

Case Study

Treating Attachment Injured Couples With Emotionally Focused Therapy: A Case Study Approach

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This paper compared the attachment injury resolution process in two distressed couples undergoing ten sessions of Emotional Focused Therapy (EFT), a short-term empirically validated treatment for relational distress. An attachment injury is a newly coined clinical construct that denotes a specific type of betrayal within the couple's relationship. The incident is so potent that it calls into question assumptions about the safety of the relationship. The task analytic method was used to examine the pathways of change as related to attachment injury of each couple. Several outcome and process measures were employed in order to differentiate the therapeutic process between the resolved versus non-resolved couple. Results indicated that the couple who resolved their identified attachment injury at the outset of therapy adhered to the attachment injury resolution model, while the non-resolved couple showed marked deviations from the expected pathways of change. Findings suggest that the resolved couple tended to show more differentiation of interactional positions and greater levels of experiencing throughout the therapeutic process in relation to the non-resolved couple. It is recommended that further research is necessary to examine the clinical utility of the attachment injury resolution model in the context of a larger number of case studies.

INTRODUCTION

Many couples enter therapy in order to restore levels of trust and satisfaction in their relationships, specifically issues regarding emotional-relational connections with their significant other. One short-term treatment modality, developed by Johnson and

Greenberg (1985), which helps couples work through their emotional-relational distress, is Emotionally Focused Therapy (EFT). This therapeutic intervention is grounded in John Bowlby's (1969) theory of attachment, which contends that individuals have a tendency to forge and maintain strong affectional bonds to particular persons (e.g., emotional attach-

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ment between child and the primary caregiver, such as the mother). Moreover, the quality of these early bonds is regarded to play a pivotal role in the overall well-being of the individual, since infant-caregiver relationships provide the bases by which the child forms healthy or non-healthy (e.g., lovable, trustworthy, avoidant, and anxious) interpersonal relationships with others later on in life.

Consequently, antecedent emotional-relational connections develop into attachment needs (e.g., security, trust, support, and safety) that contribute to the development of the self-concept or self-image which, formed during childhood, have long-term implications in the quality of adulthood relationships. For example, if a child receives love, acceptance, and trust growing up, according to Bowlby (1973), the child will develop what is called a secure attachment and, as such, will expect this emotional-relational connection from others as a basis of survival or a manner by which to explore and understand the world. Accordingly, EFT builds on Bowlby's theory that conceptualizes adult love as an attachment bond with an irreplaceable other—the primary caregiver is irreplaceable and is the one who fostered an emotional connection or attachment pattern that is difficult to be replaced by another, namely, the current partner (Johnson, 1996).

It is the purpose of this paper to explore these notions based on two clinical case studies of couples that have sustained an attachment injury. The concept of an attachment injury was recently coined from clinical observation (Johnson, Makinen, & Millikin, 2001) and 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 a clinically significant phenomenon in that it results in a tear in the fabric of, or disconnection in, the attachment bond creating negative interactional cycles that perpetuate relational distress.

Furthermore, this study investigates how an attachment-injured couple resolves their injury based on specific in-session information about how change happens. The prac-

tical utility of this approach can be used to strengthen both theory and clinical applications, since models are ameliorated based on their therapeutic findings. To understand the concept of an attachment injury, an overview of attachment theory is presented, specifically as it applies to adult love and the repair of distressed adult relationships. In addition, attachment injury resolution is conceptualized and discussed in terms of Bowlby's attachment model as per the two case studies. This paper closes with a discussion of the salient findings germane to each case study.

REVIEW OF THE LITERATURE

Adult Love

Until recently, the field of marital theory has suffered from a lack of clear theoretical models explicating the nature of adult love. Clinically, this translated into a lack of a clear sense of direction as to where a couple should be heading in their therapeutic journey (Roberts, 1992; Segraves, 1990). This is to say that the specific changes necessary for distress recovery were simply unclear, opaque, and the factors accounting for resilience in relationships were unknown. In response to this theoretical lacuna, attachment theory, as outlined by Bowlby (1969; 1988), has gained widespread popularity in providing a rich theoretical framework for conceptualizing adult intimacy. Attachment theory, in fact, is considered to be the most cogent theoretical model for understanding adult relationships (Hazan & Shaver, 1987; Johnson, 1996).

Accordingly, the attachment model of adult intimacy views love as a bond, which is a tripartite mechanism consisting of behavioral, cognitive, and emotional elements that interact in synchrony to optimize survival. As with a parent-child relationship, the behavioral component of the adult bond involves a set of actions designed to create and manage proximity to the attachment figure. Since proximity to an attachment figure must by definition involve a reference to the self, the cognitive component of the adult bond comprises that

element. More specifically, every individual has a *working model* of both self and other that contains information about one's lovability and the other's accessibility. Together these two information-containing units or *schemes* determine one's attachment style. The term *working model* was initially used by Bowlby (1973; 1980) to describe the internal representations that individuals develop of the world and of significant people within it, including the self.

As with a parent-child relationship, the most basic elements of an adult-adult love relationship are those of emotional accessibility and responsiveness. On the one hand, when attachment security is threatened—that is, when an individual perceives her attachment figure to be inaccessible or unresponsive—a set of attachment behaviors are then activated towards the goal of re-instilling the attachment bond. On the other hand, if these attachment behaviors fail to evoke the desired response from the attachment figure, a predictable sequence of responses ensues, such as angry protest, clinging, despair, and finally detachment (Bowlby, 1969). Adult bond disruption is followed by a similar set of predictable responses, namely, protest, despair, and detachment (Sperling & Berman, 1994). Differences between child-parent attachment bonds and those of adult-adult attachment bonds have been outlined by Weiss (1982), who maintains that adult attachment is between peers whereas child-parent attachment is between caregiver and care-seeker, thus hierarchical in nature. It should be noted that adult attachment relationships are not as susceptible to being overwhelmed by other behavioral systems, given that adults possess coping mechanisms to deal with stressful situations. Lastly, adult attachment relationships typically include a sexual component.

In view of these notions, an attachment style can be conceptualized as one's behavioral response to both perceived and actual distress, in addition to the separation from and re-union to an attachment figure (Sperling & Berman, 1994). Based on the extant literature of adult attachment, four styles have been identified, which include secure,

preoccupied, dismissive, and fearful avoidant (Bartholomew & Horowitz, 1991). According to Hazan and Shaver (1987), these styles may also be viewed as information-processing mechanisms that filter information from the environment to answer two basic questions: 1) "Am I worthy of love and care?" and 2) "Can I count on others in times of distress/need?" There is a finite number of answer combinations to these two basic questions, thus giving rise to four attachment styles. Attachment styles are long-standing patterns of expectations or strategies that have developed as a result of past relationships (Hazan & Shaver, 1987; Kobak & Hazan, 1991; Simpson & Rholes, 1998; Sperling & Berman, 1994; Weiss & Sheldon-Keller, 1994).

The working models that form the basis of these attachment styles, however, are not immune to change; rather, exposure to new relationship experiences do have the power to alter an attachment style. This fluidity is for obvious survival reasons in that they are more than just serving as expectations for relationships. For example, Bretherton (1990) contends that attachment styles are ways of processing attachment information. A securely attached individual generally holds a positive view of both her- or himself such that the self is regarded to be worthy of love and others, which are viewed as reliable and can be counted on in times of distress or need (Bartholomew & Horowitz, 1991). In the event of threat to the attachment bond, securely attached individuals respond with resourceful flexibility (Johnson & Greenberg, 1994), which indicates a healthy level of resilience.

Conversely, individuals whose experiences are characterized by a predominant sense of unworthiness, juxtaposed against a positive view of others, are referred to as having a preoccupied attachment style (Bartholomew & Horowitz, 1991). Those individuals, believing they are somehow deficient, will tend to cling to their partners, continuously demanding reassurance. Interestingly, dismissive individuals hold a positive view of their sense of self, but a negative view of others (Bartholomew &

Horowitz, 1991; Main & Goldwyn, 1985). The consequence of this combination is that individuals who strive to protect the self against potential disappointment tend to avoid close relationships altogether, which, subsequently, creates an illusion of invulnerability (Henry & Benjamin, 1996). Lastly, fearful avoidant individuals are those who have both a negative view of their sense of self and others. In anticipation of rejection or betrayal, these types of individuals, like the dismissive type, will not risk involvement with others (Bartholomew & Horowitz, 1991).

Hitherto, securely attached individuals have been shown to experience better adjustment and higher levels of satisfaction in their adult relationships (Collins & Reed, 1990). Being able to experience higher levels of intimacy and trust, securely attached individuals are also less prone to hypervigilance, jealousy, and fear of abandonment (Hazan & Shaver, 1987). The remaining three attachment styles can be considered variations of a general category of insecure attachment. According to Simpson, Rholes, and Nelligan (1992), insecurely attached individuals have been shown to exhibit a predictable set of emotional and behavioral responses that render relationship repair in the context of marital therapy rather difficult.

Based on this review of the extant literature, attachment theory provides one of the most conducive frameworks for clinically understanding adult love relationships. Moreover, this perspective focuses the therapist's attention on attachment needs, fears, and longings, since it emphasizes on the adaptive needs for contact and proximity to an attachment figure. Furthermore, it explains the significance of loss of connection and trust in a relationship. Additionally, attachment theory has contributed to further understanding the significance of impasses in therapy—and recently, the application of Bowlby's theory to the concept of an attachment injury and the process of change in couples therapy.

Emotionally Focused Therapy (EFT)

According to Johnson (1996) and Greenberg and Johnson (1988), EFT is con-

sidered to be an effective short-term approach to modifying distressed couples constricted interaction patterns and emotional responses. Drawing on attachment theory for understanding adult love, EFT addresses the role of affect in intimate relationships and in modifying those relationships. Dialectically, this therapeutic approach is a synthesis of experiential and systemic approaches to psychotherapy. In support of its therapeutic efficacy, research by Gottman (1994) has found that marital distress is a result of partners being stuck in certain absorbing states of negative emotion that give rise to rigid interactional cycles, which in turn leads to maintaining aversive emotional states. Consistently, research by Johnson (1996) suggests that distressed couples are readily identifiable both by their rigidly structured interactional patterns and their intense negative affect.

Understandings of this nature indicate that the essence of EFT is geared towards helping distressed couples reprocess their emotional responses and, in doing so, adopt productive and healthier interactional positions. This is achieved by allowing couples to elicit and expand—work through—their core emotional experiences that give rise to their interactional positions and then to effectuate a shift in these interactional positions. germane to this process is that emotional responses and interactional positions are reciprocally determined—that is, they are both equally addressed in therapy (Johnson, 1996). Consequently, the salient goal of the therapeutic process is to foster a secure emotional bond between partners, which has been shown to be powerfully associated with physical and psychoemotional well-being, with resilience in the face of stress and trauma, and with optimal personality development (Burman and Margolin, 1992).

Furthermore, research by Baucom, Shoham, Mueser, Daiuto, and Stickle (1998) and Johnson, Hunsley, Greenberg, and Schindler (1999) provide empirical support to maintain the validity of EFT in successfully treating distressed relationships. This has been found, for example, in terms of treatment effect size of 1.3 (Johnson et al., 1999),

rate of recovery (70–75% of couples recovered from distress), and evidence of long-term effectiveness after relatively short-term treatment (Gordon-Walker et al. 1996; Walker & Manion, 1998) as well as success in creating and maintaining secure bonds and helping couples whose relational distress is further exacerbated by additional problems, such as depression, post-traumatic stress disorder (PTSD), and chronic physical illness (Johnson & Williams-Keeler, 1998).

Change Events in EFT

Embedded in the couples therapeutic journey are three discernible process shifts, which include *cycle de-escalation*, *withdrawer re-engagement*, and *blamer softening*. Cycle de-escalation constitutes a first-order change where the couple's interactional cycle remains essentially unmodified, except for the intensity of the struggle. The second significant change process that occurs during couples therapy is that of *withdrawer re-engagement* where the withdrawn partner is not just willing to risk occasional engagement with the pursuing partner, but is becoming rather active and engaged in the relationship. Perceptions of contact, accessibility, and responsiveness are redefined within the context of the relationship. As a result, interactional positions shift, which invites the couple to engage in a different kind of therapeutic dance.

Furthermore, the therapist, by validating the withdrawn partner's sense of helplessness, primes withdrawal and facilitates expression of specific needs and wants. Consequently, the pursuing partner experiences the other differently and this in turn promotes a new interactional position where the pursuing critical partner becomes less critical. At this point, the therapist guides this partner through a *softening*, which is a critical change event in EFT and is considered to be highly predictive of change (Johnson & Greenberg, 1988). Johnson and Greenberg (1995) described the softening process as "a watershed for the relationship and a powerful attachment event that initiates a new sense safety,

trust and contact in the relationship" (p. 139). This softening process represents a shift in the direction of increased accessibility and responsiveness such that, essentially, both partners become able to respond to the other in an accepting manner in the context of a high level of experiencing. According to Greenberg and Johnson (1988), softening is the most critical and difficult task to accomplish within EFT, especially for a novice therapist.

Based on clinical observations of distressed couples during EFT, Johnson, Makinen, & Millikin (2001) provide the following sequence of events to indicate what may transpire during such a therapeutic process. Once a couple has de-escalated, and the more withdrawn the partner became relative to her or his accessibility, any attempts by the therapist at inviting the pursuing partner to risk confiding or self-disclosing has the tendency to be met with an explosion of an emotionally laden event by the latter. Regardless of whether or not this event is mentioned at the start of therapy, its re-emergence at this stage has a significantly different quality in that it is described in life and death terms and, more often than not, in the language of trauma. Moreover, talking about the incident tends to evoke compelling, constricted emotional responses, and rigid interaction patterns, such as attacking or stonewalling. Failure on the therapist's part to find ways around this clinical impasse or any attempts at moving the couple into the re-engagement phase tends to be futile.

Attachment Injury

An attachment injury or *attachment crime* was not formally defined as a theoretical concept nor integrated in the attachment framework until recently (Johnson, Makinen, & Millikin, 2001). Conceptually, attachment injury arose from the clinical observations of those couples whose initial level of distress ameliorated, but no actual recovery was made (Greenberg & Johnson, 1988; Johnson, 1996). Notwithstanding, Johnson (1996) proposed that the distress experienced by some couples can often be traced back to a

specific critical event that occurred in the relationship. For example, during that particular incident, a partner will typically experience a strong sense of betrayal either due to the inaccessibility or unresponsiveness of the other partner. As such, an attachment injury can be linked to an action of betrayal during a moment of exigency in a couple's relationship.

Most importantly, attachment injuries are to be differentiated from the general levels of trust inherent in a relationship. The concept is particularly concerned with a specific incident during which one partner's attachment needs were especially salient and the other partner's were perceived to be either inaccessible or unresponsive. The injurious incident is significant as it becomes used as the standard against the dependability by which the other partner is gauged. Clinically, couples that have sustained an attachment injury will often present it as the recurring theme of the relationship. Such incidents, in addition to calling into question the security of the attachment bond between two intimates, have the potential of unravelling the emotional tie between them and, if not addressed, will often become chronically recurrent impasses, which prevent resolution of significant hurts and betrayals.

Identifying an attachment injury is critical to its working-through and integration into the relationship. Some couples may be particularly insightful into specific incidents that have marked the deterioration of levels of trust and intimacy in their relationship while others may not be particularly aware of how such events may be blocking accessibility and responsiveness. More importantly, the degree to which an event is judged to constitute an attachment injury depends solely on the perceptions of the injured partner rather than on some external criterion. Even subtle incidents, such as being left out of a family photo may be experienced as an attachment injury. In the latter example, a wife had just recently immigrated with her husband and was inadvertently left out of a picture taken with his family. In times of transition (e.g., immigration, retirement, childbirth, miscarriage, or loss), attachment needs tend to be particularly salient. If the other partner is not perceived to be

providing the needed care and support, feelings of abandonment ensue. Moreover, if these feelings cannot be discussed and dealt with in the relationship, they remain to undermine the trust and security of the relationship and may lead to abandonment or betrayal in times of change when attachment needs are heightened (e.g., childbirth, cancer diagnosis, and miscarriage) as well as to classical infidelity (Johnson & Whiffen, 1999).

An attachment injury has also been likened to, and described as, a relationship trauma (Johnson, Makinen, & Millikin, 2001). In fact Johnson (1996; Johnson et al., 2001) contends that injury to the attachment bond due to unresponsiveness in critical moments may be equated to trauma with a small *t*. This analogy between attachment injury and relationship trauma seems to be especially apt, as a traumatic experience induces a basic sense of existential anxiety by shattering once-held assumptions. For example, one of the most basic assumptions of any relationship is the expectation that a partner will be both accessible and responsive during times of need. When an exigency is imminent, attachment needs become prominent, which induce real or perceived threat, danger, loss, or uncertainty (Bowlby, 1969). If a partner fails to respond with the expected reassurance and comfort, the entire relationship becomes defined as unsafe. This violation calls into question the significance of oneself to the other partner. As previously mentioned, clients will often describe these incidents in an intensely emotional manner, and self-worth is often called into question. One client, in particular, stated, "I was just not all that important to him, I wasn't precious. My future didn't matter."

In addition to these existential concerns, an injured partner may experience symptoms consistent with PTSD, namely re-experiencing hypervigilance and avoidance. While these symptoms arise as a natural and protective self-defense mechanism, they prevent emotional engagement, which inadvertently leads to maintaining relational distress. Similar to an attachment injury, there is an integration of the traumatic event during

treatment (see van der Kolk & McFarlane, 1996), which acts like a regulation mechanism to help cope and work through painful emotional experiences. Most importantly, the therapeutic relationship fosters the development of secure bonds or ties that provide positive emotional experiences of belonging and positive self-worth. In view of these claims, a relationship that offers a safe haven and secure base is regarded to be the most basic condition of healing (Johnson, Makinen, & Millikin, 2001).

METHOD

Participants

Two couples were randomly selected from a pool of research couples who were originally recruited to participate in a larger study relating the process of therapy to outcome. Both couples were identified at the outset of therapy as having endured an attachment injury, a recently coined clinical concept referring to a particular incident of betrayal in the couple relationship. Both couples were initially screened using a standardized telephone screening procedure. The following inclusion criteria were included as part of the screening procedure: must be living together and not in the process of seeking separation/divorce; absence of any drug/alcohol abuse; have not been recipient of any psychiatric treatment since the last year; not receiving other psychological treatment during time of therapy; no ongoing marital physical abuse; no history of physical abuse; and lastly, must identify a specific incident of betrayal (attachment injury) during the intake session. Both couples were informed and gave written consent to the audiotaping of all therapy sessions.

Couple One. Michel (32 years of age) and Maya (24 years of age) have been living together as a couple for one year, and neither has been married. They have never entered any form of marital counselling prior to this study. Michel works as a consultant for a high-tech company and Maya is a supervisor; both have completed two years of post-sec-

ondary education and their gross family income is \$73,000.

Couple Two. Sam (37 years of age) and Kate (36 years of age) have been married for fifteen years and have two children; neither was married before. They have never entered any form of marital counselling prior to this research study. Sam works as a tennis coach and Kate works as a teller on a part-time basis. Sam has attained his high school diploma, while Kate has completed three years of post-secondary education; their gross family income is \$45,000.

INSTRUMENTATION

Process Measures

Based on antecedent research (e.g., Greenberg & Foerster, 1996; Johnson & Greenberg, 1988), the following process measures were selected for their ability to capture client processes.

The Structural Analysis of Social Behavior (SASB; Benjamin, 1974). The SASB 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 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 has an intrapsychic focus. For the purposes of this study, the second grid was used in order to measure the changing quality of interaction between the couple. This grid is composed of four quadrants where the speaker's utterance is coded as lying on one of the quadrants (e.g., affiliative, distant, hostile, or friendly). The SASB, in addition to having been subjected to validation studies, has also demonstrated high inter-rater reliability (kappas ranging from 0.61 to 0.79)

The Experiencing Scale (ES; Klein, Mathieu, Kiesler, & Gendlin, 1969). The ES 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 ther-

apy. Moving up the scale, there is a gradual progression from superficial, interpersonal self-references to simple, limited, or externalized self-references, to syntheses of newly emerged feelings and new awareness that leads to problem solving and better self-understanding. Validity of the Experiencing Scale has been demonstrated by correlating with patient variables such as introspectiveness and cognitive complexity (Klein et al., 1969). The ES also been shown to predict change in client-centered approaches of therapy (Orlinsky & Howard, 1986). Reliability of the scale, captured as kappa coefficients, ranges from 0.80 to 0.84.

Outcome Measures

The following self-report instruments where selected on the basis of their theoretical relevance to EFT, their ability to detect qualitative changes in couples with an attachment injury, and their ability to predict outcome in distressed couples based on research by Johnson and Talitman (1997) and Millikin (2000).

The Dyadic Adjustment Scale (DAS; Spanier, 1976). The DAS 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 scaled score has a theoretical range of 0 to 151. High scores are indicative of less distress and better adjustment. Established norms indicate mean total scale scores of 114.8 for 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 will be considered distressed. The average of the individual couple's scores yields the couple's mean total score. To be included in this study, each couple's mean total scale score must be less than

97 but not less than 85. The DAS was used in this study in order to select mild to moderately distressed couples, and to ensure that resolving attachment injuries in these couples actually makes a difference in their relationship.

Relationship Trust Scale (RTS; Holmes, Boon, & Adams, 1990). The RTS 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 theoretical range of scores is 30 to 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. This scale was used to gauge initial levels of trust at therapy initiation and to examine any change by the end of therapy as a function of attachment injury resolution.

Revised Adult Attachment Scale (RAAS; Collins, 1990). The RAAS is a shortened version of the original Adult Attachment Scale that consists of 18 items to which each partner must answer independently. It was developed to identify the individual's attachment style and was used in this study to capture any changes in attachment style from pre-treatment to post-treatment. Each item asks the respondent to rate the extent to which an item describes him/her. A 5-point scale, with 1 (not at all characteristic of me) to 5 (characteristic of me) is used.

Attachment Injury Measure (AIM; Millikin, 2000). The AIM was developed to obtain a written description of the injury as well as a measure of its severity. The measure simply asks each partner to describe the nature of the attachment injury from his or her point of view. It also asks the couple to rate on a severity scale of 1 (not at all severe) to 7 (extremely severe). Successful resolvers tend to report "moderately" to "extremely severe" at the beginning of treatment and report below "moderately severe" after treatment.

Post-Session Resolution Questionnaire (PSRQ). The PSRQ is an instrument intended to capture the degree of in-session change perceived by the treated couple in question. It has demonstrated face validity (Greenberg & Foerster, 1996; Greenberg, Ford, Alden, & Johnson, 1993). It consists of 4 Likert-type scales and evaluates the extent to which a couple feels they have resolved their presenting issues. High scores reflect no change, while low scores reflect large change. This scale was used to corroborate clinical judgment in selecting the best sessions for analysis.

Couples Therapy Alliance Scale (CTAS).

The CTAS is a qualitative scale used to assess the presence of an adequate therapeutic alliance. Since therapeutic rapport is a basic ingredient to the success of an intervention, if it will demonstrate effectiveness, it was important to rule out inadequate rapport as a potential cause of treatment non-resolution. This scale was administered at the end of the third session.

analysis as encompassing two phases: discovery followed by verification. In the discovery phase, the treating clinician identifies a particular recurrent clinical phenomenon (e.g., attachment injury) and defines it explicitly, as the authors have above. After isolating appropriate measures that mark the event in question, a set of hypothetical performances are delineated with the goal of task resolution. In regard to the present work, the hypothetical performances refer to the attachment injury resolution model. This marks the end of discovery phase. This is then followed by the verification phase, which compares actual with possible performances, validates the proposed model, and finally relates the process to outcome.

Before discussing the seven stages of EFT, it is necessary to present an overview of the three therapeutic phases and their accompanying nine steps, since they are germane to the systematic observations.

The Three Therapeutic Phases of EFT

RESEARCH DESIGN

A case study research design was used to identify and examine the attachment injury resolution process that emerged from the two couples based on ten EFT treatment sessions, which utilizes seven stages, as proposed by Johnson, Makinen, & Millikin (2001). The seven stages, described below, indicate the attachment injury resolution process that typically emerges in the second therapeutic stage, *changing interactional positions*, of EFT treatment. They are important to address because they tend to block risk-taking and the creation of trust within the relationship. For each session, each of the stages was interpreted based on Greenberg's (1984) task analytic method, which analyzes the emotional narratives of the couples engaged in conflict resolution or working through unfinished issues during the therapeutic process. Task analysis is considered a rational-empirical methodology used to study processes of change within psychotherapeutic contexts. Greenberg and Foerster (1996) describe task

The first therapeutic phase is *Cycle De-escalation*. Step one includes assessment, which involves the creation of an alliance between couple and therapist. The core issues are uncovered and explicated in attachment terms. Step two involves the negative interactional cycle, in its entirety, and is identified with the couple. Attachment insecurity and the maintenance of relational distress are accounted for by the negative interactional cycle. Step three includes the denied or unacknowledged emotions giving rise to interactional positions. In Step four, the presenting problem is reframed in terms of the interactional cycle, underlying emotions, and attachment needs.

The second therapeutic phase is *Changing Interactional Positions*. Step five suggests that previously disowned needs and aspects of self are identified and integrated into relationship interactions. Step six involves acceptance of each partner's experience and new more flexible interactional patterns are promoted. In Step seven, expression of attachment needs

and wants are facilitated, thus creating emotional engagement.

The third therapeutic phase is *Consolidation and Integration*. Step eight addresses previous relational problems via new solutions at which the couple have arrived through the therapeutic journey. Step nine considers the couple's new positions and healthier cycles of attachment behavior.

The Attachment Injury Resolution Model According to EFT: Seven Stages

During Stage one of EFT, the couple moves into the de-escalation phase. As the therapist encourages the injured and critical partner to risk connecting with the now available offending partner, the former begins to vividly describe a specific incident during which she or he experienced a violation of trust that shifted her or his belief in the offending partner's trustworthiness and the security of the whole relationship. The specific injury is described in an intensely emotional manner. The offending partner who was briefly emotionally available will move back in self-protection as the injured partner describes the injury. The offending partner may discount, minimize or deny altogether the hurtful incident. On the Structured Analysis of Social Behavior Scale (SASB), the injured and offending partner are expected to lie on the hostile quadrant and distant quadrant respectively. The level of experiencing is expected to be low, at Stage two or three.

With the attachment injury still at the surface, at Stage two, the therapist helps the injured partner stay in touch with it for the purpose of further articulating its attachment significance. With the therapist's validation, secondary emotions of anger and rage gradually differentiate into those of hurt, fear, and shame. The impact of the injury and its accompanying emotions are related back to the present negative interactional cycle. For instance, an injured partner may say, "I feel so helpless, I just scream and swear to show him that I matter and that he can't just pretend that everything is okay." During this step, the

level of experiencing of the injured partner will typically be deeper and a less hostile stance will be taken.

During Stage three, the offending partner, with the support of the therapist, hears the pain of the injured partner. Having articulated the impact of the injury in attachment terms, the offending partner slowly moves forward. The injured partner's reaction is no longer viewed as a reflection of the offending partner's inadequacies, but rather as her or his importance to the injured partner. The offending partner, now less defensive, acknowledges the injured partner's pain and describes how the incident evolved for her or him. The level of experiencing continues to increase gradually to Stage four or five for the injured partner and the offending partner adopts an affiliative stance.

At Stage four, the emotional climate between the two partners continues to be mild. The injured partner completes articulation of the injury in an integrated fashion such that the injured partner from a position of vulnerability expresses grief at the broken trust and fear of loss of the attachment bond. The injured partner may adopt a distant position (as measured by the SASB) and the level of experiencing continues to deepen to stage five.

Having witnessed the vulnerability of the injured partner, during Stage five, the offending partner feels safer to move forward and acknowledge responsibility for her or his share in the attachment injury. Emotions of regret, remorse, and empathy are observed and an apology should be forthcoming. The offending partner's utterances are affiliative in nature and there is continued deepened experiencing. With a re-engaged partner, at Stage six, the injured partner risks asking for the reassurance and comfort that was unexpressed at the time of the injurious incident. The level of experiencing reaches a peak at Stage six for the injured and offending partner. On the SASB, the injured partner has a response of friendly and the offending partner has a response of affiliative.

Finally, at Stage seven, the offending partner responds in a caring and protective way, which restores previous relationship

trust levels and heals the rift in the fabric of the attachment bond. Both partners are now encouraged by the therapist to construct collaboratively a new narrative of the event. The manner by which the offending partner came to respond the way she or he did during the injurious event needs to be integrated in the narrative in order to be acceptable to the injured partner.

PROCEDURE

Pre-Treatment Procedure

At the initiation of therapy, the researcher administered the Demographic Data Questionnaire, Attachment Injury Measure (AIM), Dyadic Adjustment Scale (DAS), and the Relationship Trust Scale (RTS).

Inter-Treatment Procedure

At the end of each therapy session, the Post-Session Resolution Questionnaire (PSRS) was administered. This is a five-point scale ranging from (1) not at all resolved to (5) fully resolved. This was used to obtain client and therapist judgments of task resolution and to objectively isolate each couple's "best session" for examination of the therapist's interventions. By the end of the third session, the Couples Therapy Alliance Scale (CTAS) was administered in order to ensure that the quality of the therapeutic alliance was not a confounding variable in the non-resolution process of change.

In order to track the process of change, the best ten-minute segment of each of the ten therapy sessions was coded using the Structural Analysis of Social Behavior (SASB) and Experience Scale (ES). For each therapy session, the best ten-minute segment was selected from the second half of the session to ensure that the therapeutic process was at its peak level. Each segment was isolated by finding a marker as indicated by an emotionally laden event related to the attachment injury—that is, where there is an incongruity between expressing and experiencing—and

transcribing the ten-minute therapy segment following it. Two raters, doctoral students, familiar with EFT and coding procedures coded all sessions independently. The two raters were not directly involved in the therapy process of any of the couples.

For each couple, the best ten-minute segment of each therapy session was transcribed and coded using the SASB and ES. For each segment, every utterance from both the injured and the offending partner was rated on the Quadrant scale of the SASB. To arrive at one rating for each partner for each session, the modal average of her or his ratings was used. The same procedure was implemented to arrive at one rating for the level of experiencing for each partner in every session.

Post-Treatment Procedure

At the completion of therapy, the therapist administered the AIM, the DAS, and the RTS. The resolution of an identified attachment injury was based on fulfillment of the following criteria: a) judgment of resolution from the couple's vantage point; b) opinion of the therapist; c) degree of improvement on the DAS and RTS measures.

Research Hypothesis

It is hypothesized that the resolved couple, in comparison to the non-resolved couple, will show more variation in terms of their interactional positions, as captured by the SASB and will also move towards more experiencing as captured by the ES. Resolution of the identified attachment injury is expected to follow the resolution model outlined above.

RESULTS

The following section reports the findings that emerged for the two couples, the resolved and the non-resolved, as interpreted by the task analysis method and as measured by the instruments administered. The data is discussed in accordance to inter-rater reliability, narrative and explication of attachment in-

jury by each partner, process measures, outcome measures, and observed pathways of change (in relation to the proposed attachment injury resolution model)—hypotheses are mentioned where appropriate.

Inter-Rater Reliability

Inter-rater reliability was high with minor discrepancies between raters. Codings on the SASB scale were analyzed for convergence, yielding a kappa of 0.78 for couple 1 and a kappa of 0.90 for couple 2, with an overall kappa of 0.84. Similarly, raters' codes on the ES yielded kappa's of 0.85 and 0.90 for couple 1 and couple 2, respectively. The overall kappa coefficient for inter-rater reliability on the ES was 0.87.

The Resolved Couple: Michel and Maya

Narrative of Attachment Injury

The attachment injury identified at the outset of therapy was an internet relationship.

Michel

Michel, the injured partner, described the sustained attachment injury in the following narrative: "An on-line relationship. I emailed some URLs to Maya and when I was checking her email to retrieve the URLs, I saw an email from someone called Dave. I asked her who it was and she said that she didn't know him, but then I found numerous e-mails from him for the last four months. She continued to lie for three days until I told her that I saw all the emails from Dave."

Maya

Maya, the offending partner, described the incident as follows: "I spent a lot of time on the computer and whenever we had a problem, I felt lonely. I really didn't have many friends around here so I got in the habit of chatting on the computer and I started becoming addicted. After a while I became close to one guy. I was afraid that Michel would

know, so I lied about it. When he found out, Michel thought that I cheated on him, but I only needed someone to talk to when I was down."

Explication of Attachment Injury

When asked to indicate the level of severity at a subjective level, on a scale of 1 or severe and 5 or negligible, Michel rated the severity of the attachment injury as 1 or severe, while Maya rated it as 4 or considerable. However, during the initiation of therapy, Michel felt that overall he could trust his partner while Maya indicated that she could not trust her partner. Nonetheless, both partners believed, to a moderate extent, that the issue could be resolved and the trust in the relationship could be improved.

Process Measures

In terms of attachment styles, as measured by the Revised Adult Attachment Scale (RAAS), Michel and Maya endorsed answers indicative of dismissive and fearful avoidant styles, respectively, consistent with hypothesis 6. On the DAS, Maya's score was 91 while Michel's was 84, and both partners' average score was 87.5, ten points below the cut-off for distressed couples. On the RTS, Michel and Maya obtained scores of 117 and 151, respectively.

Outcome Measures

The therapeutic process adhered substantially to the attachment injury resolution model proposed earlier. The SASB and ES codings are graphed below (see Figures 1a and 1b) to illustrate the entire process of change throughout the ten sessions. Figure 1a illustrates how this couple's interactional positions showed the expected changes associated with the proposed attachment injury resolution model. This couple showed a gradual increase in the level of experiencing from the beginning of session 3 to session 10; session 3 marked the de-escalation phase and is pre-requisite to attachment injury resolution. The peak level of experiencing by the last session was at stage 6 for this couple.

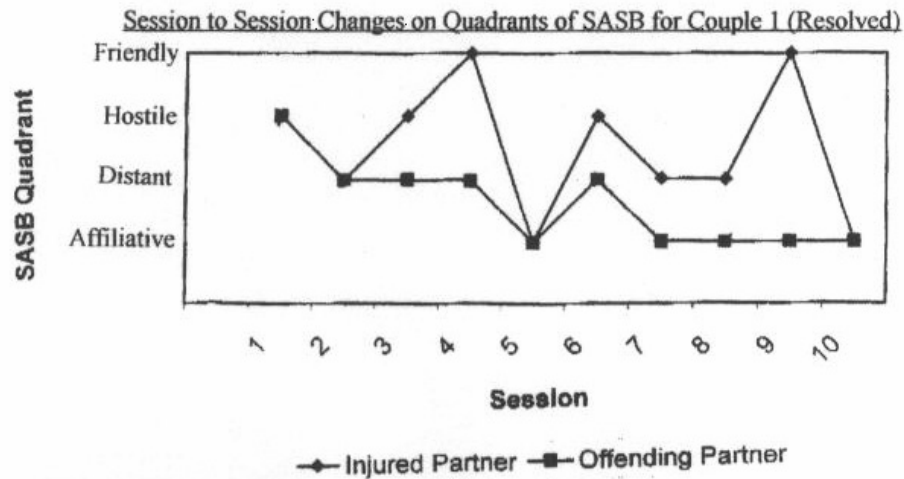


Figure 1 (a): The modal average for each partner's rating at each session depicts the expected process of change according to the proposed model of attachment injury resolution.

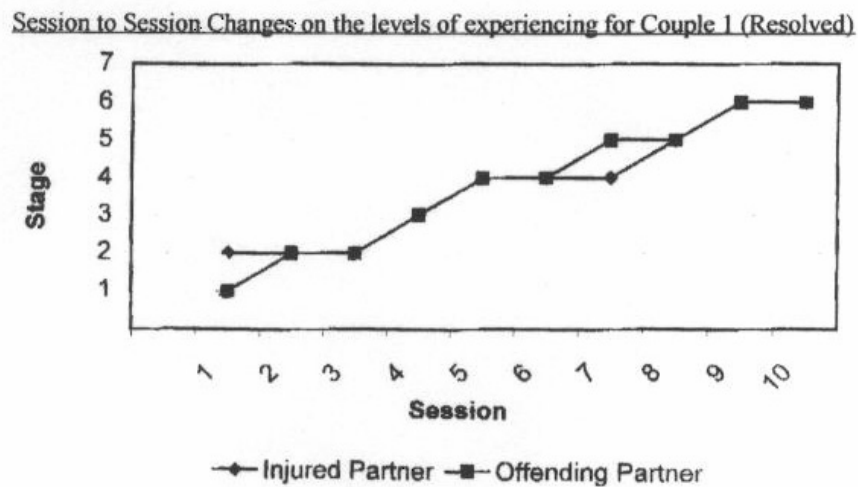


Figure 1 (b): The modal average for each partner's rating at each session illustrates the gradual deepening of experiencing throughout therapy, consistent with the proposed attachment injury resolution model.

Observed Pathways of Change

During the first therapy session, the assessment phase, the couple's dispositional presence was emotionally laden with hostility and lack of empathy, and since they were reluctant to reveal this affect, they coped by overtly behaving in a shallow or superficial demeanour (i.e., emotional distant behavior indicative of a flattened affective tone). This incongruity between affect and behavior marked the first process in the pathways of change, since the content and manner expressed the extent to which the injury affected their relational quality. At the beginning of session two, the level of experiencing was still quite shallow—a distant and detached stance towards each other, as indicated by a lack of emotional communication. However, progressively throughout the second session, the therapist succeeded in de-escalating this cycle by uncovering and explicating the emotionally laden issues associated with antecedent attachment needs stemming from their childhood working models (e.g., lack of responsiveness of Maya's father which led to a pattern of investing in multiple relationships simultaneously).

By session three, a classic withdraw-pursue was observed by the couple's dispositional presence whereby each experienced the relational distress between them and began to slowly and intermittently access these emotions by brief expressions (i.e., started to slowly open up to authentically experiencing their attachment insecurities, which indicates the building of an emotional connection). This working-through process indicated the efficacy of the therapeutic alliance (i.e., safety and trust lowers intrapersonal and interpersonal resistance), which was maintained during sessions four and five. Moreover, this therapeutic process allowed Maya to begin to identify her negative interactional cycle where she spoke about her underlying emotions and attachment needs by acknowledging her insecurities and emotionally distant behavior as a way to protect her sense of self from shame and the fear that she be exposed to Michel. She feared that

if she really exposed herself to him, if he really knew what she was about, he would leave her.

During sessions four and five, this interactional cycle led Michel, despite being the injured partner, to take a risk in communicating his painful emotions to Maya, which allowed him to reconnect to his denied emotions, and, thus, to Maya. For example, Michel said to the therapist, "I do want our relationship to work, but it is hard when she's distant." This transaction gave way for Maya to express her anger, shame, and fear through emotional outbursts, which carried the message that she may not be enough to satisfy Michel's needs or what he expects from her in a relationship. "You are a great person Michel, but everything I say . . . I mean . . . I personally think that I am not good enough for you . . . I am not asking you to leave, I'm just afraid that you'll give up, that's what I'm afraid of . . . maybe you should be with someone your level."

Consequently, this opening up—where he witnessed Maya speaking from such a vulnerable place—led Michel to be forthcoming with reassurance. Michel responded by saying that "It makes me sad that she feels this way, she said that she didn't care about looks, I guess it happened after her last relationship when her ex cheated on her, and so she pushes me away all the time." This interactional cycle was maintained throughout session five and propagated a pattern of releasing unacknowledged emotions to the point where de-escalation was attained—each became affiliative towards the other, and both entered deeper levels of experiencing their emotions, by themselves and with one another.

However, this deepening of affect released somatic pains (e.g., chest pains) and psychological distress (e.g., anxiety), which Michel attributed to suppressing his anger at Maya's uncaring attitude towards him. This session marked the first step in the proposed model of attachment injury resolution. Despite the risk he took to connect with Maya, Michel became doubtful as to her trustworthiness as he articulated the attachment injury, which continued to be high, specifically at stage five as depicted on Figure 1b. In light of

these circumstances, the therapist, through supportive encouragement, guided Michel to stay in the moment and in touch with his feelings of anger and rage that eventually differentiated into hurt and fear of relationship loss. "So, from what you just said, I hear a lot of hurt from your broken trust and feeling that she can look at another man, despite her love for you ." Michel's self-observation of hostile emotions lasted throughout session 6, which set the stage for Michel to distance himself from Maya during sessions seven and eight. This distancing stance revealed that Michel was processing his attachment injury and needed time to reflect and work through his painful emotions, which, incidentally, led to Maya to come to terms with how her actions injured Michel, specifically in his perception of the relationship.

Having now witnessed Michel's vulnerability, Maya became emotionally expressive and acknowledged her responsibility in how she dealt with the relationship. This emotional catharsis revealed how her previous relationship had conditioned her to feel untrustworthy and lacking of self-worth, which, consequently led her to express regret and offer Michel an apology for what had transpired. Notwithstanding, Maya came to experience doubt as to whether Michel believed her or not, which prompted the therapist to keep Maya in the moment of the experience and guided her to *feel*, rather than cognitively process the event, and requested that she ask Michel whether he believed her. Through non-verbal behavior, Michel acknowledged with a nod, and stated that he *did* believe her. As a consequence to this reciprocal acknowledgment, Maya's emotional expressions were tainted with shame, and to avoid her reverting to a distancing behavior, the therapist kept Maya emotionally engaged in her experience. This therapeutic move helped Maya to maintain an affiliative stance (see Figure 1a) for the last four sessions, despite her insecurity and Michel's initially distant stance. The couple continued to engage with each other in a manner reflective of deep experiencing, and by session 9, Michel had moved to a friendlier stance.

By the end of session ten, the couple reached a plateau in terms of level of experiencing, and both were relating to each other in affiliative ways. Session ten entailed consolidation of new interactional positions as a result of the new experiences that were fostered by the positive cycles and awareness of present feelings and internal processes. At the final session, it was judged by both the couple and the therapist that successful resolution of the attachment injury had taken place. This was consistent with results from the pre-treatment and post-treatment measures of the DAS and RTS scales. At therapy termination, both Michel and Maya indicated that they were trusting of each other. Their average score on the DAS has increased 16.5 points (more than one standard deviation) compared to pre-treatment. On the RTS, Michel and Maya's scores increased to 124 and 149 points, respectively, and their combined average score on the RTS had increased, though insubstantially (2.5 points). The modal average for each partner's rating at each session depicts the expected process of change according to the proposed model of attachment injury resolution (see Figure 1). The modal average for each partner's rating at each session illustrates the gradual deepening of experiencing throughout therapy, consistent with the proposed attachment injury resolution model (see Figure 1b).

The Non-Resolved Couple: Sam and Kate

Narrative of Attachment Injury

The attachment injury identified at the outset of therapy was a sexual affair.

Sam

Sam, the offending partner, described the sustained attachment injury: "The incident occurred in May 1996, Kate walked in on myself and her friend engaging in sexual relations. I was away from home when it occurred and when we did return home, we talked about it, hoping to resolve it ourselves, but it is a continuous source of stress in our

marriage. I have put it behind me, as there is no longer any involvement with this woman.”

Kate

Kate, the injured partner, described the injurious incident as follows: “On a business trip on which I accompanied my husband, I found him with my best friend in her bedroom in the middle of foreplay. At first I tried to ignore my husband when he came running after me; he wouldn’t let me just go. He needed to apologize. After I came home, I felt that I needed to prove something and I call it angry sex.”

Explication of Attachment Injury

On the Attachment Injury Measure (AIM), both Mike and Kate categorized the sustained attachment injury as severe. Mike, however, felt that the issue could be resolved considerably in therapy and that subsequently trust levels could improve. Kate, the injured partner, held that belief too, but only to a moderate degree. Sam and Kate tend to have dismissive and pre-occupied attachment styles, respectively, as determined by their response patterns on the attachment style questionnaire (Collins, 1996).

Process Measures

On the RAAS, Sam and Kate endorsed dismissive and pre-occupied styles respectively. On the DAS, both partners’ average score was 87.5, which is substantially below the cut-off point for distressed couple. Sam’s overall score on the DAS was lower than Kate’s, 84 and 92. On the RTS, Sam and Kate obtained scores of 141 and 114, respectively. At the outset of therapy, Sam, the offending partner, felt that overall he could trust Kate, while the opposite was the case for Kate, the injured partner.

Outcome Measures

The therapeutic process of this couple looked very different from the hypothesized model of attachment injury resolution model

proposed earlier. The SASB and ES codings are graphed below (see Figures 2a and 2b) to illustrate the entire process of change throughout the ten sessions. Figure 2a illustrates how this couple’s interactional positions showed rigidity and lack of differentiation throughout the ten sessions and the expected changes associated with the proposed attachment injury resolution model. Figure 2b illustrates relatively lower levels of emotional experiencing compared to the hypothesized model. Specifically, this couple showed a gradual increase in the level of experiencing from the beginning of session three to session ten; session three marked the de-escalation phase and is pre-requisite to attachment injury resolution. The peak level of experiencing by the last session was at stage 6 for this couple.

Observed Pathways of Change

From the onset of the first session of therapy, the dispositional presence of this couple was that of a classical pursue-withdraw, where Kate, the injured partner, showed a disparaging and blaming attitude towards Sam, the offending partner, who defended by withdrawing and distancing himself from Kate’s subjugation. This rigid interactional disposition, as depicted in Figure 2a, remained constant for the first four sessions, as measured by the SASB, where Kate remained hostile and overtly aggressive, while Sam maintained an isolated and reserved demeanor to contain Kate’s negative affect. Despite these patterns of exchange, both partners gradually progressed, and shifted from expressing impersonal statements (i.e., affect laden and uncongenial) to personal statements (i.e., affect expressive and emotive), as depicted in Figure 2b.

By session five, however, the couple had de-escalated, specifically Kate, who moved from a hostile to a distant stance, similar to Sam’s dispositional attitude (see Figure 2a). This dispositional style, consequently, created a calm interpersonal emotional climate that enabled the therapist to guide Sam to participate in the expression of his feelings, since the

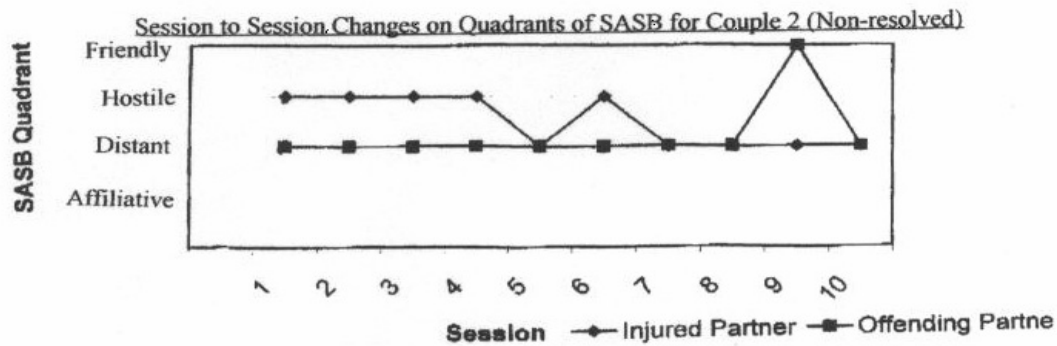


Figure 2 (a): The modal average for each partner's rating at each session illustrates the rigidity of this couples interactional positions. The injured partner has adopted one of two stances consistently; hostile and distant respectively. The offending partner adopted a predominantly distant stance, except for session 9 when he took a risk that was met with distance from his injured partner. He, then, regressed back to his distant position. Other than de-escalating the couples' vicious cycle, no gains were made. This pattern deviated from the proposed resolution model:

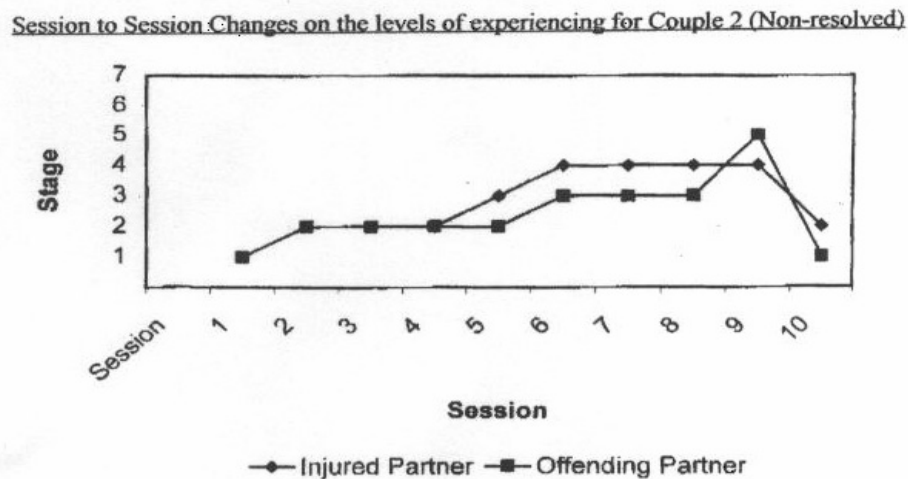


Figure 2 (b): The modal average for each partner's rating at each session reveals a profile that is consistent with the proposed model. With an offending partner that did not express remorse for the transgression, the injured partner was not willing to soften. So even when he took a risk at session 9, the injured partner did not respond in a way so as to maintain his engagement and both partners level of experiencing dropped dramatically by session 10.

environment was now much safer, which lowered his levels of resistance and increased his sense of safety. This emotional de-escalation allowed Kate to experience a deepening of affect, as compared to previous sessions. In this session, she reflected on how she was expressing and experiencing her painful emotions (i.e., venting through hostile criticizing).

In light of this forward move to de-escalation, an impasse developed between the couple following session five that was brought to attention during session six. Kate was offended when Sam went on a business trip with a woman she disliked. Sam had forgotten to mention the trip to Kate, given that it was unimportant to him as a collegial relationship. Although Kate initially claimed that she believed it was a platonic relationship, the event did trigger the attachment injury by re-awakening her attachment fears as indicated by her deepened level of experiencing her feelings (see Figure 2b). Just as the couple had managed to de-escalate in the previous session, Kate reverted back to her hostile attitude, almost in an unspoken attempt to conceal her vulnerability and unwillingness to ever trust her partner again. Sam, in response to Kate's hostility maintained his usual distance (see Figure 2a). Note that after de-escalation, couples typically move into the second stage of treatment. However, with this couple, their interactional pattern or cycle seemed so deeply entrenched (possibly as a function of the long duration of time since the occurrence of the attachment injury) that maintaining de-escalation or a first-order change presented as very challenging.

Sessions six and seven represented a *regression in the service of attachment injury*; that is, revisiting previous dispositional patterns of rigidity as observed in earlier sessions. In an attempt to resolve this impasse, the therapist began to reinitiate the de-escalation process in order to move the couple into the second stage of therapy, which was established during the end of session eight; however, both maintained distant attitudes towards each other. During session eight, Kate continued to differentiate her feelings of anger, her resentment at not being able to go back to work, and

the sacrifices she had to make for her family. Some of her anger was differentiated into feelings of aloneness, especially when she first had their children. Sam responded in a manner reflective of his continued distant attitude, specifically at a lower experiential level as compared to Kate.

It is important to note that up until session nine, there had not been any mention of the attachment injury because the emotional climate of the relationship was quite volatile. However, during session nine, an interesting shift occurred. Sam adopted a friendly stance for the first time since the beginning of therapy (see Figure 2a) and began exploring his feelings. He felt somewhat safer, given Kate's attenuated hostile attitude, which in turn lowered his levels of resistance. Although Kate articulated the attachment injury—the affair—she remained distant, as did Sam, which indicated that they were not ready to process this affect nor deal with it at this time. Despite Sam's friendliness (withdrawer engagement) in session nine, it failed to create a change in Kate's stance (softening). Since she was still quite distant, Sam regressed back to his former detached stance largely due to lack of safety. No further mention was made of the attachment injury, and the final session was marked by a sudden decrease in the level of experiencing for both partners.

At the termination of therapy, both Sam and Kate felt that they had made some gains in learning to express their emotions and disconnections between each other; however, resolution of the identified attachment injury did not take place. In view of this, Sam still felt that he could trust Kate, while Kate could not say the same for Sam. Their pattern of responses thus did not change from the onset of therapy to the outset. In addition to this therapeutic observation, indication of non-resolution was suggested by the pre-treatment measures (DAS and RTS average scores for this couple were 88 and 127.5 points, respectively), when compared to the post-treatment measures (DAS and RTS average scores were 79.5 and 130.5, respectively). In terms of this couple's resolution process in relation to the proposed model, none of the seven tasks were

accomplished. The proposed model specifies that resolution takes place during the second stage of treatment in EFT. It was evident that this couple experienced great difficulty even in maintaining de-escalation, let alone moving into the second stage of treatment.

DISCUSSION

This study used the case study approach to uncover the session-to-session changes in two couples with sustained attachment injuries that were undergoing EFT. The first couple was successful at arriving in a resolution while the second couple was unsuccessful, based on their perceptions and objective measures. Considering this, the following discusses the empirical findings of the results per each couple's therapeutic process.

First Couple

The process of change for the first couple adhered to the proposed model of attachment injury resolution, where the injured partner was initially hostile and blaming towards the withdrawn, offending partner. As de-escalation occurred, the emotional climate attenuated until the attachment injury was re-awakened and the emotional intensity increased once again. Moreover, the couple managed to de-escalate and then successfully move into the second stage of treatment, a critical step toward starting to emotionally process the attachment injury. The seven steps proposed in the model as they pertain to the resolution process are:

1. Injured partner expressed violation of trust.
2. Injured partner articulated meaning of experience at an emotionally deepened level.
3. Offending partner became less defensive.
4. Grief was expressed by the injured partner, from a position of vulnerability.
5. The offending partner moved forward

and acknowledged responsibility for her share in the injury.

6. The injured partner risked asking for the reassurance that was unexpressed at the time of the injury.
7. The offending partner responded in a caring and protective way.

It is important to note that the injured partner expressed full responsibility for the injurious event and several statements of remorse were made. With appropriate therapist interventions, a softening was elicited. Specific interventions included following the patient's affect and heightening experience in order to differentiate secondary emotion (e.g., anger) into more primary ones (e.g., hurt or fear).

Second Couple

The process of change for the second couple did not adhere to the proposed model of attachment injury resolution, since they were entrenched in a vicious cycle of volatility—negative interactional cycle—based on the period of time it took for them to de-escalate. This was largely due to the fact that de-escalating this couple was a challenge in and of itself. For example, a subtle event (husband's business trip) was powerful enough to displace the equilibrium created in the de-escalation stage. Moreover, despite the withdrawer-engagement process, the injured partner refused to risk exposing any vulnerability or expressing any need, which inadvertently led to a therapeutic impasse. The injured partner made clear statements about her unwillingness to trust, unless her partner was to prove himself to her over time. Consequently, none of the steps of the model were observable with this couples' change process.

Differences Between the Couples

Recency of the Attachment Injury

Some differences observed between the two couples may have factored into the final outcome of therapy. A major difference be-

tween the two couples was that of the recency of the attachment injury. While the first couple had experienced a rift in their emotional tie relatively recently (a few weeks prior to therapy initiation), the second couple had spent several years enduring a weak interpersonal bond as a result of the major injury sustained. Relatively recent attachment injuries may prove to be good prognostic indicators of the therapy outcome. It seems plausible to hypothesize that the longer a couple spends together interacting in a negative style resulting from an attachment injury, the more likely the interactional patterns and emotional experiences become entrenched. If the injurious incident is potent enough to alter the attachment style and the ways of relating between partners consequently change, therapy may also prove to be more therapeutically challenging. Conversely, those couples who present with recent attachment injuries may be more responsive to change in a shorter period of time. Further research is needed comparing couples with recent versus older sustained attachment injuries to compare their amenability to therapeutic change.

Style of Attachment

In the first couple, the reported attachment styles of the injured and offending partners were dismissive and fearful avoidant, respectively. At termination and as a result of successful resolution, both partners rated themselves as securely attached. This outcome was somewhat unexpected, given the resistance of a dismissive–fearful avoidant combination—Johnson and Simms (2000) have found that a fearful attachment style is difficult to change in the context of therapy. In contrast to the first couple, the injured and the offending partners of the second couple endorsed anxiously preoccupied and dismissive styles of attachment, respectively. These attachment styles remained constant throughout the course of therapy and where both partners perceived themselves to be relating in the same fashion. It may be the case that attachment injuries sustained in the context of particular combinations of attachment styles prove to be resistant to working through and integration.

For example, with the first couple, the injured partner adopted a fearful avoidant stance, where she would take one step forward followed by one step back. When her avoidant partner re-engaged, she felt it was safe to express remorse for her behavior. It is the authors' contention, however, that withdrawer re-engagement was facilitated, because of the calm emotional milieu of the relationship, since there was no hostility between partners. However, this was not the case with the second couple, as exemplified by the injured partner who remained adamant in her goal to control and punish her partner for making her feel insecure, and, as such, manifested a level of hostility that precluded his willingness to engage. Accordingly, couples with different attachment style combinations may be studied to further refine understanding of such therapeutic limitations.

Gender of Injured Partner

Another difference that emerged across the two couples was gender of the injured partner. In the first couple, the injured partner was the male, while in the second it was the female. Past research has maintained that women tend to be the “emotional managers” in relationships (Fincham, Beach, & Nelson, 1985). It could be that the gender of the injured partner juxtaposed on a particular attachment style combination may prove to be less amenable to short-term couples therapy, in which case, further research is required to substantiate the reasons.

CONCLUSION

While attachment injury has been shown to be a clinically useful construct in addressing many forms of both overt and covert experiences of betrayal and loss of trust, those unprocessed injurious events carried over from past relationships, whether from childhood trauma or from adulthood, have yet to be addressed from an attachment framework and integrated into this therapeutic approach. Qualitative differentiation of the attachment injury concept may be a fruitful endeavor to help tailor appropriate intervention. Al-

though there is support both quantitatively and qualitatively for the attachment injury resolution model, as evidenced by the resolvers' change process in comparison to their non-resolving counterparts, further research is needed to compare a larger pool of couples to determine whether or not non-resolved couples ever succeed in moving beyond de-escalation or at least maintaining it for more than one session. Although broad generalizations cannot be made at this time, preliminary

evidence suggests that couples who resolve their attachment injury work through their relational rift in a certain predictable pattern, as delineated by the model. Differentiation of interactional positions as well as deeper levels of experiencing seem to be paramount to resolution of the injurious event and restoration of the couple's emotional bond.

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