

ATTACHMENT INJURY RESOLUTION IN COUPLES WHEN ONE PARTNER IS TRANS-IDENTIFIED

DONNA M. CHAPMAN
Private Practice, San Diego, CA
BENJAMIN E. CALDWELL
Alliant International University

Trans-identified (TI) couples are a marginalized, under-served population. Extant literature concerning the treatment of relational distress with this group is sparse. Information that is available is more concerned with the transition support of the TI partner, usually male, than it is with the partner experiencing the attachment injury or the couple as a separate entity. These couples experience significant relational upheaval. This paper explores the literature on the partners and couple relationships of TI persons, and proposes the use of the Emotionally Focused Therapy attachment injury resolution model for couples experiencing this upheaval. The model, which has been supported in studies of attachment injury treatment in distressed heterosexual couples, would require minimal adaptation for use with TI couples. For example, the goal of therapy using this model with married TI couples must be repairing the relationship, not necessarily repairing the marriage. A case example is used to demonstrate the potential of this approach.

Research supports the efficacy of Emotionally Focused Therapy (EFT; Johnson, 2004) as an evidence-based treatment (EBT) in repairing moderately and severely distressed marriage relationships in heterosexual couples through the use of heightening and de-escalating techniques and enactments (Johnson, Makinen, & Millikin, 2001; Makinen & Johnson, 2006; Naaman, Pappas, Makinen, Zuccarini, & Johnson-Douglas, 2005). Some reports suggest that therapists are now broadening the application of attachment based processes like EFT to include individuals, families, and same-sex relationships (Johnson

Donna M. Chapman is a marriage and family therapist intern employed in private practice with transgender people and their families in San Diego, CA. Benjamin E. Caldwell is an Associate Professor in the couple and family therapy graduate programs at Alliant International University in Los Angeles, CA.

Address correspondence to: Donna Chapman, 3737 Camino Del Rio South, San Diego, CA 92108.
E-mail: icare@dmchapman.com

& Whiffen, 2003), however research to support the efficacy of such application is sparse.

There is a very small, largely neglected, culturally invisible group of people who could potentially benefit from the ability of EFT to repair an attachment injury. This group is made up of couples with one partner who has come out as Trans-Identified (TI; the term “TI couples” is used here for couples where one partner is TI) and may be seeking or in the process of gender reassignment. They are a small population, but are under a huge amount of relational distress deserving of attention because of a level of relational turmoil that some have previously considered impossible to overcome and indicative of the death of the marriage (Samons, 2009). These couples are marginalized and they experience existential angst as the foundations of their relationships are shattered, and the current dominant culture swings in place to ostracize the TI member. What happens to the partner? The unique experience of these couples relative to other types of distressed couples strongly suggests the need for a specifically adapted treatment process.

DEFINITIONS AND BOUNDARY EXPLANATIONS

This article concerns only TI couples. This means that at least one of the members has identified themselves as Trans-Gender (TG) or Trans-Sexual (TS; Kenagy & Hsieh, 2005). These terms have different meanings: TG people wish to alter their psychic and public gender identification to the world, while TS people wish to modify their bodies so that their bodies match their inner gender views. Transition is the process through which a TI individual initiates physiological changes including but not limited to taking hormones, facial reconstruction, and having sexual reassignment surgery in order to modify their bodies to support their internal gender identification (Kenagy & Hsieh, 2005). This manuscript uses the terms TI Male-to-Female (M2F) and TI Female-to-Male (F2M) to indicate the direction of desired or active change; these terms can apply to both TG and TS individuals (Kenagy & Hsieh, 2005).

TG and TS groups are different from gender divergent or gender variant people, who include non-TI cross dressing, transvestitism, other expressions of gender, sexual paraphilias, and dysphoric pathology (Stepleman, 2005). The needs of this group are not part of the present discussion, although the authors acknowledge that there is significant need for the development and research evaluation of specifically-adapted treatments for this population as well.

When a partner comes out as TI, an attachment injury is almost inevitably created due to the significant role and identity change the TI partner is undergoing. The remaining partner experiences a responding role and

identity change—unplanned and uncontrolled—as well. These changes occur whether the remaining partner likes it or not, and that partner has little power to stop them. These changes in role and identity can shake the foundation of the couple’s definition of relationship and their security in their roles within it. The term *attachment injury* is used

to describe any incident where an individual’s partner is perceived to be inaccessible or unresponsive in a critical moment, especially when attachment needs are particularly salient. This is significant because it results in a tear in the fabric of, or disconnection in, the attachment bond creating negative interactional cycles that perpetuate relational distress (Johnson et.al., 2001, p. 56).

When a partner comes out as TI, their presence in the relationship is such that they are no longer accessible or available to the remaining partner in the form to which the remaining partner has been bonded. On this basis, the authors believe that an attachment injury is created. For the sake of clarity, the partner who is not TI will be referred to in this manuscript as “the injured partner” when referring to the presence of the attachment injury. However, the authors readily acknowledge the potential for the TI partner also to experience attachment injury, and expect that the resolution method discussed in this article could provide a powerful experience of healing for both partners.

The first section is a review of extant literature on the treatment of couples where one partner is TI. The second section proposes a methodology for treating the type of turmoil that these couples experience with the attachment injury resolution model commonly utilized within EFT. The third section features a hypothetical case example. Due to the lack of actual case studies for reference, this is a proposal for how the treatment process could work.

REVIEW OF CURRENT LITERATURE ON THE TREATMENT OF TI COUPLES

While an increasing number of therapists are writing about family issues with transgender members, and extant literature acknowledges that therapists are not trained to work competently with TI clients, research on the treatment of such clients is fragmented and mostly theoretical in nature (Samons, 2009; Stepleman, 2005). There is minimal extant literature that is couple-centric or relationship-centric for this population. The existing research is TI-centric and usually more relevant for M2F TI individuals. There was no literature found that offered guidance of any kind for the treatment of F2M TI individuals, although many opportunities for social support within the community

were found. Similarly, there was no literature that described any method for processing the emotional upheaval experienced by a couple or family when the TI partner comes out and requests to express their gender orientation publically or requests to initiate transition.

Several authors have identified the dearth of clinical data supporting work with TI people and their families as a significant concern (Bigner & Gottlieb, 2006; Fraser, 2009; Kenagy & Hsieh, 2005; Lev, 2005; Raj, 2006; Samons, 2009; Stepleman, 2005). Raj (2006), in particular, acknowledges the lack of sensitive and competent therapists for helping couples and families with TI members. Samons (2009) mentions factors that must be taken into account when working with TI individuals, but does not mention self-of-therapist issues or issues of counter-transference, which must be addressed when therapists work with any traditionally marginalized group.

Most of the limited research that does exist focuses on assessment and data collection on the TI individual not on the couple or the remaining partner. Such research tends not to discuss treatment involving counseling and support for TI individuals and their families, or for their families alone should they choose to dissolve the relationship (Raj, 2006). All agree that any clinical intervention must be grounded in knowledge about trans-gender/trans-identification and gender diversity (Raj, 2006)

A. I. Lev has contributed significantly to de-mystifying TI couples and families. Lev views transgender emergence as a life cycle issue, and feels that it should be treated as any other lifecycle transition (Stepleman, 2005). Lev also asserts that intimate relationships that include the identification of one partner as transgender or where a partner begins the process of transition experience a variety of outcomes. Past assumptions that these relationships are doomed to failure are no longer valid (Stepleman, 2005).

The process of Trans Identification has been equated to *coming out*, however in contrast with the *coming out* experience of a gay or lesbian person who comes out to themselves but may choose to remain closeted for a variety of reasons, TI people do not just come out to themselves. They cannot remain closeted if they wish to actualize their gendered sense of self (Lev, 2005). They *must* remake themselves physically and socially, and this transition is visible and public. There is no option for the family but to cope with it whether they like it or not, and they have been considered extraneous to the process of evaluation and treatment of the TI partner. Their needs have been marginalized. Consideration needs to be given to remaining partners and their “coming out” experience of sorts. These partners can experience social disconnects on many levels. Straight women involved with TI M2F women may find themselves severed from their support systems in the straight community (such as family, friends, and church groups). If one or both partners are

people of color, even deeper cultural disconnects may occur, as they experience ethnic cut-off or are forced to make a choice between ethnic community and trans community (Nealy, 2008). Partners who are heterosexual, gay, or lesbian need time to adjust to the idea of having a TI partner (Lev, 2005). Malpas agrees with this assertion and goes on to state specifically that the experiences of heterosexual partners of TI women (M2F) have been “largely ignored” (Malpas, 2006, p.185).

The partners of TI individuals are thrown into emotional chaos. This extends across all relational domains: gay, lesbian, bisexual, and heterosexual. The cultural values and expectations of each partner can further complicate matters (Nealy, 2008). There is little professional help available for this group, while at the same time there is an abundance of professional and social services available for the TI partner. The new gender expression of the transitioning spouse may cause the remaining spouse to question their own sexual identity and how they are perceived, no matter how secure they had been about their own sexual identity (Lev, 2005). Traditionally, if a partner had transgender issues, this was considered the end of their marriage. This may or may not have been a therapist-driven or culture-driven bias (Samons, 2009). Some couples find that their partner bond is still strong but their sexual attraction and ability to be physically intimate changes (Nealy, 2008). In many parts of the world, as well as among some US populations, coming out as TI to the family creates not just the possibility, but indeed the great likelihood, of social ostracization. Globally the response to coming out as TI varies widely. In some cultures a TI family member is welcomed as a blessing, in others coming out could mean a risk of severe punishment or even death. Current literature tends to focus on the US.

In a way, the family must come out as well. Lev suggests that the family will move through its own developmental process much like a life cycle transition. Family processing may be described in four stages. The first stage, discovery/disclosure, is the stage of marital tension. Often a partner experiences feelings of shock or betrayal akin to the discovery of an affair (Lev, 2005). The second stage is turmoil. Partners respond in a variety of ways. Some shut down in denial, some explode in anger. Conflict may manifest as financial problems, health issues, career problems, and parenting conflicts (Lev, 2005). The third stage is negotiation. The family begins to cope and process the situation. How a partner will handle their spouse having a sex change, what level of changes they can live with, and what boundaries will exist in the relationship going forward are negotiated. The last stage is balance/acceptance. The family is now ready to integrate the TI partner back into the family system (Lev, 2005).

This process is well articulated by Lev but it is still centered on the TI partner. The remaining partners and families also need help, support, and

recognition (Nealy, 2008, p. 297). There is no embedded structure in Lev's treatment model for tending the shattered relationship and the emotionally wounded partner. A re-examination of the injured partner's responses reveals that they reflect the trauma of an attachment injury: emotional shutdown, denial, feelings of betrayal, and emotional withdrawal (Johnson, 2004). It stands to reason that this injury must be processed for the couple to move forward.

In "Can This Marriage Be Saved?", Samons (2009) took a subtly TI-favored perspective. Samons is one of the few professionals who offers a format for couple treatment where one partner is TI. However, the article viewed problems from a TI M2F perspective, not from a supportive position for the remaining partner or family. The voicing was one of how to position the best options favoring the M2F, and seemed to be driving a therapist agenda of helping the remaining partner understand the why's and how's of coming out as TI and how transition is initiated. There was no voice given to processing the trauma, nor were treatment methods offered. Throughout the article Samons warns of issues that are common to any couple entering therapy as if they are specific to a couple with a TI partner, for example: "a wife may view the therapist as the enemy" (Samons, 2009, p. 155). In any couple therapy care must be taken to ensure that both parties feel heard and understood. Also with any couple therapy, individual sessions must be utilized with care lest one partner feel left out or ganged up on, or that secrets are being kept from them. Samons wisely calls out the importance of ground rules and specificity regarding how confidentiality will be handled for individual sessions, however these are points common to any couple therapy situation (Samons, 2009, pp. 152–3). Any couples therapy situation has the potential of containing one member who has mentally and emotionally "checked out" of the relationship and is delivering the remaining spouse to the therapist to tend through the dissolution of the relationship, yet Samons implies that this may be more likely among this population.

The article also implies that the therapist providing transition services for the TI M2F client could also provide the couple counseling (Samons, 2009). Subtle inferences of therapist bias exist when Samons asserts that the therapist can help them look at the "positive side" of transition as an opportunity for personal growth (Samons, 2009, p. 154). If the therapist has already built an alliance with the transitioning spouse, how truly unbiased the therapist can actually be in providing couple therapy comes into question. The therapist would also need to ensure that there are no counter-transference issues, particularly if the therapist is also TI, and watch carefully for internal biases toward an expectation that the injured partner will put their own needs aside and cooperate with the TI partner. When issues of transition are being processed with the TI partner, there

is a significant risk that the relationship trauma that has ensued will not be adequately addressed. The minimum concern expressed in the article concerning a “highly agitated” couple is to utilize “crisis management” techniques (Samons, 2009, p. 160). Once again, crisis management and the ability to de-escalate emotional reactivity are important skills for any couples therapist, however all that Samons says about this is “calming them down will be a necessary first step” (Samons, 2009, p. 153). This expresses a pro M2F TI bias in that the emotional needs of the injured spouse are not given opportunity for expression with full affect.

On a positive note, Samons includes processing how the TI client came out. Was it clean or was it sloppy? Was there communication? Or did the wife stumble upon femme accoutrements (e.g. clothing, feminine undergarments, makeup)? The author also stresses that standard couple therapy techniques should be used with supplemental specific interventions and psycho-education concerning the issues and concerns unique to TI people, but they are not theory or technique specific (Samons, 2009). Samons stated that assessment is key. The TI partner should be assessed for emotional stability and gender status. Where in the process are they? How does he view his TI identity? What are his hopes for the marriage? The wife should be assessed for emotional stability, and probative questions such as “how much does she love her husband” and “how committed is she to the marriage?” should be asked (Samons, 2009, p. 157).

Neither Samons nor any other authors have yet proposed any generalized operational parameters for treating a couple where one partner is TI.

Another M2F TI-specific view was presented in an article by TI therapist R. Raj (2006). Raj utilized a great deal of “trans centric” language, calling his model “Trans-Formative” and naming it the Trans-formative Therapy Model (TfTm). It is difficult enough for families to begin to cope with the *otherness* of this situation as it is; participating in a therapy model that appears to be named after and guided toward supporting the TI partner may cause the spouse and family to feel that their needs are being ignored (Malpas, 2006). This may become an additional source of resentment. Raj (2006) acknowledged that there was no material included in his proposed therapeutic model for the support for partners of TI people. Also, the case study used to exhibit the TfTm concerned a gender-divergent child; generalization to an adult relationship where each partner is suffering in different ways may be limited.

TfTm is worth looking at, however, because it is based on several modalities: the developmental stages proposed by Lev (2005) blended with the grief processing stages proposed by Kubler-Ross (Raj, 2006). Factors that family members encounter are discovery and disclosure, emotional flooding, loss and grief, current and future status of couple or family, shifting identi-

ties and roles, possible change of status in community and society, cultural and religious concerns, and the need for support (Raj, 2006). These factors are often experienced by the injured spouse simultaneously, shattering the assumptions that they have about their own identity, about the relationship, and about their own sexual orientation, and triggering responses that meet definitions of trauma. However, what would appear to be the self-evident connections with trauma are not drawn.

Raj brackets his model into discrete phases. The authors would suggest that the emotional flooding stage actually contains grief and mourning which in turn contains the processing stages put forth in Kubler-Ross' bereavement model: denial, anger, bargaining, depression, and acceptance. Also occurring at the same time are cascading thoughts of current and future status of the marriage relationship and family relationships, shifting identities and roles, cultural and religious concerns, and the need for support in spite of possible feelings of shame arising that drive the injured party to hide rather than seek help (Raj, 2006). Out of this overwhelming onslaught of affect can emerge self-defense behaviors in the form of traumatic flashback, avoidance, hyper vigilance, and numbing. These are the symptoms of Post Traumatic Stress Disorder (PTSD) (Johnson et al., 2001).

A significant limitation of Raj's model is that he perpetuates a false dichotomy of human sexuality. In his view, when a couple works through his model the spouse will realign their sexuality to lesbian. One is either gay or straight, Raj implies, and processing gender roles in a marriage/relationship where one member is TI requires the remaining partner to reassess and reassign their own sexual orientation alliances (Raj, 2006). This differs from the view of many that sexuality exists on a continuum (Kinsey, Pomeroy, and Martin, 1948); utilization of the continuum view in treatment would allow the partner a greater level of freedom and flexibility when processing changing gender roles in their relationship.

Another issue with TfTm is that interventions are not theory specific. They are generalized as lifecycle transition phases to be negotiated rather than specific wounds to be attended to and specific structures in need of rebuilding. There is no evaluation of emotional content and no provision for the injured spouse to process their needs and feelings. On this basis, TfTm is difficult to test for effectiveness.

The development and testing of specific treatment models for TI couples would represent a major advance in the support of a traditionally marginalized population. The sociopolitical climate in the field has historically impeded research on sexual minorities, but since the removal of homosexuality as a disorder within the Diagnostic and Statistical Manual-IV, this climate has been gradually changing (Spitalnick & McNair, 2005). This is an un-studied

population. It is not known what will and will not work in terms of treatment efficacy. Malpas has stressed the importance of systemic interventions with these couples because they can unify the couple and help make the relationship the central focus (Malpas, 2006). There is good reason to believe that the EFT approach and its focus on resolving attachment injuries would be appropriate for use with same-sex couples (Johnson & Whiffen, 2003), and particularly appropriate for use with TI couples because they have already been demonstrated to be effective for addressing other types of conflict.

PROPOSED TREATMENT OF TI COUPLES USING EMOTIONALLY FOCUSED THERAPY

EFT is rooted in attachment theory and in humanistic/experiential and systemic modalities (Johnson, 2004). It appears to be a much better fit, relative to cognitive or trans-focused treatment, to cover the areas of concern for TI couples and families.

Attachment theory suggests that humans have a natural tendency to create and maintain deep and powerful bonds to significant others. We are hard-wired for this type of connection. This is a reciprocal relationship that is based on “profound psychological and physiological interdependence” (Johnson et al., 2001, p. 145). If we accept core EFT concepts that secure adult attachment exists when the internal answer to the question “will you be there for me when I really need you” is a resounding, unhesitating “yes,” and that adult intimacy is a secure attachment bond created by sufficient accessibility, responsiveness, and emotional engagement, then we can see that relational conflict challenges the security of the attachment bond (Johnson, 2004). The authors suggest that the coming out experience of TI couples is a significant challenge to the security of the attachment bond. The unique role of the EFT therapist as a “process consultant” and as an admitted member of the relationship is crucial to the change process (Johnson, 2004). Malpas confirms this role as particularly relevant in the case of TI couples therapy (Malpas, 2006).

Attachment Injuries

Attachment injury is a specific type of event that involves the violation of trust or betrayal coupled with the inaccessibility of the partner. The partner is unresponsive or unavailable when the injured partner reaches out for support. This creates an impasse, experienced as abandonment, and affect escalates. If these events are unresolved then relationship repair is blocked (Johnson

et al., 2001). Attachment injuries often occur during times of transition, loss, physical danger, and uncertainty. Johnson asserts that attachment injuries are perceived as disproportionately severe and may seem to cause irreparable damage to the relationship. They behave much like PTSD injuries in that they re-emerge in the form of traumatic flashback, avoidance, hyper-vigilance, and numbing and are overwhelming (Johnson et al., 2001, p. 150).

These injuries cause the injured partner to question their core beliefs about relationships, the other, and themselves. Their sense of self-worth is shaken along with their sense of security in the world (Johnson et al., 2001).

TI couples seem particularly likely to benefit from application of the attachment injury resolution model presented in EFT because of the great likelihood that TI couples experience attachment injuries during the coming out process. The nature of the attachment injury is most certainly traumatic relationally, and partners' behaviors during the process can bear a symptomatic resemblance to PTSD (Johnson et al., 2001).

When a partner comes out as TI and requests transition the remaining partner's sense of self-worth is shaken along with their sense of security in the world (Lev, 2005). Their core beliefs about relationships, their partner, and themselves are challenged even down to their sexual identification and orientation. The significant difference between the type of attachment injury put forth by Johnson and the attachment injury experienced in a TI couple is that the injury in Johnson's view is usually a long-past event that ripples through to the present, triggered by the inaccessibility of the distant partner (Johnson et al., 2001). The attachment injury with TI couples is occurring in real time and is ongoing. This is the moment of the relationship trauma.

A state of paradox occurs when the party causing the attachment injury, in this case the TI partner, is both the source of and solution to pain and fear. This fundamentally shakes the attachment system (Johnson et al., 2001). The injured party tends to swing from one state of hyper arousal to another. Hyper arousal is a cardinal symptom of PTSD; it is defined as a physiological sense of impending danger, restlessness, and extreme fight, flight, and freeze responses. The injured party often accuses and clings, then numbs and withdraws (Johnson et al., 2001). The level of shock and disruption of attachment system that a spouse experiences when their partner comes out as TI clearly parallels the experience of any other couple experiencing the manifestation of an attachment injury.

Attachment injury and relationship trauma are analogous terms (Johnson herself defines EFT as a theory of trauma) from the standpoint that traumatic experience invokes a state of existential anxiety by shattering once held assumptions of security (Naaman et al., 2005). These events cause severe relationship distress, and create an impasse that blocks relationship healing in

couple therapy because one partner does not trust the security of the relationship and holds the other partner responsible (Johnson et al., 2001).

The shattering of these assumptions calls into question the significance of oneself to the other partner and challenges the injured party's view of their lovability and their partner's accessibility (Makinen & Johnson, 2006). Out of these existential crises can arise symptoms of PTSD. These symptoms are a natural self-defense mechanism; however, they prevent emotional engagement because the wounded partner keeps the other partner at a "safe" distance. This in turn creates a feedback loop that actually maintains relational distress (Naaman et al., 2005). Attachment injuries can be repaired using EFT and positive outcome is measurable on two domains: client self report survey and through analysis of coded session (Makinen & Johnson, 2006). When the attachment injury resolution model is utilized during EFT with couples in moderate distress, resolved and unresolved couples are clearly discriminated. Resolution indicators are consistent and reliable across the domains of affiliation, dyadic satisfaction, level of experiencing, and forgiveness (Johnson et al., 2001).

Naaman, Pappas, Makinen, Zuccarini, and Johnson-Douglas (2005) supported the notion that Johnson's attachment injury resolution model is efficacious in treating heterosexual couples with traumatic relationship injury. The authors suggest that the model can also be specifically applied to repair relationship injury brought about by the coming out of a partner as TI.

Adaptation of the Attachment Resolution Model

The level of attachment injury and relational turmoil caused by the revelation that one partner is TI is similar in some ways to coming out as lesbian or gay; however, gay and lesbian people often remain closeted for the sake of their families (Lev, 2005). This type of injury also can be similar to an affair in terms of the level of betrayal experienced by the partner; the relationship will be changing permanently with or without the consent of the injured partner and there may or may not be a recommitment to the marriage (Johnson et al., 2001). Unlike the instance of recovery from an affair, TI couples simply cannot expect a return to earlier ways of functioning in the relationship. Regardless of the marital outcome, partners often need to engage in a mourning process for the relationship as they had previously lived it, in order to move on to whatever the next stage of the relationship will be.

Recovery from trauma in general includes constructing an integrative narrative of the event, its meaning, and 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 of

purposefulness, connection, and belonging (Johnson et al., 2001). Creating a safe haven and a secure base is the basic condition for healing (Johnson et al., 2001). In this case the job of the therapist is to create a safe haven and secure base when a couple has experienced a traumatic attachment injury in the form of one partner coming out as TI and requesting transition. The authors readily acknowledge that as the attachment injury resolution process unfolds, it is possible to reveal additional injuries either in the TI or the non-TI partner. When this occurs, the attachment injury model could be utilized to process the additional injuries one at a time.

Examining the stages of resolution of attachment injury resolution as they may be applied to couples where one partner is TI, we would expect to see the following:

Attachment Injury Marker

1. A live attachment injury incident exists, the injured partner risks connecting with the TI partner—assuming partner accessibility (Johnson et al., 2001). This phase may be the most difficult with TI couples where the coming-out process was abrupt, as trust may have been severely damaged.
2. The injured partner stays in touch with the injury, and is allowed to express them without blaming. Anger evolves to hurt, shame, helplessness, disappointment. This is a point of high affect. The challenge of the therapist is to stick with it, not diffuse it or emotionally rescue either party (Johnson et al., 2001).

Differentiation of Affect

3. The partner begins to hear and understand the significance of the event in terms of his/her importance to the injured partner, rather than as a reflection of his/her personal inadequacies, insensitivities, and/or selfishness (Johnson et al., 2001). This will be difficult because inherent in TI processing is a profound self-centeredness. If the TI partner can acknowledge (take ownership) of the pain being caused, it is hypothesized that relationship healing may occur.
4. The injured partner moves into a more integrated and complete articulation of the injury, expressing grief at the loss, fear concerning life, and the loss of the attachment bond (Johnson et al., 2001). The injured partner expresses their vulnerability and allows the TI partner to see it (Johnson et al., 2001).

Re-engagement

5. The injured partner becomes more engaged emotionally and owns their part in the creation of the injury, expresses regret, empathy, and/or remorse (Johnson et al., 2001). In the case of the couple in question, this stage may involve regret for expression of hatred toward the TI partner, or possibly attempting to cause children or other family members to reject the TI partner.
6. The injured partner reaches out to the TI partner and asks for comfort and caring from the partner (Johnson et al., 2001). This may be a point at which affect resolves. It may not be possible for the injured partner to reach out for comfort, but they may be able to connect with feelings of friendship and comfort on a different relational level (Johnson et al., 2001).

Forgiveness and Reconciliation

7. The TI partner responds in a caring manner that acts as an antidote to the traumatic experience (Johnson et al., 2001). They construct a new narrative of the event together, with clear and acceptable communication of how each of them came to respond the way they did during the attachment injury event. The author of this paper would hypothesize that stage 7 represents a new construct of the relationship.
8. Therapist then seeks to foster trust and the growth of positive cycles of bonding and connection. This process defines relationship as safe haven (Johnson et al., 2001).

Defining Effectiveness

Traditionally, success in couples therapy has not necessarily meant saving the relationship (Malpas, 2006). Because TI couples exist under very unique circumstances, any research on effective treatments needs to exercise caution in how it defines what effectiveness looks like. Success must be determined by the *healing and restoration of the interpersonal relationship between the partners*, and not necessarily on the healing and restoration of the marriage/commitment. In spite of social pressures and cultural assumptions to the contrary, perhaps they will be able to approach the question of whether dissolving the marriage is even necessary, and if it *is* necessary, to perhaps negotiate it smoothly without animosity and bitterness. If they choose to stay together, they may be motivated to enjoy the journey and see what kind of new rules they might put in place to build a relationship of an entirely new type, one

that works for *them*. It is possible that the couple may be motivated to create a new relationship type altogether.

CASE EXAMPLE

Because there are no existing case studies for this premise, the authors offer a hypothetical example of how a study could work and what the results could be. This example includes elements from the authors' direct clinical work and personal experience with TI couples and with the partners of TI individuals. This example highlights the effect of the attachment injury resolution model contained in Emotionally Focused Therapy (EFT) on a severely distressed, committed relationship pair where one partner is Trans Identified (TI) and in transition (taking active steps toward sexual/gender reassignment). As discussed above, the therapist defined success in this example by *relationship* repair, not marriage or commitment repair. Treatment would typically consist of 12-20 sessions of EFT with emphasis on the resolution of attachment injury.

Although a heterosexual married couple was chosen for the case example, the authors feel that a truly comprehensive study must also include a couple where one partner is TI F2M. Sexual orientation would have no bearing on the application of the attachment injury resolution model.

John(Sara) and Cathy have been together for 15 years. They have two children: Jeremy, aged 14, and Krysta, aged 10. John came out as TI M2F two months ago. She has started hormone therapy, has asked to have feminine pronouns used, and has chosen the name "Sara." John(Sara) is a computer programmer and Cathy is a manager at a large retail store. When John came out Cathy was shocked. She had no idea that John was TI. There has been high conflict in the relationship ever since and the children are being affected.

During the early stages of the attachment injury resolution process, incidents where trust may have been broken were explored. In this transcript section we can see the first three steps of the resolution process. When the therapist asked our couple about how John(Sara) came out Cathy became very emotionally reactive. The therapist holds the affect and Cathy is allowed to express her feelings without blame. She becomes very quiet and begins to cry. John(Sara) is then integrated in such a way that (s)he can come to understand the significance of the attachment injury event in terms of its effect on Cathy.

CATHY: I hurt so much. I feel like I've lost my husband—like he's dead, ripped away from me. Then I open my eyes and "she" is in front of me. I feel so betrayed, like how long has this been going on and am I last to find out? I've lost my husband to another woman and the other woman is him!

Then I feel so guilty because I love her so much. I feel angry, then my heart aches then I feel numb like I'm in a fog.

THERAPIST: It is as though your husband has died. He is gone and there is a stranger to take his place. So many emotions colliding all at once all the time. It must be exhausting! John(Sara), have you seen this? What is it like for you to hear this from Cathy?

JOHN(SARA): I know this is going on. I keep telling her that this is like mourning and she has to mourn the passing of my "other." I give her things to read that I think would help her but she is not interested in reading about transition.

CATHY: I get so angry at her and at me. I'm not interested in her books and articles. I want her to listen to what I am feeling! My husband used to listen to what I was feeling. When I relax I almost forget this is happening. When I smell his after-shave, when I see his worn out pajamas and slippers . . . Then I catch myself and have to jerk myself back into reality. And it hurts and I get angry because my heart aches and I didn't want this and I didn't ask for this and there is no one for me anymore. [Sobs]

THERAPIST: Your heart aches so much and I hear such loneliness, even though she is still here, you feel so alone. It sounds as if you feel that you have to be alert all the time, because if you let your guard down that hurt . . . that looking for him and again realizing he's gone, is more devastating than staying here and looking at your partner as a woman.

CATHY: Exactly. When I talk to her about it she doesn't want to hear it. She gets angry because I'm not happy for her. It's like she doesn't care how I feel. We've been together for 15 years and here I am by myself. That's when I know I have to deal with this on my own.

THERAPIST: When you reached out for him, he was not there for you. What did you need right then?

CATHY: I needed HIM back to hear me and understand and hold me and take care of me.

THERAPIST: You reached out for him and not only was he not there, but you find "her" there in his place. And you have to deal with this huge thing all on your own because he is gone.

CATHY: Yes, then I fall apart all over again and the whole thing starts over. [Sobbing]

THERAPIST: John(Sara), what is it like for you to hear this right now?

JOHN(SARA): I know that this has been hard for Cathy, but I had no idea about all of these conflicting feelings and thoughts. I am so excited about actualizing the woman I am that I don't want to be reminded of the masquerade self I was before. Having to go back and relate as that man is difficult for me and I don't want to do it. I want that man to be dead and gone. I feel that she

should understand that this is who I always was. I never stopped to realize that the person I want to be gone is Cathy's husband. When I think about it that way my heart aches. I had no idea it was like this for her.

At the end of this transcript we can see that we have the potential for resolution because John(Sara) is able to take some ownership of the pain that the injury has caused.

In the stages that followed the couple was able to articulate the attachment injury in terms the loss of the attachment bond. They were able to feel safe enough over time to express their vulnerability to each other. Outcome measurement scores indicated that the therapeutic alliance was sound and that the attachment injury had been resolved. As such the case example is considered successful.

The physical results from the study differed for the couple in terms of outcome. The pre-existing partner bond was not strong enough for the couple to stay together and successfully adjust to the new relational dynamics and redefined identities of each partner. They couple did not stay together due in part to impasses generated by changes in sexual attraction and expression of intimacy, however they were able to dissolve the marriage without animosity or bitterness and the children in this family were able to continue loving and nurturing relationships with both parents in full partnership with each other. This outcome had no bearing on the success of the study.

Potential Complications

There are several potential complications with this treatment. First, this is a *live* attachment injury similar in severity to the revelation of an affair. However, at some point when working with affair couples, it is typically mandated that the affair be stopped immediately and all connection with the affair partner be severed, assuming that both partners are committed to continuing the relationship (Coop Gordon, Baucom, Snyder, & Dixon, 2008). This mandate is not possible with TI people who are in the process of transition. It is not possible for a TI person to immediately cease being TI and stop *becoming* in spite of the desire of the non-TI spouse that they do exactly this. Any resolution of attachment injury must take place in real time while the attachment injury is ongoing and the gender presentation of the TI partner is evolving. In a real sense the non-TI partner may feel the attachment injury in the form of loss, grieving the loss of the original partner every time they look at the TI partner. Conflict in the non-TI partner can also arise when they experience a strong supportive desire that the TI partner be made whole and at the same time experience the deep grief associated with the death of a partner.

Dealing with the attachment injury may be difficult because when a partner decides to come out, they often have waited for years to be out, and may approach the therapy process eager for rapid change. They do not want to be reminded of how much it hurts someone else because they may have often been suffering for years in a gender role that did not fit. Future research might be fruitful concerning the pre-identification of a TI individual and the correlation with PTSD symptoms. There is also room for investigating the experience of a TI F2M individual who identified as lesbian when they were female but who loses their community connection as they transition to a gender that has no place in that world and is not welcome.

Some TI couples may have been same-sex couples *before* the TI partner came out. While we would emphasize that there is support for the notion that EFT is likely to be highly effective with same-sex couples, it is worth investigating whether treatment has different impacts when the couple would *no longer* be a same-sex couple *after* the transition of the TI partner as opposed to being a same-sex couple *before* transition.

Finally, some or all assessment inventories commonly given in couples therapy may need to have content modified to be more appropriate to TI couples and live attachment injuries where the cessation of the activity causing the attachment injury (i.e., the transition) is not an option.

Ultimately, we believe these limitations can be addressed, and that the need for some treatment—any treatment—specifically adapted for use with this population outweighs these concerns. In order to most effectively serve the TI population, systemic therapists must be able to successfully treat not only the TI individual, but the relational impacts of that process as well.

REFERENCES

- Bigner, J. J., & Gottlieb, A. R. (2006). *Interventions with families of gay, lesbian, bisexual, and transgender people from the inside out*. New York: Harrington Park Press.
- Coop Gordon, K., Baucom, D. H., Snyder, D. K., & Dixon, L. J. (2008). Couple therapy and the treatment of affairs. In A.S. Gurman (Ed.), *Clinical handbook for couple therapy* (4th ed., pp. 429–458). New York: Guilford.
- Fraser, L. (2009). Depth psychotherapy with transgender people. *Sexual and relationship therapy*, 24(2), 126–142.
- Johnson, S. A. (2004). *Creating connection: The practice of emotionally focused couple therapy*. New York: Routledge.
- Johnson, S. A., Makinen, J. A., & Millikin, J. W. (2001). Attachment injuries in couple relationships: A new perspective on impasses in couples therapy. *Journal of Marital and Family Therapy*, 27(2), 145–155.
- Johnson, S. M., & Whiffen, V. E., (Eds.) (2003). *Attachment processes in couple and family therapy*. New York: Guilford Press.

- Kenagy, G. P., & Hsieh, C.-H. (2005). Gender differences in social service needs of transgender people. *Journal of Social Service Research*, 31(3), 1–21.
- Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948). *Sexual behavior in the human male*. Philadelphia, PA: W. B. Saunders Co.
- Lev, A. I. (2005). Transgender emergence: A family affair. *Division 44 Newsletter*, 21(3), 11–12.
- Makinen, J. A., & Johnson, S. M. (2006). Resolving attachment injuries in couples using Emotionally Focussed Therapy: Steps toward forgiveness and reconciliation. *Journal of Consulting and Clinical Psychology*, 74(6), 1055–1064.
- Malpas, J. (2006). From otherness to alliance. *Journal of GLBT Family Studies*, 2, 183–206.
- Naaman, S., Pappas, J. D., Makinen, J., Zuccarini, D., & Johnson-Douglas, S. (2005). Treating attachment injured couples with emotionally focused therapy: A case study approach. *Psychiatry*, 68(1), 55–77.
- Nealy, E. C. (2008). Working with LGBT families. In M. McGoldrick & K.V. Hardy (Eds.), *Re-visioning family therapy: Race, culture and gender in clinical practice* (4th ed., pp. 289–299). New York: Guilford.
- Raj, R. (2006). Transforming couples and families: A trans-formative therapeutic model for working with the loved-ones of gender divergent youth and Trans-Identified adults. *Journal of GLBT Family Studies*, 4(2), 133–163.
- Samons, S. L. (2009). Can this marriage be saved? Addressing male-to-female transgender issues in couples therapy. *Sexual and Relationship Therapy*, 24(2), 152–162.
- Spitalnick, J. S., & McNair, L. D. (2005). Couples therapy with gay and lesbian clients: An analysis of important clinical issues. *Journal of Sex & Marital Therapy*, 31, 43–56.
- Stepleman, L. (2005). Review of transgender emergence: Therapeutic guidelines for working with gender-variant people and their families. *Journal of Sex & Marital Therapy*, 31(2), 169–171.