

Resolving Attachment Injuries in Couples Using Emotionally Focused Therapy: Steps Toward Forgiveness and Reconciliation

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The goal of this study was to use task analysis to verify that the attachment injury resolution model described in this article discriminates resolved from nonresolved couples. Twenty-four couples with an attachment injury received, on average, 13 sessions of emotionally focused therapy (EFT). At the end of treatment, 15 of the 24 couples were identified as resolved. Segments of best sessions for all couples were transcribed and rated on 2 process measures. Resolved couples were found to be significantly more affiliative and achieved deeper levels of experiencing than nonresolved couples. They also showed significant improvements in dyadic satisfaction and forgiveness than nonresolved couples. The results support the attachment injury resolution model and suggest that resolution during EFT is beneficial to couples.

Keywords: attachment injury, emotionally focused therapy, forgiveness, impasses, reconciliation

Many couples encounter situations or life events that may lead to emotional distress. However, attachment-related incidents can have deleterious effects on the relationship bond. These incidents have been called *attachment injuries* (Johnson, 1998) and have been characterized as a perceived abandonment, betrayal, or breach of trust in a critical moment of need for support expected of attachment figures (Johnson, Makinen, & Millikin, 2001). The incident becomes a clinically recurring theme, is often used as a standard for the dependability of the other partner, and creates an impasse that blocks relationship repair. As such, the couple becomes stuck in a rigid, negative, interactional cycle (e.g., attack–defend, pursue–distance), which may then escalate into severe marital distress.

The attachment injury concept emanated from the practice of emotionally focused therapy (EFT). EFT is an empirically validated approach to marital therapy, and it is recognized as one of the most effective approaches in resolving relationship distress (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998). It has demonstrated a very large effect size of 1.3, with recovery rates between 70% and 73% (Johnson, Hunsley, Greenberg, & Schindler, 1999).

EFT, although not developed from attachment theory, is suited to address important aspects of relationship functioning described by attachment theory. Adult attachment theory is one of the most promising theories of adult romantic relationships (Hazan &

Shaver, 1987; Johnson & Whiffen, 2003). Attachment theory emphasizes the propensity for human beings to make and maintain powerful affectional bonds with significant others. In couples, a secure attachment bond is an active, affectionate, reciprocal relationship in which partners mutually derive and provide closeness, comfort, and security. These bonds are based on a “profound psychological and physiological interdependence” and, therefore, have an impact on psychological well-being (Hazan & Zeifman, 1999, p. 351). Self-reports of a secure romantic attachment are linked with positive aspects of relationship functioning, including high levels of trust, commitment, interdependence, and higher dyadic satisfaction (e.g., Kirkpatrick & Davis, 1994; Mikulincer, 1998). Supportive relationships encourage the creation of optimal experiences for both partners. Attachment theorists have pointed out that, perhaps because of this interdependence, incidents in which one partner fails to respond at times of urgent need seem to disproportionately influence the quality of an attachment relationship (Simpson & Rholes, 1994).

Attachment theory has also been referred to as a *theory of trauma* (Atkinson, 1997, p. 3). When people are without physical or emotional support, they are most vulnerable and have difficulty regulating their emotions. Disturbances of affect are central to all descriptions of traumatic stress and its sequelae (Stone, 1996). It has been argued that wounds to attachment relationships resulting from emotional inaccessibility by one partner may be equated to trauma with a small “t” (Johnson, 2002). Following traumatic abandonment, the injured partner may exhibit symptoms characteristic of posttraumatic stress disorder. As Abrahms-Spring (1997) pointed out, disturbing memories, vivid images, and sensations puncture an injured partner’s concentration and sleep. When awake, they ruminate excessively, and hypervigilance becomes the norm. Avoidance and numbing, which are both natural and self-protective strategies against the barrage of intrusive symptoms, interfere with emotional engagement and attunement between partners. Couples dealing with trauma incurred by a partner

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tend to express more intense negative affect than typical distressed couples (Johnson & Williams-Keeler, 1998), and clinical experience shows that this is true also for couples dealing with relationship traumas or attachment injuries. As attachment theorists have pointed out, situations in which an attachment figure is both the source of and the solution to emotional pain are inherently difficult to tolerate and result in a fundamental disorganization of the attachment system (Main & Hesse, 1990).

Recently, couples therapists have attempted to address relationship traumas that make the resolution process difficult to achieve. The forgiveness literature is particularly relevant (e.g., Enright & Fitzgibbons, 2000; Hargrave, 2004) as couples that have recovered from the impact of a relationship betrayal often allude to the role of forgiveness in the resolution process (Gordon, Baucom, & Snyder, 2000). Forgiveness occurs in response to an interpersonal violation and involves mending emotional wounds, restoring trust, and repairing the relationship bond. Rowe et al. (1989) were among the first researchers to acknowledge that forgiveness has a positive impact on both the injured and the offending parties. Gordon and Baucom (1998) concurred that forgiveness involves a "complex interaction including the person who is forgiving, the person who is being forgiven, and the dyadic interaction between these two people" (p. 426). Thus, although not directly related to EFT or attachment theory, forgiveness may be an important step in the process of resolving attachment traumas among couples.

The goal of this study was to describe how attachment injuries may resolve during EFT, according to the attachment injury resolution model. The attachment injury resolution model emanated from task analysis of change process in EFT (Johnson & Greenberg, 1988), clinical experience (Johnson, 2004; Johnson et al., 2001), and empirical research (Millikin, 2000; Naaman, Pappas, Makinen, Zuccarini, & Johnson, 2005). The task analytic approach to studying the process of change involves two phases. The first phase, which is discovery-oriented, consists of six steps beginning with task selection and proceeding to a model of change. The second phase, which is referred to as the *verification phase* and is the focus of this study, consists of two steps (Greenberg, 1984; Greenberg & Foerster, 1996). The first step involves comparing couples that successfully complete the change process with those that remain at an impasse to verify the markers of successful performance. The second step involves beginning to link successful task performance to outcome.

In preliminary exploratory studies, Millikin (2000) used task analysis to study the process of change in mildly to moderately distressed couples that successfully resolved the attachment injury in 10 to 15 sessions of EFT. The findings showed that, although attachment injuries often emerge at the assessment stage, a therapist could not effectively intervene until the negative interactional pattern between partners had de-escalated. The attachment injury comes alive again when the injured partner is invited to risk emotionally engaging with his or her partner with the hope of creating a new positive emotional experience. This is the optimal time for therapeutic intervention and the resolution process. The steps of the attachment injury resolution model (which act as a guide for therapists working with such couples), along with the process measure descriptions on the Structural Analysis of Social Behaviour (SASB; Benjamin, 1974; Benjamin, Foster, Roberto, & Estroff, 1986) and the Experiencing Scale (ES; Klein, Mathieu-Coughlin, & Kiesler, 1986) are outlined below. The SASB and ES

assess key components of what are believed to be the indicators of change during the resolution process. Identifying these key events in therapy is essential in task analysis as it scales down data into manageable amounts for coding and analysis.

Attachment Injury Resolution Model

Attachment Injury Marker

1. In a highly emotional manner, the injured partner describes the incident in which he or she experienced a violation of trust that damaged his or her belief in the relationship. The incident is alive and present rather than a calm recollection (SASB = 6 [blame] and 7 [attack]; ES = 3 [describes events/reactive]).
2. Offending partner discounts, denies, or minimizes the incident and his or her partner's pain and moves into a defensive stance. (SASB = 7 [defend and withdraw]; ES = 3 [describes events/reactive]).

Differentiation of Affect

3. Injured partner stays in touch with the injury and begins to articulate its impact and attachment significance (SASB = 6 [blame] and 1 [assert]; ES = 2 [intellectual description of event]).
4. Offending partner begins to hear and understand the significance of the injurious event (SASB = 7 [defend and withdraw]; ES = 2 [intellectual description of event]).

Reengagement

5. Injured partner tentatively moves toward a more integrated articulation of the injury and allows the other to witness his or her vulnerability by expressing grief and fear concerning the specific loss of the attachment bond (SASB = 2 [disclose and express]; ES = 4 to 5 [increasing emotional involvement]).
6. Offending partner becomes more emotionally engaged and acknowledges responsibility for his or her part and expresses empathy, regret, and remorse (SASB = 2 [affirm and understand]; ES = 4 to 5 [increasing emotional involvement]).

Forgiveness and Reconciliation

7. Injured partner then risks asking for comfort and caring that was unavailable at the time of the injury (SASB = 4 [trust and rely]; ES = 6 to 7 [express feelings/awareness of present feelings]).
8. Offending partner responds in a caring manner that acts as an antidote to the traumatic experience (SASB = 3 [nurture and comfort]; ES = 6 to 7 [express feelings/awareness of present feelings]).

In this study, we employed a quasi-experimental, task analytic research methodology to build on previous research by verifying the resolution model. A strict adherence to the EFT treatment manual assisted in treating the therapists' behavior as a controlled variable (Johnson & Greenberg, 1988), thus examining couple processes and describing how change occurs within the couple system. The SASB and ES were used to test whether the attachment injury resolution model discriminated resolved from nonresolved couples. We predicted that resolved couples would exhibit (a) significantly more affiliative responses (i.e., disclose and express needs, affirm and understand) and fewer hostile or distant responses (i.e., belittle and blame, protest and withdraw) and (b) deeper levels of experiencing in "best sessions" than nonresolved couples. In addition, we predicted that, at the end of treatment, resolved couples would exhibit (a) significant decreases in marital distress, (b) significant gains in the level of relationship trust, (c) significantly less avoidant and anxious attachment, and (d) significantly more forgiveness and less emotional pain than nonresolved couples.

Method

Participants

Of the couples meeting inclusion criteria (see *Procedure* section), 30 couples identified an event that altered the quality of their relationship bond and expressed a desire for closure. Of these, 3 couples withdrew prior to the onset of therapy. One couple dropped out of the study after the initial session. Two couples terminated their relationship once therapy commenced. Therefore, 24 couples received, on average, 13 sessions of therapy and completed the pre- and posttreatment questionnaire packages. The couples (the "completers") were included in analyses because the focus was on describing processes among couples actually undergoing the therapy. Of these couples, there were 19 injured wives and 5 injured husbands. The types of attachment injuries reported were an actual abandonment ($n = 3$), perceived abandonment following a miscarriage ($n = 2$), infidelity ($n = 10$), flirtation ($n = 4$), exotic massage ($n = 1$), Internet relationship ($n = 1$), friendship with opposite sex ($n = 1$), insulting remark ($n = 1$), and financial deception/loss ($n = 1$). The couples were moderately distressed, with the mean couple dyadic adjustment of 84 (range = 67–100). The majority of couples were Caucasian with 1 East Indian and 1 couple of European descent. Their ages ranged from 25 to 52 years ($M = 39.79$ years, $SD = 7.87$), they had been married for 1 to 30 years ($M = 13.53$ years, $SD = 8.99$), and had on average 2 children. Of the 48 individuals, 33 (69%) had a postsecondary college diploma or university degree. The gross family income for the entire sample ranged from \$40K to \$100K ($M = 73.33$, $SD = 23.90$).

Process Measures

The ES and SASB were used to code best sessions.

ES. The ES (Klein et al., 1986) is a 7-point rating scale used to rate partner's level of emotional involvement in therapy. Stage 1 reflects a low level of emotional experiencing. The content is impersonal, abstract, and general. Moving up the scale, there is a gradual progression from superficial external events to an internal experience and a synthesis of new feelings and meanings. At Stage 7, there is an expanding of awareness of present feelings in internal processes. The validity of this scale has been supported by its correlation with client variables, such as introspection and cognitive complexity, and has been used to predict client change (Orlinsky & Howard, 1986).

SASB. The SASB (Benjamin, 1974; Benjamin et al., 1986), a coding system designed to measure the changing quality of interaction between partners, comprises a two-dimensional grid consisting of a two axes. The horizontal axis describes degrees of affiliation (i.e., *unfriendly to friendly*), and the vertical axis describes degrees of interdependence (i.e., *autonomous to submissive/controlling*). Social interactions may be coded at varying levels of complexity. At the simplest level, the model is divided into 4 quadrants with Affiliative in the top right-hand corner, and Distant, Hostile, and Friendly proceeding in a counterclockwise order. The model may be further divided into eight clusters (i.e., 1 = assert and separate/free and forget, 2 = disclose and express/affirm and understand, 3 = approach and enjoy/nurture and comfort, 4 = trust and rely/help and protect, 5 = defer and submit/watch and manage, 6 = sulk and appease/belittle and blame, 7 = defend and withdraw/attack and reject, 8 = wall off and avoid/ignore and neglect). Cluster 1 falls at the top pole of the vertical axis, and the remaining clusters proceed in a clockwise order with Clusters 3, 5, and 7 falling on the remaining three poles. The most complex level involves coding statements as belonging to 1 of 36 tracks. In this study, statements are characterized as belonging to one of the quadrants and clusters. Coded data are nominal and, therefore, require nonparametric statistical analysis.

Raters and reliability. Two graduate students who were unaware of the hypotheses and the resolved status of the couples were trained on both process measures to a satisfactory reliability (i.e., Cohen's kappa level of .70). Training consisted of coding transcripts from the training manuals prior to carrying ratings on the transcripts from the study. To arrive at a single rating for each partner for each session, the peak rating (deepest level in the segment) was used for the ES (Klein et al., 1986), and the modal rating (most frequent cluster and quadrant rating) was used for the SASB (Benjamin et al., 1986). Interrater reliability was high, yielding kappas of .83 ($p < .001$) for the ES and .84 ($p < .001$) for the SASB quadrant and .73 ($p < .001$) for the SASB cluster.

Self-Report Measures

Attachment Injury Measure (AIM). The AIM (Millikin, 2000) is a modification of the single-item Target Complaints Discomfort Box Scale (Battle et al., 1966). The measure was expanded to four items designed to measure the current severity of the injury using a 5-point scale ranging from 1 (*severe*) to 5 (*negligible*). For example, it asks the couple to rate the significance of the event that injured the relationship bond. Reliability coefficients for the injured and offending partners at pre- and posttreatment ranged from .67 to .90.

Post-Session Resolution Questionnaire (PSRQ). The PSRQ (Orlinsky & Howard, 1975) is a four-item measure designed to assess the amount of in-session change and to identify best sessions. It consists of three 5-point and one 7-point session evaluation items. For example, one item asks the couple how resolved they feel at the end of the session regarding the issue that brought them into counseling. High scores are indicative of no change, and low scores are indicative of much change. This instrument has face validity only, but it has been used in previous studies to successfully identify best sessions (e.g., Greenberg & Foerster, 1996).

Couples Therapy Alliance Scale. The Couples Therapy Alliance Scale (Pinssof & Catherall, 1986), a 28-item measure designed to assess the perception of the therapeutic alliance, was administered to each partner to ensure that differences between resolved and nonresolved groups could not be attributed to the therapeutic alliance. Partners rate each item using a 7-point scale ranging from 7 (*completely agree*) to 1 (*completely disagree*). High scores reflect a higher quality of the alliance between the couple and therapist. This measure was administered once after the third session. Cronbach's alpha was .96 for the injured and offending partners.

Dyadic Adjustment Scale (DAS). The DAS (Spanier, 1976) is a widely used, 32-item self-report measure of marital satisfaction. Both partners completed the DAS. All items were answered using a Likert-type response format. Scores can range from 0 to 151, with higher scores (97 and higher) indicative of greater marital satisfaction. Reliability coefficients for the

injured and offending partners at pre- and posttreatment ranged from .74 to .95.

Relationship Trust Scale (RTS). The RTS (Holmes, Boon, & Adams, 1990) is a 30-item inventory designed to assess interpersonal trust. Both partners respond to items on a 7-point scale, ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). A high overall score indicates a higher level of trust. Reliability coefficients for the injured and offending partners at pre- and posttreatment ranged from .92 to .96.

Experiences in Close Relationships (ECR). The ECR (Brennan, Clark, & Shaver, 1998) is a 36-item measure used to assess individual differences with respect to attachment-related anxiety (i.e., the extent to which people are insecure vs. secure regarding the availability and responsiveness of romantic partners) and attachment-related avoidance (i.e., the extent to which people are uncomfortable being close to and depending on others). Both partners respond to items on a 7-point scale ranging from 1 (*disagree strongly*) to 7 (*agree strongly*). The four attachment-style categories may be derived from the two 18-item dimensional subscales and the classification coefficients provided by the authors (Brennan et al., 1998). Internal consistency for the injured and offending partners at pre- and posttreatment ranged from .87 to .90.

Interpersonal Relationship Resolution Scale (IRRS). The IRRS (Hargrave & Sells, 1997) is 44-item measure consisting of two scales designed to assess the extent to which a person continues to feel pain as a result of the offense and has forgiven his or her partner for the offense. Injured partners were asked to respond with a *yes* or *no* to each of the items. Summing the weights of each response yields a score for the two scales. High scores indicate emotional healing and progress in the work of forgiveness. Internal consistency for the forgiveness scale was .76 at pretreatment and .87 at posttreatment. For the pain scale, internal consistency at pre- and posttreatment was .58 and .73, respectively.

Procedure

All couples ($N = 107$) that responded to media advertisements that described the University of Ottawa Research Ethics Board-approved study were assessed for suitability using a telephone screening interview. Couples were probed for the presence of an attachment injury and had to meet eligibility criteria, including living together for at least 1 year, no history of sexual abuse, no reported psychiatric history, no problems with drugs and alcohol, and no physical violence in the relationship. Suitable couples ($n = 43$) were invited to the university, at which time informed consent was obtained and a questionnaire package consisting of demographic information, the AIM, DAS, RTS, ECR, and IRRS was completed. The DAS was scored and used to further identify prospective couples. To be included in the study, the injured partner's DAS score ideally fell within the mild to moderately distressed range (i.e., 80 and 97). Although mild to moderate distress was preferred, more severely distressed couples were included in the study providing both partners were committed to the relationship (as measured by a score of 3 to 5 on DAS Item 32). Couples included in the study were randomly assigned to 1 of 13 trained EFT therapists and offered 12 free sessions of couples therapy. Those that did not meet criteria were referred to another provider of psychological services.

At the end of each therapy session, therapists asked both partners to complete the PSRQ. At the end of the third session, therapists asked each partner to complete the Couples Therapy Alliance Scale. At the final session, each partner completed the PSRQ, AIM, DAS, RTS, ECR, and IRRS. At the end of the study, couples had the option of continuing with their therapist or being referred to another therapist.

Selection of resolved and nonresolved couples. At the end of the treatment, couples were identified as either resolved or nonresolved. To be identified as a resolved couple, three criteria had to be met: (a) Both partners had to have a mean score greater than 10 on the AIM, (b) the therapist had to indicate that the couple had completed the resolution steps at the end of therapy, and (c) a clinical judge had to indicate that the couple

moved beyond the impasse and was making progress toward resolution. To facilitate this, researchers selected "best sessions" for each couple based on highest PSRQ ratings by the couple during the study. The clinical judge, trained in EFT and the attachment injury resolution model, listened to best sessions. Note that all best sessions occurred later in the process of therapy (i.e., approximately Session 10 for both groups). There was no difficulty identifying the 15 resolved couples. These couples had AIM ratings between 11 and 18, were selected by the therapist as having resolved the injury, and were selected by the clinical judge as having made progress toward forgiveness and reconciliation. Only 1 of the nonresolved couples had an AIM rating higher than 10 but did not meet the other two criteria.

Selection of transcripts for coding. Audiotapes of first sessions were queued by the therapist to the place that marked the telling of the attachment injury. Best sessions were queued by the therapist to the place that marked the most advanced step in the model. As in previous research, these were used as a starting point for a 10-min segment that was transcribed for process coding (Johnson & Talitman, 1997; Millikin, 2000). Although both the designation of resolved status and the examination of change process variables focused on best sessions, the designation of resolved status resulted only in part from clients' cognitive assessment of movement beyond their impasse at the end of the best sessions, whereas the coding of process variables focused on client behaviors during these sessions. The designation of resolved status also required the unanimous judgment of movement beyond the impasse to be made by a clinical judge and couples therapist.

Implementation check. To verify that treatment was implemented according to the EFT manual, several verification checks were carried out. First, segments of therapy sessions were played during weekly group supervision to ensure proper implementation. Second, the researcher audited therapy sessions, randomly selected during the course of the study, and judged that treatment was more than adequate. Third, two independent, trained raters coded therapists' statements in 10-min segments of each couple's 1st and 10th therapy sessions (randomly queued) against a checklist of 16 (8 EFT and 8 non-EFT) interventions (Dandeneau & Johnson, 1994; Johnson & Talitman, 1997). Interrater reliabilities (Cohen's kappa) for total therapists' interventions, therapists' interventions for the resolved group, and therapists' interventions for the nonresolved group were .80, .79, and .84, respectively. The mean rater percentages of EFT statements for the resolved and nonresolved groups were 96% and 90%, which were not significant, $t(22) = -1.6, p > .05$.

Results

At the end of treatment, 15 couples were identified as having resolved the attachment injury, and 9 couples were identified as nonresolved. The data file was examined for accuracy of data entry. Data were missing for 3 couples on the ECR and the IRRS. In addition, 2 couples did not complete the Couples Therapy Alliance Scale. To avoid losing data because of casewise deletion, we used mean substitution as it did not produce any systematic bias to the results. Univariate normality was assessed by an examination of skewness, as well as an examination of the histograms. The scores were within reasonable limits. No univariate or multivariate outliers were found. Multicollinearity and singularity were assessed using SPSS collinearity diagnostics and by examining correlation coefficients of the dependent variables. No multicollinearity or singularity was evident. Finally, analysis of Box's M test of homogeneity of variance-covariance matrices within each cell for the two groups at pre- and posttreatment for the injured and offending partners using a significance level of .001 showed no violation of the assumption. Levene's test of equality of error variances for the univariate between-groups analyses showed no violation at $p = .001$.

Group Differences

No significant group differences were found on any of the demographic variables, including age, gender, relationship length, number of children, family income, level of education, previous marriage, previous couples therapy, type of injury, and onset of injury. No group differences were found in the therapeutic alliance for the injured partner, offending partner, and the couple. There were no pretreatment group differences on the severity of the attachment injury, dyadic adjustment, the attachment dimensions (i.e., avoidance and anxiety), and emotional pain and forgiveness. However, significant pretreatment group differences were found for the injured partners' level of trust, $F(1, 22) = 9.29, p = .006, \eta_p^2 = .30$. The injured partners in the nonresolved group reported significantly lower levels of trust at pretreatment than the injured partners in the resolved group. Pretreatment trust was used as a covariate in the parametric analyses.

The Process of Change

To test the hypotheses related to the process of change, we used the SASB and the ES. Chi-square analyses were conducted on first session coded process data to see whether the resolved and nonresolved groups differed on the following process variables: belittle and blame, defend and withdraw, disclose and express needs, affirm and understand, and depth of experiencing. In analyses in which the expected frequency was less than 5 in a cell, Fisher's exact test was used. The results showed that the frequency of the partners' responses was similar for both groups.

For best sessions, chi-square analyses showed that resolved couples had significantly more affiliative responses (i.e., disclose and express, affirm and understand) than hostile/distant responses (i.e., belittle and blame, defend and withdraw). Resolved partners openly disclosed and expressed their needs and were affirming and understanding, whereas nonresolved partners remained in a blame/withdraw stance. In terms of level of experiencing, both partners had significantly deeper levels of experiencing than the nonresolved group. All of the resolved couples exhibited deeper levels of experiencing, ranging from a self-description of feelings (Stage 4) to expanding awareness of feelings (Stage 7). All but one of the nonresolved couples had significantly lower levels of experiencing, ranging from totally detached/superficial (Stage 1) to reactive responding (Stage 3). The frequencies of response categories are presented in Table 1.

Outcome

To test the hypotheses that resolved couples would exhibit significant improvements on the outcome variables compared with nonresolved couples, we conducted repeated-measures analyses with resolved and nonresolved groups as the between-subjects independent variable and partner type (i.e., injured vs. offending) and time (i.e., pre- vs. posttreatment) as the within-subjects independent variables. Separate analyses were conducted on each dependent variable (i.e., dyadic adjustment, attachment avoidance, and attachment anxiety). Given that the IRRS forgiveness and emotional pain scores were available for only the injured partners, we performed a doubly multivariate analysis (i.e., MANOVA with

Table 1
Response Frequencies in Best Sessions for the Resolved and Nonresolved Groups on the Process Measures

Response category	Resolved	Nonresolved
Disclose and express needs (injured)		
Present	14	1
Absent	1	8
Affirm and understand (offender)		
Present	15	0
Absent	0	9
Belittle and blame (injured)		
Present	0	7
Absent	15	2
Defend and withdraw (offender)		
Present	0	7
Absent	15	2
Injured high experiencing		
Present	15	0
Absent	0	9
Offender high experiencing		
Present	15	1
Absent	0	8

Note. All $ps = .000$.

a repeated-measures component) on forgiveness and emotional pain. Trust was used as a covariate in all of the analyses.

The first set of repeated-measures analyses involved the dependent variable dyadic adjustment. There was no three-way interaction for partner type by time by group, $F(1, 21) = 2.68, p > .01, \eta_p^2 = .11$. There were no two-way interaction effects for partner type by group, $F(1, 21) = 1.97, p > .01, \eta_p^2 = .09$, or partner type by time, $F(1, 21) = .00, p > .01, \eta_p^2 = .00$. However, there was a significant two-way interaction for time by group, $F(1, 21) = 36.19, p = .000, \eta_p^2 = .63$, which is a large effect. There was a main effect for group, $F(1, 21) = 27.35, p = .000, \eta_p^2 = .57$, and for time, $F(1, 21) = 12.28, p = .002, \eta_p^2 = .37$. There was also a main effect for partner type, $F(1, 21) = 13.42, p = .001, \eta_p^2 = .39$, suggesting that the injured partners were significantly more distressed than the offending partners. The main effects for group and time are best interpreted in terms of their interaction. Figure 1 shows the mean DAS scores for the resolved and nonresolved couples at pre- and posttreatment. Paired-samples t tests showed no significant improvement in dyadic adjustment over time, $t(8) = .58, p > .05$, for the nonresolved group. However, the resolved group showed a significant improvement in dyadic adjustment from pre- to posttreatment, $t(14) = -6.76, p = .000$. According to the three criteria outlined by Jacobson and Truax (1991), the 22-point increase in dyadic adjustment is a clinically significant improvement. Of the 15 resolved couples, 47% of the injured partners and 27% of the offending partners scored in the clinically significant change range. See Table 2 for the means and standard deviations.

The second repeated-measures analysis involved the anxiety attachment dimension as the dependent variable. There were no three-way interaction effects for partner type by time by group interaction, $F(1, 21) = 3.73, p > .01, \eta_p^2 = .003$. There were no two-way interaction effects for partner type by group, $F(1, 21) = 1.30, p > .01, \eta_p^2 = .06$, for partner type by time, $F(1, 21) = 4.45, p > .01, \eta_p^2 = .18$, or for time by group, $F(1, 21) = .31, p > .01,$

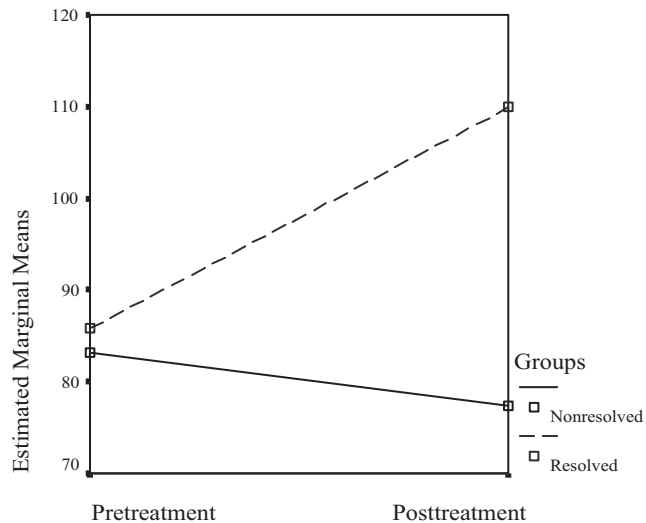


Figure 1. Mean dyadic adjustment as a function of time with pretreatment trust as a covariate.

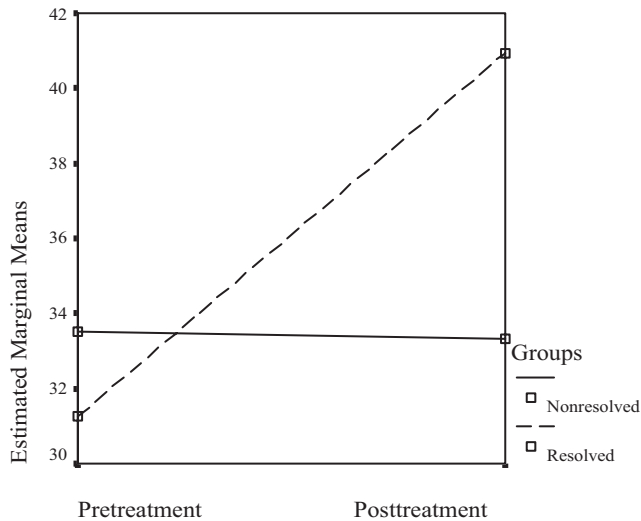


Figure 2. Mean forgiveness as a function of time with pretreatment trust as a covariate.

$\eta_p^2 = .02$. There were no main effects for group, $F(1, 21) = .001, p > .01, \eta_p^2 = .00$, partner type, $F(1, 21) = .16, p > .01, \eta_p^2 = .01$, or time, $F(1, 21) = 2.53, p = .13, \eta_p^2 = .11$.

Similarly, the avoidance of closeness dimension revealed no three-way interaction effects for partner type by time by group, $F(1, 21) = 4.60, p > .01, \eta_p^2 = .18$. There were no two-way interaction effects for partner type by group, $F(1, 21) = 1.75, p > .01, \eta_p^2 = .08$, for partner type by time, $F(1, 21) = .005, p > .01, \eta_p^2 = .000$, or for time by group, $F(1, 21) = .02, p > .01, \eta_p^2 = .001$. There were no main effects for group, $F(1, 21) = 5.95, p > .01, \eta_p^2 = .22$, partner type, $F(1, 21) = .000, p > .01, \eta_p^2 = .000$, or time, $F(1, 21) = .75, p > .01, \eta_p^2 = .03$.

To investigate whether scores on the IRRS differed for the resolved and nonresolved groups over time, we performed a doubly multivariate analysis on the dependent variables emotional pain and forgiveness. Pretreatment trust was used as a covariate. Using Wilks's criterion, we found that the combined dependent variables revealed a significant group by time interaction, $F(2, 20) = 8.31, p = .002, \eta_p^2 = .45$. There were no main effects by

group, $F(2, 20) = 2.46, p > .01, \eta_p^2 = .20$, but there was a main effect for time, $F(2, 20) = 5.10, p = .01, \eta_p^2 = .34$.

Univariate analyses of emotional pain revealed no group by time interaction effects, $F(1, 21) = 3.78, p > .01, \eta_p^2 = .15$. There was no main effect for group, $F(1, 21) = 2.20, p > .01, \eta_p^2 = .10$. There was, however, a significant main effect for time, $F(1, 21) = 6.53, p = .01, \eta_p^2 = .24$, suggesting that both groups benefited from EFT. This difference was not considered clinically significant because it was less than 2 standard deviations from the sample mean (Jacobson & Truax, 1991).

For the forgiveness factor, univariate analyses revealed a significant group by time interaction, $F(1, 21) = 17.38, p = .000, \eta_p^2 = .45$, with significant main effects for time, $F(1, 21) = 29.46, p = .006, \eta_p^2 = .31$, but not for group, $F(1, 21) = 4.89, p > .01, \eta_p^2 = .19$. Figure 2 shows the interaction for the resolved and nonresolved groups at pre- and posttreatment. Paired-samples t tests revealed no significant improvement in the work toward forgiveness over time for the nonresolved couples, $t(8) = .62, p > .05$. However, the resolved group showed a significant improve-

Table 2
Injured and Offending Partners Dyadic Adjustment, by Group and Time

Partner type	Pretreatment		Posttreatment		Bonferroni t
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Resolved group ($n = 15$)					
Injured	85.47	8.23	110.13	12.32	-7.11*
Offending	90.07	10.19	108.53	10.93	-5.80*
Nonresolved group ($n = 9$)					
Injured	78.89	13.38	75.67	9.98	.96
Offending	80.89	6.70	81.00	11.20	.03

* $p < .001$.

Table 3
Injured Partners for the Two Interpersonal Relationship Resolution Scale Variables, by Group and Time

Variable	Pretreatment		Posttreatment		Bonferroni <i>t</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Resolved group (<i>n</i> = 15)					
Pain	36.72	2.88	39.68	1.32	-4.24
Forgiveness	32.02	3.31	40.75	1.84	-9.92*
Nonresolved group (<i>n</i> = 9)					
Pain	35.56	3.01	37.11	4.81	-0.62
Forgiveness	32.22	4.79	33.67	4.33	-1.39

* $p < .001$.

ment in forgiveness from pre- to posttreatment, $t(14) = -9.92, p = .000$. This improvement is considered clinically significant (Jacobson & Truax, 1991). See Table 3 for the means and standard deviations for the resolved and nonresolved groups on emotional pain and forgiveness at pre- and posttreatment.

Discussion

The purpose of this study was to build on previous attachment injury process research by describing the resolution process among couples treated with EFT. Task analysis was employed to investigate whether the resolution model discriminated resolved from nonresolved couples and to explore differences in outcome. The goal was to validate the attachment injury resolution model so as to better explain therapeutic change using EFT.

At the outset, the resolved and nonresolved couples did not differ on the frequency of hostile responses (i.e., belittle and blame, defend and withdraw) or on their depth of experiencing. These findings are consistent with the first two steps of the attachment injury resolution model that mark the disclosure of the event (Johnson et al., 2001; Millikin, 2000; Naaman et al., 2005). When the injured partner speaks of the incident, there is often an explosion of emotions, such as anger and rage. The offending partner finds this aversive and moves into a defensive stance or withdraws. Although a couple with an attachment injury may appear similar to any other distressed couple (i.e., they get caught in a pursue-withdraw interactional pattern), the defining feature in attachment-related events is that they are not easily forgotten and are often used to define relationship safety. Attachment injuries often exacerbate conflicts and block risk taking and intimacy (Johnson, 2004).

The prediction that resolved couples would be more affiliative and exhibit deeper levels of experiencing as treatment progressed, compared with nonresolved couples, was supported. As expected, the frequency of affiliative responses, such as disclosing and expressing needs and affirming and understanding, was significantly different for the resolved and nonresolved couples. Furthermore, the frequency of hostile responses, such as belittle and blame and defend and withdraw, significantly differed, as did the frequency of injured and offending partners' level of experiencing. These robust findings are consistent with the attachment injury resolution model that has shown

that deeper levels of experiencing are key ingredients of change (Johnson et al., 2001; Millikin, 2000). Previous EFT process research also has found that when "blamers" move from impersonal, self-limiting emotional involvement to an exploration of underlying needs, particularly when their partner is emotionally engaged, a softening occurs. A *softening* is a shift from anxious, emotional reactivity to showing vulnerability by expressing needs in a manner that pulls for emotional connection. This softening changes the relationship by initiating safe emotional engagement and connection (Johnson & Greenberg, 1988).

To illustrate the process of change, a generic example of an attachment-injured couple (John and Pat) is provided. John and Pat, both successful professionals, had been married for 30 years when Pat found out that John had had an affair 3 years before when he was away on business. Pat felt betrayed, and her trust for John was shattered. Over the years, Pat and John never discussed the incident, although John complained that Pat repeatedly reminded him of his indiscretion. At the intake, Pat presented as angry and hostile toward John, and he was very defensive. Pat was hypervigilant whenever John went out. She wanted to know where he was going, whom he was meeting, and when he was coming home. When he was late, she would become distraught, and the cycle would escalate immediately upon his return. John reported feeling controlled and refused to comply with her unrealistic demands. When John was home, he often retreated to his music studio and listened to music with headphones, which incited Pat's anger.

- Therapist:* Help me here, John; from what you are telling me, the incident that brought you into therapy is still very much in the foreground.
- John:* Well, I don't know if it is in the foreground, but it definitely is still there for me. I kind of blocked it out for the longest time. The more she would throw it at me, the more I built a wall around it and myself. Now, I feel ashamed about what I did.
- Therapist:* I'm wondering if it would help if you talked about your shame?
- John:* I don't know. I'm scared to bring up all the emotions.

- Therapist:* You have compartmentalized your feelings, never talked about your shame because when she got scared she would remind you of it. Is that it?
- John:* Yeah, she would get angry, and it was like replaying an old movie. I'd hear it over and over again . . . I couldn't escape. I knew that I'd have to deal with it one day, but . . .
- Therapist:* So this is new for you to talk about your feelings, yes?
- John:* Maybe it's because I have a really hard time choosing my words and how I would say it.
- Therapist:* It's hard to take that in when there is so much shame and regret about what happened. Can you try to tell her now?
- John (tearfully turning to Pat):* I am so, so sorry . . . I'm really sorry. I wasn't thinking, and it was a silly, selfish thing to do . . . without any thought on my part of how it would affect you.
- Pat:* Well . . . I accept your apology.
- John (sobbing):* Because I do love you so very much, and I do want to grow old with you.
- Pat:* I can't believe how I feel . . . since we've been coming here. It is in the past, and I don't carry it with me anymore. My life doesn't revolve around it anymore. I don't get up in the morning and think about it. I am sad to hear that you are dealing with it more now than before. I don't want you to worry about it.
- Therapist:* It saddens you to hear that he still carries this?
- Pat:* Uh hmm . . . because it is gone for me, I have forgiven him. It is in the past. It is not even an issue anymore. I will never again . . . I know . . . that I will never worry about it. I just miss you. I need you in my life. I too want to grow old with you.
- John:* It has helped talking about the affair and hearing how you felt. When you told me how you felt before, all I heard was your anger, which is now gone. This makes such a big difference when we talk now.

Although John was processing his shame, they both indicated that the incident that brought them to therapy was clearly in the past. They moved from the negative pattern of attack–defend to a more affiliative stance. They were able to openly disclose and respond to each other in an affirming and understanding manner. In addition, they both shifted from reactive responding and describing the event to a greater awareness of primary feelings as they emerged. In general, resolved couples were open to exploring feelings related to the event. Injured partners were able to disclose and express their needs once the offending partner took responsibility for his or her behavior. Unresolved couples, however, remained stuck in an attack-and-blame and defend-and-withdraw stance. They were reactive and intellectualized the event.

Couples identified as having resolved the attachment injury also showed significant gains on outcome. For the resolved couples, both the injured and offending partners' dyadic adjustment scores significantly increased from moderately distressed to the nondistressed range. Similarly, resolved couples made significant gains in their reported level of forgiveness, whereas no change was noted for the nonresolved couples. This clinically significant finding gives an indication as to where the injured partners are in the process of forgiveness, which involves being able to recognize negative interactional patterns, setting limits, restoring trust and building emotional bonds, and taking responsibility (Hargrave & Sells, 1997). Despite this group difference on forgiveness at posttreatment, there were no group differences with respect to emotional pain. However, the injured partners in the resolved and nonresolved groups showed a significant decrease in emotional pain over time. Given that the injured partners are the ones emotionally wounded by their partner, it makes sense clinically and theoretically that the injured partners in both groups would experience significant decreases in emotional pain as a result of EFT.

Although it can be argued that the research design used in this study does not definitely rule out the possibility that change occurred as a result of time, the average time that couples nursed these wounds before seeking treatment was 5 years. This length of time and clinical experience of the impasse that these violations of trust create in relationships argue against the notion that changes observed in this study were simply the result of the passing of time. Other models of therapy may also be able to elicit a similar process to the change described here; however, other models do not use an attachment frame to understand relationship events and focus on other change processes besides the ones described here (i.e., deepening and sharing of reprocessed emotional experience).

The attachment dimensions, however, revealed no significant group differences. It has been argued that these patterns, which have also been referred to in the literature as styles, strategies, orientations, and habitual forms of engagement (Bartholomew & Horowitz, 1991; Brennan et al., 1998; Johnson, 2002), may be more enduring characteristics that are not easily modified. Individuals with a secure style have developed constructive coping strategies and may be better able to talk openly with their partners in response to violations of trust (Mikulincer, 1998), communicate their needs, and reach out for and provide support (Simpson, 1990). As such, secure individuals may be better equipped to work through attachment-related events. In this study, very little is known about the attachment patterns prior to their injurious events. Most of the injured partners were insecurely attached at intake. In other words, the attachment injury may not have caused the pretreatment attachment patterns. The injurious event may have elicited attachment-related behaviors consistent with the various attachment patterns. The old strategies for dealing with conflict may become activated by the injury, thus maintaining the negative interactional cycle.

It may also be that changing attachment as measured here is a long-term process that cannot be captured within the time period of the study. Traditional attachment theory states that working models of self and other have to be revised for change to occur. This revision may require a number of positive experiences even after an optimal "corrective" experience of new and reparative interactions in therapy.

Another explanation may be a measurement issue. The attachment measure used in this study instructs each partner to respond to the 36 statements in terms of how he or she generally experi-

ences romantic relationships. Thus, the measure may not have been sensitive enough to detect changes in attachment anxiety and avoidance with the specific partner as a result of treatment. Perhaps if the items were modified to capture how he or she experiences the current partner, rather than the history of romantic partners, a significant shift in attachment anxiety and avoidance may have been detected for the resolved couples.

Overall, the results of this study have both theoretical and clinical implications. They provide empirical support for the attachment injury resolution model. Many couples with an attachment injury seem unaware of the impact such events have on their relationship bond. In addition, couples therapists may not attend to seemingly minor incidents that can impede the therapeutic process. In our working definition of attachment injuries, we focused on the meaning of these events. Prototypical attachment-related injuries, such as infidelity, may be more obvious to a therapist. However, both the couple and the therapist may overlook the significance of seemingly benign emotional wounds (e.g., insulting remark at a key moment). Therefore, the couple may reach an impasse in therapy (i.e., partners are unable to move beyond de-escalation and relapse once therapy is terminated).

In this study, 63% of the sample successfully resolved the attachment injury to the point of achieving a clinically significant improvement in relationship distress and forgiveness. Although this recovery rate is less than what has been found in the EFT literature (Johnson et al., 1999), the results of the current study were found to be stable at a 3-year follow-up (Schnare, Makinen, & Johnson, 2006). It is important to note that over the course of therapy, therapists discovered that seven of the nine nonresolved couples had compound injurious events that may have contributed to the lower levels of trust at the beginning of treatment. In some cases, the offending partner repeatedly injured his or her spouse. In other cases, partners hurt each other at two different points in time. In either case, compound injuries may be potent enough to irretrievably shatter the trust in the relationship, thus making the resolution process even more arduous.

An important prognostic indicator of outcome is trust, particularly placing faith in one's partner (Johnson & Talitman, 1997). Faith in one's partner curbs feelings of uncertainty, thus enabling one to relax and surrender fears and insecurities about the relationship (Holmes et al., 1990). Given that attachment injuries have been likened to trauma, restoring trust in couples with compound injuries may require longer treatment than the limited number of sessions offered in this study. The resolution process may involve more extensive treatment to work through the emotional wounds and rebuild trust. The clinical norm for working with traumatized couples is 30 to 35 sessions (Johnson, 2002). But before the therapist can even begin to address the injury, the therapist has to develop a good working alliance with both partners and complete the de-escalation stage of EFT. Depending on the couple, building an alliance and then attaining de-escalation may be a long process. Therapists working with couples that have compound attachment injuries may need to extend the duration of treatment even further to heal connections (Johnson, 2002).

This study has several methodological limitations that suggest possible future research. First, regarding the process of change, the study focused solely on client behaviors. There are now some studies that use task analysis research to investigate therapists' behaviors that facilitate change in couples that have undergone

EFT (e.g., Bradley, 2004). To further extend the theoretical understanding of the attachment injury resolution process and to provide a more detailed clinical map for therapists working with such couples, it would be beneficial to track and identify therapist interventions. However, tracking client behaviors from session to session may lead to the examination of the contribution of different change factors in successful outcomes. For example, changes in the injured partner's attributions about the offending partner may be less important in the overall process than changes in the injured partner's affect regulation and, thus, his or her ability to engage with their spouse in bonding enactments.

Second, task analysis is a labor-intensive project that inevitably requires realistic limits on the number of participants involved. EFT has been shown to be highly effective at reducing general marital distress (Johnson et al., 1999). The results discussed here were consistent with subsequent regression analyses showing that attainment of forgiveness in this small sample predicted dyadic adjustment ($p < .002$) at posttreatment. However, it is not possible in task analysis to make the three-way link between in-session process, resolution of a task, and treatment outcome. It is possible that in-session change processes are not causal and that resolution is the result of other factors. A large randomized control study with a focus on outcome may provide more robust findings.

Finally, a key issue in evaluating psychotherapy research is the extent to which the findings may be generalized. The motivation of couples responding to media advertisements offering free couples' therapy may differ from couples seeking therapy. Specifically, couples in this study may not have been as distressed as couples typically presenting with attachment-related injuries. Moreover, many of the couples in this study had complex attachment injuries. To be able to generalize these findings beyond couples with a single attachment injury, research with a focus on complex attachment injuries and the process involved in restoring trust, fostering forgiveness, and facilitating attachment security is warranted. In addition, it may be beneficial to look at the impact of a single event (e.g., infidelity) versus more chronic incidents, such as continuous minor flirtations.

These limitations notwithstanding, this study contributes to the attachment literature and the field of couples therapy. To summarize, we used task analysis to better understand couples with attachment-related problems that often block relationship repair. The study provided validation for the attachment injury resolution model, as outlined in the EFT literature, by providing therapists with a map of key responses and moments in the forgiveness change process. It also showed that it is important for therapists to attend to attachment injuries so that they can foster the growth of trust and create positive cycles of bonding and reconciliation. Moreover, it brings EFT into the realm of forgiveness and reconciliation and thus allows the EFT therapist to address key impasses in couples therapy and maximize success.

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