partners' post-treatment Trust, ipoforg = injured partners' post-treatment Forgiveness, ipopain = injured partners' post-treatment Pain, ipoanx = injured partners' post-treatment Anxiety, ipoavoi = injured partners' post-treatment Avoidance.

* $p < .05$, ** $p < .01$

Predictors of Resolution for the Offending Partners

The same procedure was used to determine if dyadic adjustment, trust, avoidance and anxiety are good predictors of attachment injury resolution for the offending partners. Separate hierarchical regression analyses were carried out for each predictor variable. To control for pre-treatment differences, dyadic adjustment, trust, anxiety, avoidance, and the AIM were entered as a block. These variables accounted for only 18% of the variance in attachment injury resolution, $F(5,18) = .79, p > .05$. In the second step, dyadic adjustment accounted for 54% of the variance, $F(1,17) = 31.89, p = .000$, and trust 44% of the variance in attachment injury resolution. The F values presented represent incremental F change. Similar to the injured partners, the attachment dimensions were not good predictors of resolution. Anxiety accounted for 1% of the variance, $F(1,17) = .11, p > .05$, and avoidance 3% of the variance in attachment injury resolution, $F(1,17) = .67, p > .05$. A summary of these analyses is presented in Table 15.

Table 15

Summary of Hierarchical Regression Analyses for Variables Predicting AttachmentInjury Resolution for the Offending Partners (N = 24)

Variable	B	SE B	β
Step 1			
Opraim	.47	.64	.17
Oprdas	-.04	.12	-.12
Oprrts	.02	.04	.20
Opranx	.04	.05	.18
Opravoi	-.07	.05	-.29
Step 2			
Opodas	.26	.05	1.0***
Oports	.14	.03	1.0***
Opoanx	-.02	.07	-.12
Opoavoi	-.08	.10	-.34

Note. opraim = offending partners' pre-treatment Attachment Injury, oprdas = offending partners' pre-treatment Dyadic Adjustment, oprrts = injured partners' pre-treatment Trust, opranx = offending partners' pre-treatment Anxiety, opravoi = offending partners' pre-treatment Avoidance, opodas = offending partners' post-treatment Dyadic Adjustment, oports = offending partners' post-treatment Trust, opoanx = offending partners' post-treatment Anxiety, opoavoi = offending partners' post-treatment Avoidance.

*** $p < .001$

Summary of Results

The preliminary results suggested that the measures used to assess the independent and dependent variables were reliable. The resolved and non-resolved groups were equivalent with respect to treatment implementation, therapeutic alliance, and demographic characteristics. There were no group differences in terms of types of attachment injuries, onset of injury, and number of sessions received. Analyses assessing the equivalence of groups on the pre-treatment measures revealed that the non-resolved group reported significantly less trust than the resolved counterparts. Moreover, non-resolved offending partners were significantly more distressed, reported less trust, were more avoidant but less anxious than the resolved offending partners. These pre-treatment group differences were used as covariates in the analyses.

The results concerning the process model revealed no significant pre-treatment differences in response frequencies on the Structural Analysis of Social Behaviour and the Experiencing Scales. At the end of treatment, resolved couples were significantly more affiliative and had significantly higher levels of experiencing than non-resolved couples.

In terms of linking the process of change to outcome, repeated measures analyses revealed a significant difference from pre-treatment to post-treatment for the resolved and non-resolved couples on dyadic adjustment, trust, and forgiveness. Analyses with the attachment dimensions, anxiety and avoidance, did not reveal any significant differences for the two groups over time. No significant difference was found between the two groups over time with respect to emotional pain. However, both groups were significantly less anxious reported less emotional pain over time. Multivariate analysis of

covariance confirmed the findings. However, when pre-treatment trust was used as a covariate, emotional pain was significantly less for the resolved couples.

Finally, multiple regression analyses revealed that dyadic adjustment, trust, forgiveness and emotional pain were good predictors of attachment injury resolution for the injured partners. For the offending partners, after controlling for pre-treatment differences, the best predictors of attachment injury resolution were trust and dyadic adjustment. The two attachment dimensions (anxiety and avoidance) did not account for a significant amount of the variance in attachment injury resolution for either partner.

Discussion

The purpose of this study was to build on the previously developed rational-empirical model of attachment injury resolution by investigating whether the model discriminates resolved from non-resolved couples and by relating the process of change to outcome. Task analysis was the research methodology used in this study. At the end of treatment, couples were assigned to resolved and non-resolved groups, according to three criteria (i.e., couples' perception, therapists' identification, and clinical judge). Segments of first and best sessions were transcribed and rated on two process measures: SASB (Benjamin, 1974) and the ES (Klein et al., 1986) to assess if the observed patterns or components of the model discriminate the two groups. To investigate the relationship between the process of change and distal outcomes, couples were measured pre- and post-treatment on the DAS (Spanier, 1976), a measure of dyadic adjustment; the RTS (Holmes et al., 1990), a measure of trust; the ECR (Brennan et al., 1998), a two-dimensional measure of adult attachment; and the IRRS (Hargrave & Sells, 1997), a measure of emotional pain and forgiveness. The goal of this study was to validate the attachment injury resolution model in order to better explain and predict therapeutic change using EFT.

Pre-treatment Group Differences

At the beginning of treatment the resolved and non-resolved groups did not differ in terms of treatment implementation, therapeutic alliance and demographic variables. Treatment was implemented equally to both the resolved and non-resolved groups in accordance with the EFT manual. The therapeutic alliance did not account for group differences, suggesting that the therapists were equally effective at establishing rapport

with the resolved and non-resolved couples. Demographic information also did not differentiate the resolved and non-resolved groups. Therefore, it was not necessary to use these variables as covariates when testing the main hypotheses.

The data, however, did show significant differences between groups on some of the pre-treatment measures, which were used as covariates. With the exception of the injured partners' level of trust, the remaining significant findings were found among the offending partners. Non-resolved offending partners reported more dyadic distress and less relationship trust. On the attachment dimensions, the non-resolved offending partners were significantly less anxious and more avoidant than the resolved offending partners. Since seven of the nine non-resolved couples had disclosed compound attachment injuries later in the therapy process, it is understandable that trust levels would be significantly lower. Trust, being one of the most desired qualities in intimate relationships and a necessary component for relationship functioning (Rempke, Holmes & Zanna, 1985; Mikulincer, 1998), may explain why the non-resolved group's level of trust was significantly lower than the resolved group's level.

The Process of Change

At pre-treatment, no significant differences between the resolved and non-resolved groups on response types were found. As expected, there were no significant difference in the frequency of affiliative responses, such as "disclosing/expressing needs" and "affirming/understanding." There were only three instances of these responses in the resolved group and one instance in the non-resolved group. Moreover, the frequency of hostile responses, such as "attack/blame" and "defend/withdraw" were the same for both groups as was the frequency of injured and offending partners' level of experiencing.

These findings are consistent with the first two steps of the attachment injury resolution model (Johnson et al., 2000; Millikin, 2000). These two steps mark the disclosure of the event. When the injured partner speaks of the incident there is often an explosion of secondary emotions such as anger and rage. The offending partner finds this aversive and moves into a defensive stance and/or withdraws.

A couple with an attachment injury may appear similar to any other distressed couple, in that they get caught in a negative cycle of attack/blame and defend/withdraw. The defining feature in attachment-related events, which is often not understood by the offending partner, is that these events are not easily forgotten and are often used as ammunition during conflicts (Johnson, 1996). The following excerpt illustrates a blame-defend pattern and the emergence of the attachment injury. In this particular case, the attachment injury was flirtatious behavior on the part of the husband when his wife was vulnerable following her recovery from surgery. The incident occurred three years into Ann and Jim's ten-year marriage. Ann presented as very reactive and Jim was defensive.

Case Illustration: Ann and Jim

Ann: I know that if he could drop everything and go back to this new age group that he used to hang out with...alcoholics and sex addicts...this group of people that I see him with...they're so...so distasteful.

Therapist: Distasteful?

Ann: Yes, but at the same time I feel bad because they're human and are probably not all that bad. But I don't like what I'm hearing and seeing (angry voice)!

Therapist: What I'm hearing is that part of you feels guilty for thinking that but part of you feels...

Ann: Threatened by them...(raising her voice) because he would seek advice from these people.

Therapist: And you're afraid that they will mislead him?

Ann: Exactly, and he is just going to gravitate toward what they're doing. You know...screwing around with other women.

Therapist: You afraid that he will be unfaithful too.

Ann: (**Attachment injury marker**) Yes, like when he used to flirt with other women. (Angry voice) Like when I was in the hospital recovering from surgery, I will never forget (eyes well up)...there he was flirting with the nurses and other female visitors (loud angry voice). I was so drugged that I couldn't say anything but I saw him. It was disgusting!

Jim: I was not flirting. And these guys were my support group...the only support I had when you were in the hospital.

Therapist: They were the core people in your life. The people you went to when things looked bleak. Is that it?

Jim: Yes, and she is exaggerating. They are not addicts of any kind. I was able to use them as a sounding board...that's all.

Ann: (Hysterical) He told them everything. I told him, "Look I'm a very private person. You may not be, but please respect that I am." He tells people how much I make, what my hat size is (laughs a bit)...everything. It got bigger and bigger...right down to the personal stuff like my health, my surgery, everything that was terrible between us. I felt so horribly violated by this man (angry sobs), yet so completely dependent on him because I was sick.

Jim: That's unfair. I did not tell them everything. I needed to talk to somebody. You were sick and flipping out and I had to take care of you and the baby.

Therapist: It was a scary time for both of you?

Jim: Yeah.

Ann: Yeah...(with a trembling voice) well, I had no choice but to put up with this man. He treated me so badly, flirting, telling everyone about my personal matters (enraged). There is not a lot of trust left.

Jim: But I was never unfaithful!

It is clear from the transcript that Ann and Jim are distressed and that perhaps their distress can be traced back to that moment when Ann was particularly vulnerable

and, although Jim was physically available, he was not responsive to his wife's needs. In terms of the process ratings of the first session, Ann engaged in blaming and belittling (1-6), attacking and rejecting (1-7) and he defended (2-6), protested (2-7) and distanced (2-8). Their level of experiencing was predominately reactive with descriptions of feelings and personal experiences. There was one occasion where Ann's level of experiencing reached a "5" when she identified an inner conflict of feeling bad but, at the same time, feeling threatened. After 16 sessions of therapy Ann and Jim did not resolve the attachment injury. What became evident was that trust had been violated several times prior to Jim's flirtatious behavior during her illness. Consequently, they remained stuck in the negative cycle. In terms of the process of change, they did not move beyond de-escalation. The multiple events that injured their attachment bond were often raised. The next excerpt, taken from the best of 16 sessions, illustrates the impasse.

Jim: I would say that these days she has been in a negative headspace and has a short fuse. And a couple of times she has gotten angrier than she has gotten in many months.

Ann: That is interesting because during these times I'm not looking to get mad at him. I'm looking to talk to him about stressful situations and I feel him retreating. That's maybe due to his fear of my temper when I talk about these things. I say, "talk to me." I try to reach him but he's already huddled in the corner. I get frustrated but not angry.

Therapist: Where are you when she is trying to reach you?

Jim: Well, I find it interesting when she says that I'm not available. It is so bizarre. How could you possibly say that? I'm always there to talk to you.

Ann: You're there physically but not emotionally.

Jim: I'm there more than physically. I'm participating, listening, telling you my opinion and thoughts.

Ann: Well, let me tell you how he summed up the stressful visit from my family. You said just try to make light of it. Laugh at it. It is really hard on me when he

responds with, “you just have to laugh at it.” I find these visits hard and would like to express my feelings but he has this sort of flippant attitude.

Jim: Why is that all you remember of the hours and hours of talking?

Ann: There were no hours and hours.

Jim: You can’t possibly mean that?

Ann: I mean it.

Jim: Well, there is obviously a disjoint here. You make it sound like we spent five minutes talking.

Ann: It is about the way you are during the conversation. I never said we didn’t spend time. It is the reception or quality of the interaction.

Therapist: What do you need from him during those times?

Ann: (with an angry voice) A simple...how do you feel? Or, that must be stressful. But instead I get instruction. I’m looking for some comfort, validation, and recognition.

Therapist: So you needed validation and although he was right there with you physically, you did not feel supported emotionally. Is that it?

Ann: He has never really been there for me emotionally. Oh yeah, he is with me physically. At the hospital he was with me physically, but his mind was on the nurses. He has always been trying to connect with everyone else but me.

The prediction that the resolved couples would be more affiliative and exhibit deeper levels of experiencing at the end of treatment than the non-resolved couples was supported by the data. As expected, the frequency of affiliative responses, such as “disclosing/expressing needs” and “affirming/understanding” was significantly different for the resolved and non-resolved couples. Furthermore, the frequency of hostile responses, such as “attack/blame” and “defend/withdraw” significantly differed as did the frequency of injured and offending partners’ level of experiencing. These robust findings are consistent with the attachment injury resolution model that shows deep levels of

experiencing are key ingredients of change (Johnson et al., 2000; Millikin, 2000).

Previous EFT process research also found that when “blamers” move from impersonal, self-limiting emotional involvement to an exploration of underlying needs, particularly when their partner is emotionally engaged, a softening event occurs (Johnson & Greenberg, 1988).

In contrast to the previous case illustration, the following excerpt is taken from a best session of John and Pat, a couple who resolved their attachment injury. In this case, the attachment injury was infidelity. John and Pat have been married for 25 years and John had an affair several years ago. When Pat found out about it she felt betrayed and her trust for John was absolutely shattered. Over the years, Pat and Jim never spoke about the incident, although John complained that Pat repeatedly reminded him of his indiscretion. At the intake, Pat presented as angry and hostile toward John and he was very defensive. Pat was hypervigilant, that is whenever John went out, she wanted to know where he was going, was he going alone, and when was he coming back. When he was late she would “rage” at him. John reported feeling controlled and refused to comply with her unrealistic demands. When John was at home he often retreated to the basement where he listened to music and drank alcohol, which incited Pat even more. They received 13 sessions of couple therapy and this transcript is taken from their final (best) session.

Case Illustration:

Therapist: Help me here John; from what you are telling me, the incident that brought you into therapy is still very much in the foreground.

John: Well, I don't know if it is in the foreground but it definitely is still there for me. I kind of blocked it out for the longest time. The more she would throw it at me the more I built a wall around myself. But then coming here and listening to

how she felt...umm changed that. I feel super good about her and how she is feeling toward me. But now that the wall is down, I am left feeling ashamed about what I did.

Therapist: I'm wondering if it would help if you talked about your shame?

John: I don't know. I'm scared to bring up all the emotions.

Therapist: All the emotions?

John: Yeah because it did bother her much more than it bothered me over the long term. It has always been about her and I have never had time to think about my feelings.

Therapist: You have been able to compartmentalize your feelings and keep them at bay. But every now and then when she got scared she would remind you of it. Is that it?

John: Yeah, she would hold up a mirror and reflect it back to me and I knew that the wall would have to come down and I'd have to deal with it one day.

Therapist: So this is new for you to talk about your feelings, yes?

John: Maybe that's because I have a really hard time choosing my words and how I would say it. I know that I do tell her that I love her and want to grow old with her and all that stuff. It was really important to hear her say that she forgives me.

Therapist: It's hard to talk about your shame and regret about what happened. Can you try to tell her now?

John: (he turns to her). I am so sorry...I'm really sorry. I wasn't thinking and it was a silly, selfish thing to do...without any thought on my part of how it would affect you.

Pat: Well...I accept your apology.

John: (He sobs) Because I do love you very much and I want to stay with you.

Pat: I can't believe how I feel now since we've been coming here. It is in the past and I don't carry it anymore. It's fine...my life doesn't revolve around it anymore. I don't get up in the morning and think about it. I am sad to hear that you are dealing with it more now than before. I don't want you to worry about it. Maybe because you had put it on a shelf for so long that you are dealing with your feelings for the first time.

Therapist: It saddens you to hear that he still carries this?

Pat: Uh hmm...because it is gone for me. It is in the past. It is not even an issue anymore. I will never again...I know...that I will never worry about it.

John: Well, I think it has helped talking about the affair and hearing how you felt. You told me how you felt before but all I heard was your anger, which is now gone. This makes such a big difference when we talk now.

Although John was processing some of his own feelings, they both indicated that the incident that brought them to therapy was clearly in the past. They moved from the negative pattern of attack-defend to a more affiliative stance. They were able to openly disclose and respond to each other in an affirming and understanding manner. In addition, they both shifted from reactive responding and describing the event to a greater awareness of primary feelings as they emerged. This is a sharp contrast from the previous couple that could not get past the hurt and overwhelming sense of betrayal.

To summarize the process of change, resolved couples were open to exploring feelings related to the event. Specifically, injured partners' were able to disclose and express their needs and the offending partner responded in an affirming and understanding manner. Unresolved couples, however, remained stuck in an attack/blame and defend/withdraw stance. They intellectualized the event and were emotionally reactive.

Relating the Process to Outcome

The prediction that couples identified as having resolved the attachment injury would show significant gains in dyadic adjustment from pre-treatment to post-treatment was supported. For the resolved couples, the injured partners' mean DAS score increased from 86 at pre-treatment to 110 at post-treatment. Similarly, the offending partners' mean DAS score increased from 90 to 109. Conversely, the non-resolved couples not

only showed non-significant results in dyadic adjustment, the injured partners mean post-treatment DAS scores actually decreased, albeit not significantly.

Similarly, couples identified as having resolved the attachment injury showed significantly more gains in relationship trust from pre-treatment to post-treatment than the non-resolved couples. Although the non-resolved couples had significantly less trust than the resolved couples at pre-treatment, the resolved couples made significant gains over time. Their mean couple score increased from 123 to 157. The non-resolved couples showed no significant increase from pre-treatment (couple mean score of 95) to post-treatment (couple mean score of 102).

These analyses revealed a consistent pattern of statistically significant differences between resolved and non-resolved couples on dyadic adjustment and relationship trust. This suggests that resolved couples, who were able to work through the specified steps outlined in the process resolution model, were more likely to restore trust in their relationship and achieve greater marital satisfaction than those who did not go through the process of change in the specified manner. Given the significant positive correlation between dyadic adjustment and trust, an increase or decrease in one variable would result in a similar directional change in the other variable. This relationship between dyadic adjustment and trust is consistent with the literature (Holmes & Remple, 1989).

The prediction that resolved couples would show more significant decreases in avoidant and anxious attachment at post-treatment than non-resolved couples was not supported by the data. Despite the non-significant findings between groups, there was a significant effect with respect to time on the anxiety dimension. This suggests that both groups equally benefited from treatment, such that all couples were less anxious about the

relationship at post-treatment than they were at pre-treatment. The avoidance dimension, however, did not show any changes with respect to time. The findings also show that both anxiety and avoidance are poor predictors of attachment injury resolution.

There are several explanations for the lack of significant findings on the attachment dimensions. One possible explanation is that both groups with varying levels of attachment insecurity at intake may benefit from EFT; however, 15 sessions may not be adequate to detect a change between the groups. There was a reduction in anxiety for both groups, suggesting that EFT is effective in increasing the level of accessibility and responsiveness between partners and, therefore, restructuring attachment for some couples. However, attachment injury resolution is a process that may continue long after termination. Perhaps attachment injured couples need more compelling emotional experiences of comfort and connection that extends beyond the therapeutic setting before attachment security can be established.

A second reason for the lack of significant group differences in the attachment dimensions has to do with the stability of attachment patterns over time. It has been argued that these patterns, which have also been referred to in the literature as styles, strategies, orientations, and habitual forms of engagement (Bartholomew & Horowitz, 1991; Brennan et al., 1998; Johnson, 2002) are more enduring characteristics that are not easily modified. In this study, very little is known about the attachment patterns prior to their respective injurious events. It would be erroneous to assume that all the couples in this study were secure-secure. In other words, the attachment injury did not necessarily cause the pre-treatment attachment patterns. A more plausible explanation is that the injurious events elicited attachment-related behaviors consistent with the various

attachment patterns. Securely attached individuals have developed constructive coping. Individuals with a secure style are better able to openly talk with their partners in response to violations of trust (Mikulincer, 1998), communicate their needs, and reach out for and provide support (Simpson, 1990). As such, secure individuals may be better equipped to work through attachment-related events. The couples in this study, most of whom were insecurely attached at intake, may have old strategies that become activated that maintain a negative interactional cycle. What the results seem to suggest is that EFT helps couples have more positive interactions and create more safety in the relationship rather than alter attachment styles *per se*.

A related issue is the Experiences in Close Relationships measure used in this study instructs each partner to respond to the 36 statements in terms of how he/she generally experiences romantic relationships. Thus, the measure may not have been sensitive enough to detect any changes in anxiety and avoidance as a result of treatment. Perhaps if the items were modified to capture how he/she experiences the current partner rather than the history of romantic partners, a significant shift may have been detected for the resolved couples.

Finally, the non-significant findings may also be due to low power. Although EFT has been shown to be highly effective at reducing relationship distress (Johnson et al., 1999) and that trust is a good predictor of success (Johnson & Talitman, 1997), it is possible that the changes in the attachment dimensions are small and not readily detected with a small sample size. In view of the small clinical sample, it is possible that there was insufficient power to detect significant group differences.

In terms of forgiveness and pain, the prediction that resolved couples would show significant decreases in emotional pain and significant gains in forgiveness than the non-resolved couples was partially supported. The resolved and non-resolved injured partners reported less emotional pain at termination. This finding is consistent with the process resolution model in that the non-resolved couples tend to get stuck after the de-escalation stage, which is a first-order shift in EFT (Johnson, 1996). At this stage, the negative interactional cycle is still present, but partners are more engaged and less reactive. Given that the injured partners are the ones emotionally wounded by their partner, it makes sense clinically and theoretically that the injured partners in both groups would experience significant decreases in emotional pain as a result of EFT. In the multivariate analysis of covariance a significant group difference was detected. The regression analysis, which controlled for pre-treatment trust, showed that emotional pain accounted for a small, albeit significant, amount of variance in resolution. An explanation for the discrepant findings across analyses may be due to the low internal consistency of the emotional pain subscale. Reliability analyses revealed poor internal consistency for the pain subscale at pre-treatment (.58) and, although some improvement was noted at post-treatment (.73), it was still low.

With regard to forgiveness, the significant finding of group differences over time was as expected. At pre-treatment, the means for the resolved and non-resolved couples did not differ. However, at termination, the resolved couples made significant gains in terms of their level of forgiveness, whereas no change was noted for the non-resolved couples. This significant finding provides an idea of where the injured partners are in the process of forgiveness, which involves the ability to recognize negative interactional

patterns, setting limits, restoring trust and building emotional bonds, and responsibility-taking (Hargrave & Sells, 1997).

In summary, the current study was designed to build on the EFT literature in general but on the construct of attachment injuries in particular. This study set out to validate the attachment injury resolution model by investigating whether the model discriminates resolved from non-resolved couples and by relating the process of change to outcome. In view of the results, several conclusions can be made. First, the process resolution model was effective at discriminating resolved and non-resolved couples. Resolved couples shifted from a hostile to a more affiliative stance. Moreover, rather than talking about and describing the injurious event, as their counterparts continued to do, partners began to differentiate affect and explored the attachment significance of the event.

Second, the process resolution model was linked to treatment effects. The resolved couples reported less dyadic distress, more trust, achieved higher levels of forgiveness, and had less emotional pain than couples that remained stuck. For the injured partners, the best predictors of resolution were trust, followed by dyadic adjustment, forgiveness, and pain. For the offending partners, dyadic adjustment and trust were the best predictors of attachment injury resolution. It appears that the general benefits of treatment experienced by the non-resolved couples were enough to result in significantly less anxiety and emotional pain. Having the opportunity to talk about the injurious event in the safety of the therapy session appears to have lessened the symptoms over time for all of the injured partners. Contrary to expectations, these measures did not differentiate the two groups.

Clinical and Theoretical Implications

The results of this study have both theoretical and clinical implications. The study provides empirical support for the attachment injury resolution model. The model is based on EFT, an empirically validated approach to treating distressed couples, and provides couple therapists with insight into factors that may limit the effectiveness of therapy. Many couples with an attachment injury seem unaware of the impact such events have on their relationship bond. In addition, couple therapists may not attend to seemingly minor incidents that can impede the therapeutic process. Prototypical attachment-related injuries, such as infidelity, may be more obvious to a therapist. However, both the couple and the therapist may overlook the significance of seemingly benign emotional wounds (e.g., negative comment). Therefore, the couple may reach an impasse in therapy that is, they are unable to move beyond de-escalation, or relapse once therapy is terminated.

In addition, EFT has demonstrated a 79% recovery rate for marital distress and an improvement rate at follow-up ranging from 66% to 86% (Johnson et al., 1999). In this study, 63% of the sample successfully resolved the attachment injury. This recovery rate is less than what has been found in the EFT literature. It is important to note that over the course of therapy therapists discovered, seven of nine non-resolved couples had compound injurious events. In some cases, the offending partner repeatedly injured his/her spouse. In other cases, partners hurt each at two different points in time. Impasses make healing relationships more difficult. Compound injurious events may be potent enough to shatter the trust in the relationship and impact the ways in which the couples relate, thus making the resolution process even more arduous. Resolving

compound events may require longer treatment. The number of sessions offered to the couples in this study was limited. Given that attachment injuries have been likened to trauma, the resolution process may involve more extensive treatment to work through the emotional wounds. The clinical norm for working with trauma couples is at least 30 to 35 sessions (Johnson, 2002).

Limitations of the Study

Although this study contributes to literature on the process of resolving an attachment injury, it also has some methodological limitations that need to be addressed.

Measures. The Attachment Injury Measure (AIM), which was further developed for this study, had low internal consistency at pre-treatment. Although two of the six items were dropped to raise the reliability, it remained below acceptable levels for the offending partners. However, the measure was used because it demonstrated good internal consistency at post-treatment.

Sample. Task analytic process research and linking of the process of change to outcome is a labor-intensive project that inevitably requires realistic limits on the number of participants involved. As such, one of the shortcomings of this study is its small sample size and the absence of a control group. Small cell sizes raise the issue of power and the possibility of Type I error. The failure to find significant differences between the resolved and non-resolved groups on some of the measures might be due to the variability among subjects within groups. Furthermore, the inclusion of a control group may have provided an assessment of the clinical treatment effect with this population.

Length of Treatment. Couples in this study were offered 10 sessions of therapy, with the average length of therapy being 13 sessions. In retrospect, 10 to 15 sessions of

therapy was sufficient to achieve resolution for more than half the couples. However, in reality, the desired treatment goal is for all couples to resolve. Given that attachment injuries can be traumatic, more sessions may be necessary to achieve the desired outcome and minimize relapse. Further, the treatment period was very brief considering that before the therapist can even begin to address the injury, the therapist has to develop a good working alliance with both partners and complete stage one of EFT (de-escalation). Depending on the couple, building an alliance and then attaining de-escalation may be a long process, thus leaving few sessions to work on the attachment injury. Therapists working with couples that have compound attachment injuries may need to extend the duration of treatment even further in order to heal connections (Johnson, 2002).

Generalizability of Findings. One of the drawbacks to clinical research is the possible lack of generalizability of the findings. The motivation of couples responding to media advertisements offering free couples' therapy may differ from couples seeking therapy. Perhaps couples that pay for their sessions are more invested in their relationship and may work harder at restoring trust than couples receiving free therapy. Moreover, the couples for this study were asked to identify at the outset an attachment-related event that ruptured their relationship bond. Many distressed couples seeking therapy are not always aware of a specific instance and the impact that event had on the quality of their relationship.

Follow-up. One of the shortcomings of this research is that there was no follow-up to investigate whether changes that occurred at post-treatment were sustained at a three or six-month follow-up. In addition, given that resolving an attachment injury is a process, it is possible that some couples that were categorized as non-resolved made

significant gains after termination of treatment. EFT has demonstrated continued improvement at 10-week follow-up (e.g., Dandeneau & Johnson, 1994). Significant improvements at three or six months following termination would have added confirmatory evidence and validity to the process resolution model.

Future Directions

While these results lend support to the validity of the attachment injury resolution model and its relationship to treatment effects, some suggestions for future research are as follows. First, further attachment injury process research that employs task analytic methodology is warranted. Previous research provided the rational-empirical model for resolving attachment injury and the eight steps in the resolution process were verified (Millikin, 2000). The current study examined first and best sessions of therapy and relating the process to outcome. A more in depth process study that identifies markers of change at each of the eight steps would provide more detailed information regarding the process of change and further validate the attachment injury model. Ratings of other process measures, such as the emotional arousal scale and an expression of responsibility scale, would be informative.

Second, further research is needed to specifically identify therapy interventions that are most helpful in the attachment injury resolution process. Rather than focus solely on client performances, the focus would be on client-therapist processes. Identifying therapists' behaviors that precipitate the resolution process may expedite the resolution and prevent relapse.

Third, the Attachment Injury Measure used in this study needs further development. Perhaps a review of the process-outcome literature would be useful to see

what resolution measures have been developed. This may facilitate the selection of additional items for the AIM that would be meaningful to both the injured and offending partners. Ideally, a pilot study should be conducted first to establish the new measure is both valid and reliable.

Finally, given that attachment injuries can be complex, a conceptual model explicating the process of change in couples with more complex attachment injuries is warranted. The current study terminated treatment after a limited number of sessions. Perhaps a study involving the treatment of a few couples with complex attachment injuries to delineate the resolution process would be fruitful. In addition, it may be beneficial to look at the impact of a single event (e.g., infidelity) versus more chronic incidents, such as continuous minor flirtation.

In conclusion, this study is a call to process research. It utilized task analysis to study the process of change in couples with complex problems that often block relationship repair and it linked the change process to treatment effects in a relatively brief period of time. The study not only showed that EFT was effective at alleviating marital distress and increasing trust, it provided validation for the attachment injury resolution model, thus providing a map for therapists working with such couples. Moreover, it brought EFT into the realm of forgiveness and the important role forgiveness plays in the resolution process.

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APPENDIX A
Media Advertisement
Standardized Telephone Screening Procedure
Implementation Checklist
Information and Consent Form

MEDIA ADVERTISEMENT

Couples Needed For Research

Has your partner let you down?

Are you having a hard time getting past the emotional hurt?

Researchers at the University of Ottawa are offering 10 FREE sessions of therapy to eligible couples who want to attain closure and restore trust and security in their relationship.

For further information contact:

Judy Makinen

STANDARDIZED TELEPHONE SCREENING PROCEDURE

Thank you for calling. We will be conducting a research study on a counseling approach designed to help distressed couples. The study has been approved by the Research Ethics Committee of the University of Ottawa and is conducted by counselors experienced in working with couples. A registered psychologist in the province of Ontario will supervise the project.

Participation in the study involves both you and your partner coming in for a total of 10 counselling sessions of approximately one hour. The sessions will take place on a weekly basis. Your participation in this study is voluntary and you and your partner may withdraw from this project at any time without jeopardizing access to further counselling. To participate you will need to satisfy certain criteria. In a moment, I will ask you some questions that will help me determine if you might be suitable for this study. If you do seem suitable you will be asked to come in to the Centre for Psychological Services of the University of Ottawa to complete some questionnaires that will in fact determine if you can participate in this study. If you come in to complete these questionnaires you will be given more information about the study and will be asked to read and sign a consent form before completing the questionnaires.

I would now like to ask you some questions to see if you and your partner are suitable for this study. The nature of these questions may seem very personal and you may wish not to answer them.

1. Is your partner aware of your interest in participating in this study and has he/she consented to participate in the study? _____ (Answer must be YES).
2. Are you and your partner currently living together? _____ (Answer must be YES).
3. How long have you been living together? _____ (Minimum: 1 year).
4. Does either one of you experience problems related to drugs or alcohol? _____ (Answer must be NO).

If the caller reports substance abuse ask if they wish to be referred for treatment elsewhere

Al-Anon 725-3431
Rideauwood Institute 728-1727
R.O.H. 724-6508

5. Has either one of you received any psychiatric treatment/medication in the past year? _____ (Answer must be NO).
6. Are you currently receiving any form of psychological or psychiatric treatment? _____ (Answer must be NO).
7. Will either one of you be participating in any form of psychological or psychiatric treatment in the next three to four months? _____ (Answer must be NO).

8. Do you have a history of physical or sexual abuse? _____ (Answer must be NO).
9. Is there any physical violence between you and your partner? _____ (Answer must be NO).
10. Can you or your partner recall a instance of betrayal or rejection in your relationship that is associated with your current problem? _____ (Answer must be YES).

If yes, specify _____

Does NOT meet the criteria

If the caller does not meet inclusion criteria, thank them for their interest in the study. Ask caller if he/she would like to be referred elsewhere for treatment.

Has the caller been referred elsewhere for treatment? _____

If yes, please specify:

Centre for Psychological Services	_____
Family Service Centre of Ottawa	_____
Ottawa Academy of Psychology	_____
Ottawa Civic Hospital	_____
Catholic Family Services	_____
Royal Ottawa Hospital	_____

Does meet the criteria

If the couple meets all the inclusion criteria, obtain the names of the potential subjects and their phone numbers.

Names: _____

Tel.: (H) _____
(W) _____
(H) _____
(W) _____

Address: _____

Set up an appointment for completion of questionnaires and advise couple that this may take up to 1½ hours.

Date _____ Time _____

Place: Centre for Psychological Services (give appropriate directions).

IMPLEMENTATION CHECKLIST

Couple No. _____

Session No. _____

Rater _____

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

Intervention Checklist

Definition of Problematic Event

1. ____ The problematic event is defined/redefined in terms of the emotions and needs underlying the positions taken in the relationship.
2. ____ The therapist elicits the couple's ideas/theories/beliefs about why the problematic event has developed.
3. ____ The therapist clarifies and elaborated the basic positions taken by the partners in the relationship.
4. ____ The therapist asks the couple to disclose biographical data that may be relevant to explaining why the relationship is the way it is, such as how the parents' marriage influenced their own.

Attacking Behavior

5. ____ The therapist validates or develops the positions implied by negative behavior such as name-calling; such behavior is interpreted in terms of underlying needs and feelings.
6. ____ Negative behavior such as blaming or name calling is immediately stopped with authority on the part of the therapist and/or is defused by asking the blamer's theory on how he/she was attracted to and got involved with such a person.

Process Focus

7. ____ The therapist probes for and heightens emotional experience, especially fears and vulnerabilities, clarifying emotional triggers and responses and focusing upon inner awareness.
8. ____ The therapist avoids and suppresses affective interchange, and/or behavioral interpretation, or confrontation. No feeling or behavior is accessed, confronted or interpreted.
9. ____ The interacting sensitivities underlying behavior are clarified and the meaning of individual emotional experience is interpreted in terms of the other partner and the relationship.
10. ____ The therapist invites the couple to speculate about general explanations they might consider for couples with similar problems and/or offers a possible theory to trigger the partners' thinking.
11. ____ Therapist keeps a focus on what is occurring in the present between partners.
12. ____ Therapist takes what is happening in the present and brings it back to the past, to their parents' relationship, to their background and upbringing.

Resolution of Problematic Event

13. ____ Therapist facilitates expression of affectively based needs and wants to the partner.
14. ____ Therapist helps each partner identifying and express to the therapist his/her expectations from the other partner without basing them in feelings.
15. ____ Therapist helps clients to share their new perspective of each other and/or of the relationship, and to explore their new feelings in response to this new perspective.
16. ____ Therapist asks each partner to disclose opinions/thoughts/theories about what throughout the sessions has led to improvement.

INFORMATION AND CONSENT FORM

Couple No. _____

M ____ F ____

General Information

Purpose of this Research Project

This research project is designed for couples that wish to restore lost intimacy and trust in their relationship following a hurtful incident. The project is conducted by Judy Makinen for her thesis and is under the supervision of Dr. Susan Johnson, a registered psychologist in the province of Ontario. The purpose of this project is to study how you and your partner attain closure to past negative events and how resolving these events has an impact on the quality of the relationship bond between you and your partner.

Major Procedures

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

If you meet our criteria for participation, you will be assigned to a therapist who will call you to arrange your first appointment. You will be seen for approximately ten (10) weekly sessions for one (1) hour. Both you and your partner will be asked to attend the sessions together each week. Sessions will be conducted by senior doctoral level students, social workers, or psychologists trained in Emotionally Focused Therapy. Supervision of the therapy process will be carried out by Dr. Susan Johnson, a registered clinical psychologist at the Centre for Psychological Services of the University of Ottawa and the Director of the Ottawa Couples & Family Institute. All sessions will be audio- or video-taped for supervision and to ensure that the approach is faithfully implemented. At the end of each session, you will be asked to complete a questionnaire. At the end of the final session, you will be asked to complete another set of research questionnaires.

Therapeutic Approach Used in This Study

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

Benefits

No benefits are guaranteed to you for taking part in this study. As a result of the therapy, you may experience less distress and more intimacy in your relationship and you may also begin to resolve conflicts with more satisfaction, but no guarantees are made.

Risks

The risks of the study include experiencing uncomfortable feelings when discussing relationship problems during the therapy process. You may find that therapy does not adequately resolve your presenting issues.

Confidentiality

Confidentiality of all tape recordings and written responses will be respected according to the ethical guidelines of the College of Psychologists of Ontario. Your names will be known only to the people who are directly involved in the research. These include the principal investigator, the clinical supervisor, and your therapist. Anonymity will be assured through the pooling of all data so that the published results will be presented in group format and no individual or couple will be identified.

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

Confidentiality is an integral to this study. Everything that you say during the therapy sessions will remain confidential. However, there are some situations where the investigator and/or therapist must break the confidentiality agreement. First, if we heard that you were a danger to yourself or to someone else, then we are obliged by law to take steps to protect you and others. Second, if you disclosed or we suspected child abuse, we are required by law to report it. Third, if we learned that a health care professional had acted unethically, it is our responsibility to report that to the professional authorities. Finally, if we were subpoenaed to give testimony, the file may be opened in the interest of justice.

Consent for Services

I, _____, am interested in collaborating in the research conducted by Judy A. Makinen, of the Department of Psychology at the University of Ottawa. This project is under the supervision of Dr. Susan Johnson. I consent to the use of tape recordings of therapy sessions and for my written responses to the questionnaires for the purposes of this research with the understanding that all information gathered will be held in strict confidence within the limits of the law and according to the ethical principles of the College of Psychologists of Ontario, and that this information will be available only to those who are directly involved in the study.

Freedom to Withdraw

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

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

Signature of Subject: _____

Date _____

Signature of Researcher: _____

Date _____

Any questions about the conduct of the research project should be directed to the researcher or her supervisor:

Judy A. Makinen
Investigator

Dr. Susan Johnson
Faculty Supervisor

APPENDIX B

Process Measures

THE EXPERIENCING SCALE (ES)

General description of the seven stages:

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

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

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

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

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

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

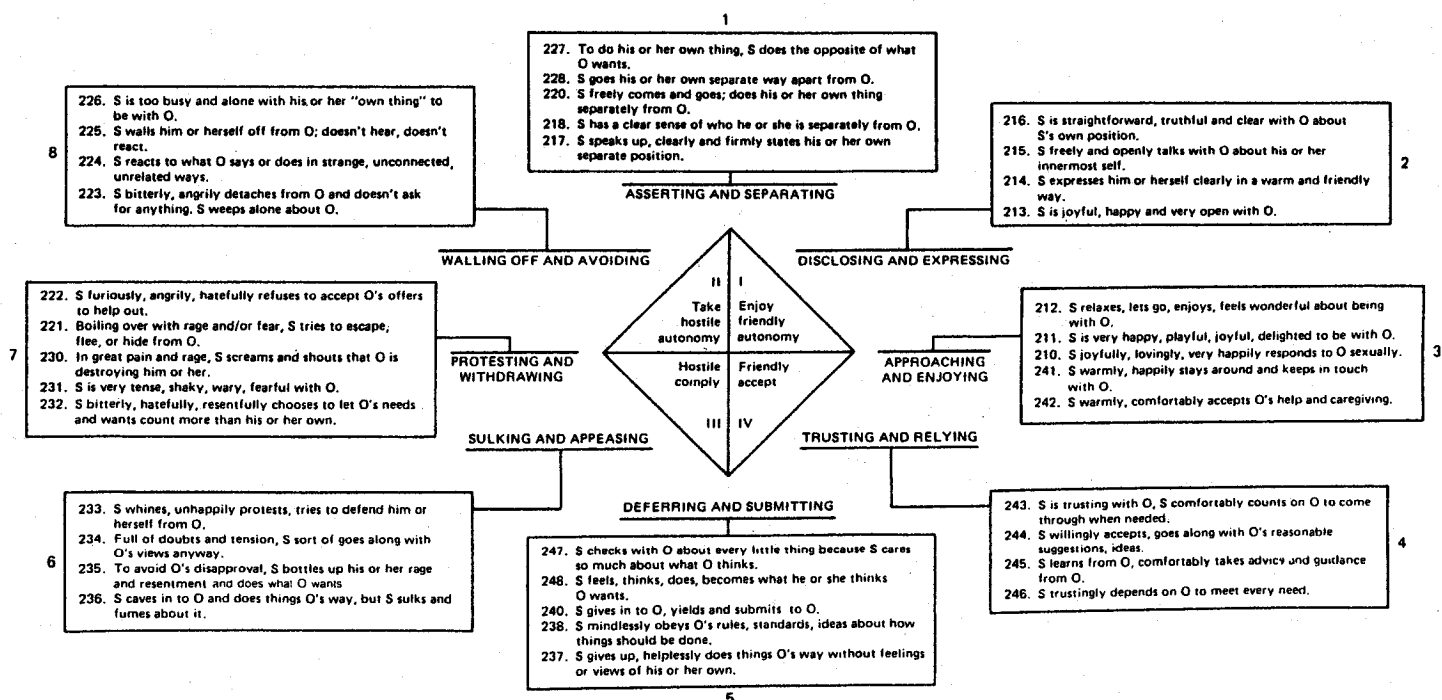
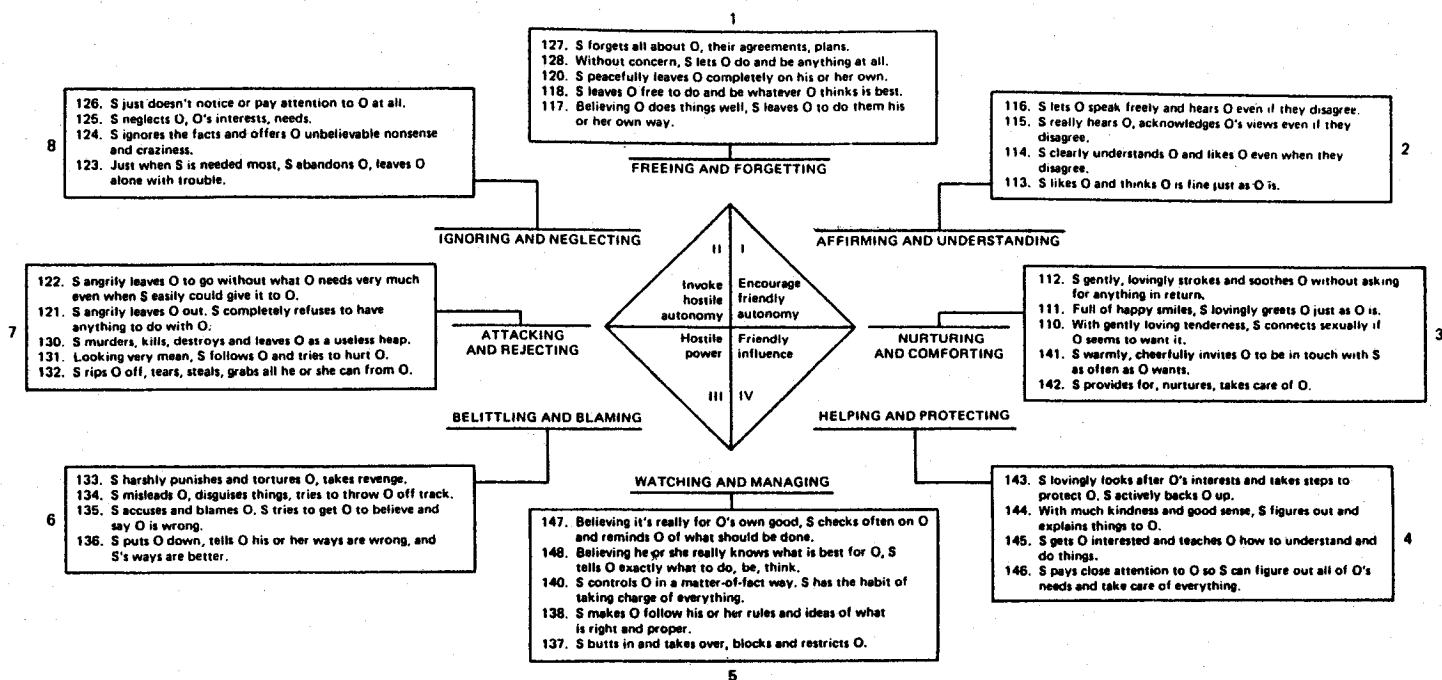
Stage 7: The content reveals the speaker’s steady and expanding awareness of immediately present feelings and internal processes. He or she clearly demonstrates the ability to move from one inner referent to another, linking and integrating each immediately felt nuance as it occurs in the present experiential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

Short Form of Experiencing Scale

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

Note. Reprinted from M.H. Klein, P. Mathieu-Coughlan & D. J. Kiesler, The experiencing scales, in L. G. Greenberg & W. M. Pinsoff (Eds.), *The psychotherapy process: A research handbook* (pp. 22-23). New York: Guilford Press. Copyright 1970 by The Regents of the University of Wisconsin, Revised, 1983.

STRUCTURAL ANALYSIS OF SOCIAL BEHAVIOR (SASB)



Appendix C

Self-Report Measures

DEMOGRAPHIC DATA QUESTIONNAIRE

Couple No. _____

M _____ F _____

1. How many years have you lived together as a couple? _____
2. How many children do you have? _____
3. Have the two of you had any marital counselling before taking part in this project?
Yes _____ No _____
4. What is your gross family income (annual)? _____
5. Please state your age (in years) _____
6. What is your present occupation? _____
7. Have you had a previous marriage? Yes _____ No _____
8. Please indicate the highest level of education that you have completed to date:
____ Grade 10 or less
____ Grade 12 or less
____ 2 years of post-secondary education
____ Community college diploma program
____ Bachelor's degree
____ Master's degree
____ Ph.D. degree

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

		<u>Every Day</u>	<u>Almost Every Day</u>	<u>Occasion- ally</u>	<u>Rarely</u>	<u>Never</u>
23.	Do you kiss your mate?	_____	_____	_____	_____	_____
		<u>All of Them</u>	<u>Most of Them</u>	<u>Some of Them</u>	<u>Very Few of Them</u>	<u>None of Them</u>
24.	Do you and your mate engage in outside interests together?	_____	_____	_____	_____	_____

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

	<u>Never</u>	<u>Less than once a Month</u>	<u>Once or twice a Month</u>	<u>Once or twice a Week</u>	<u>Once a Day</u>	<u>More Often</u>
25. Have a stimulating exchange of ideas						
26. Laughter together						
27. Calmly discussing something						
28. Work together on a project						

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

	<u>Yes</u>	<u>No</u>	
29. _____			Being too tired for sex.
30. _____			Not showing love.

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

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

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

- _____ I want desperately for my relationship to succeed, and would go to almost any length to see that it does.
- _____ I want desperately for my relationship to succeed, and will do all I can to see that it does.
- _____ I want desperately for my relationship to succeed, and will do my fair share to see that it does.
- _____ It would be nice if my relationship succeeded, but I can't do much more than I am doing now to help it succeed.
- _____ It would be nice if it succeeded, but I refuse to do any more than I am doing now to keep the relationship going.
- _____ My relationship can never succeed, and there is no more that I can do to keep the relationship going.

RELATIONSHIP TRUST SCALE

Couple No. _____

M _____ F _____

Instructions

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

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

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

- | | | | | | | | | |
|-----|--|---|---|---|---|---|---|---|
| 7. | When we are dealing with an issue that is important to me, I feel confident that my partner will put my feelings first. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8. | If a better alternative were to come along, there is the possibility that my partner would at least consider leaving our relationship. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9. | My partner is truly sincere in his/her promises. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 10. | Even when my partner and I are very angry at each other, we still know that we love each other fully and unconditionally. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 11. | My partner is perfectly honest and truthful with me. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 12. | Through our concerted efforts at problem solving, we have managed to cope with the stresses on our relationship very efficiently. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 13. | Our marriage could easily be explained in terms of "(s)he contributes this" and "I contribute that". At times it doesn't feel like we're in it together. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 14. | It is sometimes difficult for me to be absolutely certain that my partner will always care for me. Too many things can change in our relationship as time goes on. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 15. | My partner and I are compatible enough that my personal needs can be realized in our relationship. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 16. | At times I am uncomfortable when I think about how much I have invested in my relationship with my partner. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 17. | In our day-to-day interactions, my partner consistently acts in ways that are positive. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 18. | There are times that my partner cannot be trusted. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

- | | | | | | | | | |
|-----|---|------------------|---|---|---|---|---|---|
| 19. | I am never concerned that conflicts and serious tensions can damage our relationship because I know we can weather any storm. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 20. | My partner is not necessarily someone others consider to be reliable. (S)he can't always be counted on. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 21. | My partner is deeply committed to our relationship. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 22. | Issues in our relationship don't seem to sort themselves out over time. They seem to build up, mushrooming into concerns that are out of proportion to the problem at hand. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 23. | My partner treats me fairly and justly. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 24. | My partner has proven to be a faithful person. (S)he would never be unfaithful, even if there was absolutely no chance of being caught. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 25. | I feel that my partner does not show me enough consideration. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 26. | When problems have surfaced in our relationship, we have shown considerable ability to work through them successfully. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 27. | My partner is a thoroughly dependable person. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 28. | I feel that I can trust my partner completely. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 29. | Our two styles of dealing with conflicts make me concerned about our capacity to confront problems that arise in our relationship. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 30. | My partner typically behaves in ways that are very rewarding to me. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 31. | At the present time, do you trust your partner? | Yes_____ No_____ | | | | | | |

EXPERIENCES IN CLOSE RELATIONSHIPS

Couple No. _____

M _____ F _____

Instructions: The following statements concern how you feel in romantic relationships. We are interested in how you generally experience relationships, not just in what is happening in a current relationship. Respond to each statement by indicating how much you agree or disagree with it.

Write the number in the space provided, using the following rating scale:

Disagree Strongly

Neutral/Mixed

Agree Strongly

1

2

3

4

5

6

7

- ___ 1. I prefer not to show a partner how I feel deep down.
- ___ 2. I worry about being abandoned.
- ___ 3. I am very comfortable being close to romantic partners.
- ___ 4. I worry a lot about my relationships.
- ___ 5. Just when my partner starts to get close to me I find myself pulling away.
- ___ 6. I worry that romantic partners won't care about me as much as I care about them.
- ___ 7. I get uncomfortable when a romantic partner wants to be very close.
- ___ 8. I worry a fair amount about losing my partner.
- ___ 9. I don't feel comfortable opening up to romantic partners.
- ___ 10. I often wish that my partner's feelings for me were as strong as my feelings for him/her.
- ___ 11. I want to get close to my partner, but I keep pulling back.
- ___ 12. I often want to merge completely with romantic partners, and this sometimes scares them away.
- ___ 13. I am nervous when partners get too close to me.
- ___ 14. I worry about being alone.
- ___ 15. I feel comfortable sharing my private thoughts and feelings with my partner.
- ___ 16. My desire to be very close sometimes scares people away.
- ___ 17. I try to avoid getting too close to my partner.
- ___ 18. I need a lot of reassurance that I am loved by my partner.
- ___ 19. I find it relatively easy to get close to my partner.
- ___ 20. Sometimes I feel that I force my partners to show more feeling, more commitment.
- ___ 21. I find it difficult to allow myself to depend on romantic partners.
- ___ 22. I do not often worry about being abandoned.
- ___ 23. I prefer not to be too close to romantic partners.
- ___ 24. If I can't get my partner to show interest in me, I get upset or angry.
- ___ 25. I tell my partner just about everything.
- ___ 26. I find that my partner(s) don't want to get as close as I would like.
- ___ 27. I usually discuss my problems and concerns with my partner.
- ___ 28. When I'm not involved in a relationship, I feel somewhat anxious and insecure.
- ___ 29. I feel comfortable depending on romantic partners.
- ___ 30. I get frustrated when my partner is not around as much as I would like.
- ___ 31. I don't mind asking romantic partners for comfort, advice, or help.
- ___ 32. I get frustrated if romantic partners are not available when I need them.
- ___ 33. It helps to turn to my romantic partner in times of need.
- ___ 34. When romantic partners disapprove of me, I feel really bad about myself.
- ___ 35. I turn to my partner for many things, including comfort and reassurance.
- ___ 36. I resent it when my partner spends time away from me.

INTERPERSONAL RELATIONSHIP RESOLUTION SCALE

Couple No. _____

M _____ F _____

In any relationship it is possible for people to experience hurts that can lead to emotional pain. In some cases, these hurts can be severe and long lasting. This scale is designed to measure:

- Some of the emotions and behaviors that you feel and exhibit toward the person who caused you hurt.
- Some of the feelings you have about yourself
- Some of the ways you act in other situations and relationships

Since each person is unique, there is no right or wrong answer. Just try to respond as honestly as you can.

Rate the following statements as they apply to you and the person who hurt you in such a way that causes you distress. Even though many people may have caused you hurt, keep your partner in mind when answering the statements.

1. This person has apologized to me for the pain he or she has caused in my life.
 ____ Yes, I believe this is true ____ No, I believe this is false.
2. I believe we are on the road to restoring our relationship.
 ____ Yes, I believe this much of the time ____ No, I seldom feel this way.
3. I have a current relationship with this person and feel little need to talk about the past hurt.
 ____ Yes, this is mostly true ____ No, this is mostly false.
4. I believe this person would not intentionally hurt me again because he or she is now trustworthy in our relationship.
 ____ Yes, this is true much of the time ____ No, this is hardly ever true
5. The only way I can deal with this relationship is to keep my distance from this person.
 ____ Yes, this is mostly true ____ No, this is mostly false.
6. My relationship with this person has improved gradually over time by just being together and having mostly good times.
 ____ Yes, this is mostly true ____ No, this is mostly false.
7. I feel powerless over circumstances of our relationship when I'm with this person.
 ____ Yes, I feel this way most of the time ____ No, I do not feel this way often.
8. I have difficulty in stopping this person from causing me hurt.
 ____ Yes, I have this difficulty often. ____ No, this is mostly not the case.

9. This person has pain that has nothing to do with me.
____ Yes, I am fairly sure this is true. ____ No, I do not believe this is true.
10. Things are not completely resolved in our relationship, but it is getting better.
____ Yes, this is mostly true ____ No, this is mostly false.
11. I have trouble sorting out my emotions with regard to this person.
____ Yes, this is mostly true ____ No, this is mostly false.
12. This person acknowledges that he or she has done things wrong in the past concerning our relationship.
____ Yes, this is mostly true ____ No, this is mostly untrue
13. I never seem to "win" when it comes to relating to this person.
____ Yes, this is mostly true ____ No, this is mostly untrue
14. When this person is cruel to me, it has more to do with his or her problems than it does with me.
____ Yes, I believe this most of the time. ____ No, I have difficulty believing this.
15. For the most part, I deserve the things that have happened to me.
____ Yes, most of the time. ____ No, I hardly ever believe this.
16. I know how to effectively stop this person from causing me pain.
____ Yes, most of the time. ____ No, almost never.
17. This person has taken responsibility for causing me pain.
____ Yes, I believe this much of the time. ____ No, I hardly ever believe this.
18. I understand why I feel pain from this person.
____ Yes, it is fairly clear to me. ____ No, I am fairly confused.
19. Our relationship is improving a little each time we are together.
____ Yes, I find this mostly true ____ No, this is mostly false.
20. If I had come from this person's background, I might do some harmful things to people.
____ Yes, I may have made the same mistakes ____ No, I think I would have done better
21. When I talked to this person about the damage he or she caused, he or she accepted responsibility.
____ Yes, for the most part ____ No, he or she mostly did not

22. I believe that our relationship is making progress and someday may be totally healed.
____ Yes, I believe this much of the time ____ No, I seldom feel this way
23. People don't ask my advice or opinion.
____ Yes, I believe this is mostly true ____ No, this is mostly false.
24. Nobody knows how I really feel.
____ Yes, I believe this is mostly true ____ No, I believe this is mostly false.
25. I easily misplace things.
____ Yes, I do this much of the time. ____ No, this is hardly ever the case.
26. I am ashamed of what has happened to me.
____ Yes, I feel this way much of the time. ____ No, I seldom feel this way.
27. I hit things when I am really angry.
____ Yes, this happens often. ____ No, I hardly ever happens.
28. Winning is very important to me.
____ Yes, I believe this is mostly true ____ No, I hardly ever feel this way
29. I can stay with tasks until they are complete.
____ Yes, I do this much of the time. ____ No, this is hardly ever the case.
30. I need to cover up how I really feel.
____ Yes, I feel this way most of the time. ____ No, I seldom feel this way.
31. I feel like smashing things.
____ Yes, I feel this way often. ____ No, I hardly ever feel this way.
32. I swear a lot when I am mad.
____ Yes, I do this much of the time. ____ No, I hardly ever happens.
33. I don't want people to know what happened to me.
____ Yes, this is mostly true ____ No, this is mostly false.
34. I have difficulty compromising with other people.
____ Yes, I believe this is mostly true ____ No, this is seldom true
35. I feel hopeless and alone.
____ Yes, this is mostly true ____ No, this is mostly false.
36. It is often better to cover up your feelings.
____ Yes, I believe this is mostly true. ____ No, I hardly ever feel this way.
37. This person causes me to feel so angry, I cannot think.
____ Yes, this happens often. ____ No, this seldom happens.

38. I feel responsible for what this person did to me.
____ Yes, I feel this way much of the time. ____ No, I seldom feel this way.
39. When in an argument, I have been known to throw things.
____ Yes, this happens often. ____ No, this hardly ever happens.
40. People say that I'm co-dependent.
____ Yes, I believe this is mostly true. ____ No, I hardly ever feel this way.
41. After work or school, I have no motivation to get anything accomplished.
____ Yes, I believe this is mostly true. ____ No, I hardly ever feel this way.
42. Life feels organized.
____ Yes, I believe this is mostly true. ____ No, I hardly ever feel this way.
43. I feel enraged often.
____ Yes, this happens much of the time. ____ No, this hardly ever happens.
44. People say that I am a person that has to have my way.
____ Yes, I believe this is mostly true. ____ No, this is mostly false.

PRE-TREATMENT ATTACHMENT INJURY MEASURE

Couple No. _____

M ____ F ____

Please describe as thoroughly as possible the nature of the incident that injured the bond between you and your partner. Include a description of the incident, how you dealt with it when it occurred, how you are dealing with it now.

-
1. How do you rate the significance of the event that injured your relationship bond?

1.....2.....3.....4.....5
Severe Considerable Moderate Mild Negligible

2. How does it affect the level of trust between you and your partner?

1.....2.....3.....4.....5
Severe Considerable Moderate Mild Negligible

3. How does the injury interfere with your relationship now?

1.....2.....3.....4.....5
Severe Considerable Moderate Mild Negligible

4. When you talk to your partner about the injury how much of a problem does it create?

1.....2.....3.....4.....5
Severe Considerable Moderate Mild Negligible

5. Do you think your partner would respond favorably if the subject came up in the future?

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

6. Do you believe that this issue can be resolved and the trust in your relationship improved?

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

POST-TREATMENT ATTACHMENT INJURY MEASURE

Couple No. _____

M _____ F _____

Now that you have completed therapy:

1. How do you rate the significance of the event that injured your relationship bond?

1.....2.....3.....4.....5
Severe Considerable Moderate Mild Negligible

3. How does it affect the level of trust between you and your partner?

1.....2.....3.....4.....5
Severe Considerable Moderate Mild Negligible

3. How does the injury interfere with your relationship now?

1.....2.....3.....4.....5
Severe Considerable Moderate Mild Negligible

4. When you talk to your partner about the injury how much of a problem does it create?

1.....2.....3.....4.....5
Severe Considerable Moderate Mild Negligible

5. Do you think your partner would respond favorably if the subject came up in the future?

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

6. Do you believe that this issue can be resolved and the trust in your relationship improved?

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

POST-SESSION RESOLUTION QUESTIONNAIRE

Couple No. _____

M _____ F _____

Session No. _____

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

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

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

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

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

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

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

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

COUPLE THERAPY ALLIANCE SCALE

Couple No. _____

M _____ F _____

The following statements refer to your feelings and thoughts about your therapist and your therapy right now. Each statement is followed by a seven-point scale. Please rate the extent to which you agree or disagree with each statement at this time.

If you completely agree with the statement, circle number 7. If you completely disagree with the statement, circle number 1. Use the numbers in between to describe variations between the extremes.

Please work quickly. We are interested in your first impressions. Your ratings are confidential. They will not be shown to your therapist or your partner and will only be used for research purposes.

Although some of the statements appear to be similar or identical, each statement is unique. Please be sure to rate each statement.

	Completely Agree 7	Strongly Agree 6	Agree 5	Neutral 4	Disagree 3	Strongly Disagree 2	Completely Disagree 1
1 The therapist cares about me as a person					7	6 5 4	3 2 1
2 The therapist and I are not in agreement about the goals for this therapy.					7	6 5 4	3 2 1
3 I trust the therapist.					7	6 5 4	3 2 1
4 The therapist lacks the skills and ability to help my partner and myself with our relationship.					7	6 5 4	3 2 1
5 My partner feels accepted by the therapist.					7	6 5 4	3 2 1
6 The therapist does not understand the relationship between my partner and myself.					7	6 5 4	3 2 1
7 The therapist understands my goals in therapy.					7	6 5 4	3 2 1
8 The therapist and my partner are not in agreement about the goals for this therapy.					7	6 5 4	3 2 1
9 My partner cares about the therapist as a person.					7	6 5 4	3 2 1
10 The therapist doesn't understand the goals that my partner and I have for ourselves as a couple in this therapy.					7	6 5 4	3 2 1
11 My partner and the therapist are in agreement about the way the therapy is being conducted.					7	6 5 4	3 2 1

	Completely Agree 7	Strongly Agree 6	Agree 5	Neutral 4	Disagree 3	Strongly Disagree 2	Completely Disagree 1					
12	The therapist does not understand me.					7	6	5	4	3	2	1
13	The therapist is helping my partner and me with our relationship					7	6	5	4	3	2	1
14	I am not satisfied with the therapy.					7	6	5	4	3	2	1
15	The therapist understands my partner’s goals for this therapy.					7	6	5	4	3	2	1
16	I do not feel accepted by the therapist.					7	6	5	4	3	2	1
17	The therapist and I are in agreement about the way the therapy is being conducted.					7	6	5	4	3	2	1
18	The therapist is not helping me.					7	6	5	4	3	2	1
19	The therapist is in agreement with the goals that my partner and I have for ourselves as a couple in this therapy.					7	6	5	4	3	2	1
20	The therapist does not care about my partner as a person.					7	6	5	4	3	2	1
21	The therapist has the skills and ability to help me.					7	6	5	4	3	2	1
22	The therapist is not helping my partner.					7	6	5	4	3	2	1
23	My partner is satisfied with the therapy.					7	6	5	4	3	2	1
24	I do not care about the therapist as a person.					7	6	5	4	3	2	1
25	The therapist has the skills and ability to help my partner.					7	6	5	4	3	2	1
26	My partner distrusts the therapist.					7	6	5	4	3	2	1
27	The therapist cares about the relationship between my partner and myself.					7	6	5	4	3	2	1
28	The therapist does not understand my partner.					7	6	5	4	3	2	1