

FORGIVENESS AND RECONCILIATION IN EMOTIONALLY FOCUSED THERAPY FOR COUPLES: THE CLIENT CHANGE PROCESS AND THERAPIST INTERVENTIONS

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

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

The Attachment Injury Resolution Model (AIRM) has demonstrated that it successfully alleviates relationship distress and promotes forgiveness in injured couples (Makinen & Johnson, 2006). However, research into the client change process and interventions that promote forgiveness upon implementation of the AIRM within emotionally focused therapy (EFT) has yet to be conducted. Process research is of increasing interest to couple therapy researchers as it deepens knowledge about how clients change as a result of treatment (Pinsof

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& Wynne, 2000). Clinical model development based on process research that specifies a resolution path for client problems and effective interventions is most relevant to clinicians (Johnson & Lebow, 2000). Such research bridges the gap between theory, research, and clinical practice in the field of couple therapy (Johnson, 2003). Process research of AIRM supports clinicians in their work of promoting forgiveness and reconciliation in couples beleaguered by emotional injuries. The goals of this psychotherapy process study are to investigate the client change process underlying AIRM, validate the AIRM model, and identify EFT interventions associated with the successful resolution of an injury.

EFT FOR COUPLES: CLIENT CHANGE PROCESS AND INTERVENTIONS

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

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

Client change occurs in three stages. In stage I of EFT, cycle de-escalation, secondary emotional reactions are placed in the context of the cycle and are identified as promoting emotional disconnection. Stage II consists of two critical change events, the withdrawer re-engagement and the blamer softening. These change events mark a shift in partners' emotional processing as disowned primary attachment-related emotions and needs are accessed and integrated. In the blamer-softening event, the pursuing partner discloses soft primary emotions, such as fear of abandonment and rejection, and asks for care and support. His or her partner's new ability to respond with care and compassion is often an antidote to rigid, negative interaction cycles and shapes a positive cycle of reaching and caring responsiveness. In stage III, couples consolidate and integrate their new positions and new cycles of positive attachment behavior.

In EFT, experiential and systemic interventions are used to facilitate the client change process. Experiential interventions (e.g., empathic reflections/attunement, validation, evocative responding), heightening, and empathic conjectures are used to facilitate access to, exploration and expansion of attachment-related emotions and needs. Systemic interventions (e.g., tracking and reflecting process, reframing partners' experiences/interactions in terms of the negative cycle) and enactments are used to restructure negative interaction cycles and facilitate new cycles of emotional engagement that foster more secure emotional bonding. In a recent analysis of the blamer-softening event, EFT interventions used included evocative responding, heightening, validation, empathic conjecture/interpretation, reframing, and restructuring interactions (Bradley & Furrow, 2004). Experientially oriented interventions support the pursuer to access and express vulnerability and withdrawers to emotionally re-engage, while systemic-oriented interventions facilitate the creation of new enactments characterized by increased mutual accessibility and responsiveness.

MEASUREMENT OF CLIENT CHANGE IN EFT RESEARCH

Process measures are used to examine critical shifts in client's manner of engagement that contributes to successful outcome. In EFT, primary emotions are accessed, explored, and expanded to facilitate client shifts toward more adaptive integrated emotion and need expression in relationships. This involves greater experiential involvement in therapy as clients focus inward on their meaning-making process. Client experiential involvement in EFT has been assessed using the Experiencing Scale (ES; Klein, Mathieu-Coughlan, & Kiesler, 1986). As a client's level of experiential involvement deepens, the client's discourse shifts from superficial and impersonal to more internal self-referenced statements. Deeper levels of engagement have been associated with positive and successful therapy outcomes in EFT for couples (Johnson & Greenberg, 1988; Makinen & Johnson, 2006).

A client's manner of processing and articulating primary emotional experience may also be critical to the client change process. The Levels of Client Perceptual Processing (LCPP; Toukmanian & Gordon, 2004) classifies client discourse from automatic, rigid, and undifferentiated to more flexible, differentiated, reflective, and integrative modes of perceptual processing. Client representations are primarily changed through controlled modes of processing that allow a wider range of information (e.g., emotions, thoughts, images) to be integrated. Automatic processing constricts the ability to attend to differentiate, reflect upon, and integrate available information related to client problems (Toukmanian, 1992; Toukmanian & Gordon, 2004). A controlled mode of perceptual processing has been related to a reduction in depression symptoms and improved interpersonal functioning in EFT for individuals (Missirlian, Toukmanian, Warmar, & Greenberg, 2005). This measure of client engagement has not been previously used in couple therapy research.

Critical shifts in client's engagement may also be measured through in-session interpersonal responding. The Structural Analysis of Social Behavior (SASB; Benjamin, Foster, Roberto, & Estroff, 1986) has been used to identify how partners respond to each other at critical moments in EFT. Research has found that clients become increasingly open to primary emotions and needs in EFT (Makinen & Johnson, 2006). EFT research suggests that partners typically move from more hostile and unfriendly to more affiliative interpersonal responses. More affiliative responses include "trusting and relying" and "comforting and nurturing" in-session statements.

AIRM AND THE CLIENT CHANGE PROCESS

The AIRM consists of three stages (de-escalation of the injury cycle, new emotional engagement regarding the injury, and consolidation) and eight steps (see Figure 1). An attachment injury occurs when a partner is betrayed or abandoned, and trust is violated at a moment of critical need for support and care (Johnson et al., 2001). The injury is traumatic as the injured partner is left with a sense of helplessness, isolation, and intense fear about the other's availability. The traumatic incident becomes a barometer of the offending partner's trustworthiness, dependability, and reliability (Johnson et al., 2001). Steps to forgiveness and reconciliation are set out within AIRM to address lingering hurt and anger and heal the frayed bond. The emotional processing of the hurt allows for the regulation of negative emotions and clarification of the nature of the wound and its impact on the relationship. New emotional signals and understandings lead to new interactions where offending partners' emotional responsiveness restores emotional connection and allows for a renewal of trust.

Attachment Injury Resolution Model is implemented in the second stage of general EFT for couples. In Phase I of AIRM, de-escalation of a negative, injury-specific interaction cycle (i.e., attack/defend) occurs. In Step 1 of Phase I of the AIRM, the change event marker, the injured partner speaks of the injury in an emotional, self-protective manner (i.e., hostile, angry, critical, blaming or numb detachment). The offending partner's dismissive responding in Step 2 often minimizes the injured partner's emotional pain and impedes deeper attachment-related emotional processing of the incident. With Steps 3 and 4 of Phase I of the AIRM, secondary, more superficial, emotion responses and associated negative views of self and other are unpacked and placed within the context of the cycle. The injured partner's intense emotional

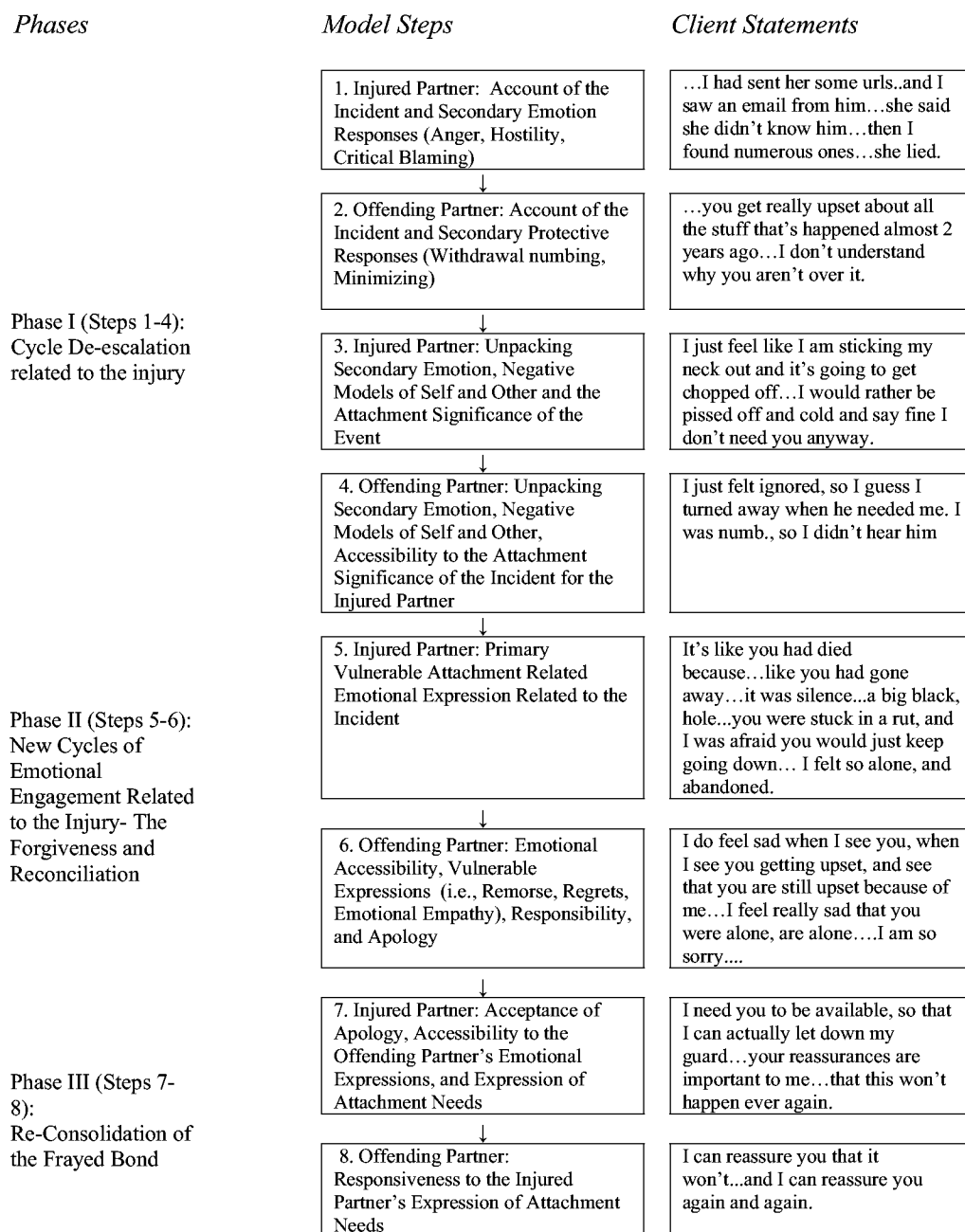


Figure 1. Attachment injury resolution model process of change.

reactions (most often reactive anger but sometimes mute, withdrawal) and the offending partner's nonresponsiveness are reframed in attachment terms. Injuring partners are also guided to explore and reflect on their injuring responses and own them in a way that allows the injured partner to understand how these responses occurred.

In Phase II of the AIRM, new positive cycles of emotional engagement related to the injury are promoted. An injury-specific blamer-softening process begins in Step 5 as the injured partner accesses and integrates disowned attachment-related emotions linked to the incident. The essence of the attachment injury is clarified, and new signals of hurt and longings are communicated. From an emotionally engaged stance, the offending partner expresses his or her

regrets, remorse, takes responsibility, and offers an apology for causing the injured partner emotional pain. He or she also shares sadness and fears about the ruptured attachment bond. In Phase III of the AIRM, the injured partner risks asserting attachment needs for comfort and support related to the injury. The offending partner's responsiveness now serves as an antidote to the ruptured bond. Reconciliation, the restoration of trust and a softer emotional connection, transpires as a result of this process. It is important to note that one may forgive but may not necessarily reconcile. Forgiveness involves the emotional engagement between partners and an apology from the injuring partner, but this may not necessarily lead to reconciliation. Reconciliation involves behaviors that show the intention to restore trust and maintain the relationship. Reconciliation at the end of Phase III parallels the more general bonding events that are usually completed in Stage II of general EFT.

AIRM DEVELOPMENT AND EMPIRICAL SUBSTANTIATION

The important steps leading to attachment injury resolution have been defined and empirically verified using task analysis research methodology (Makinen & Johnson, 2006; Naaman, Pappas, Makinen, Zuccarini, & Johnson, 2005). In a recent outcome study, 63% of couples fully resolved an injury in approximately 13 sessions of EFT (Makinen & Johnson, 2006). Significant differences between resolved and nonresolved couples were found on measures of forgiveness, relationship satisfaction, and trust. When first sessions were compared with best sessions, resolved couples had deeper levels of experiential involvement and moved toward more affiliative responses. A 3-year follow-up of the AIRM study suggested that resolved couples maintained relationship satisfaction, trust, and diminished pain concerning the attachment injury; whereas, nonresolved couples moved toward avoidance and less trust (Halchuk, Makinen, & Johnson, 2010).

Further empirical verification and definition of the client change process in the AIRM is warranted. Process measures can be used to empirically specify critical shifts in client processing associated with successful resolution. Knowledge of client's manner of engagement as they resolve an attachment injury can guide clinical decision-making as to whether a specific performance task is resolved. Further model validation will also verify whether completion of specific performance tasks or steps of therapy distinguishes resolved from nonresolved cases. In addition, the examination of therapist interventions used to facilitate client change in each step is beneficial in guiding clinical work at each phase of the model.

AIRM PROCESS STUDY: CLIENT CHANGE PROCESS, MODEL VALIDATION, AND EFT INTERVENTIONS

This study had three objectives. The first objective was to empirically specify injured and offending partners' manner of in-session engagement as they completed steps in the attachment injury resolution path and reached successful resolution. Process measures were used to empirically describe AIRM components, including the Experiencing Scale (ES; Klein et al., 1986), the Structural Analysis of Social Behavior (SASB; Benjamin et al., 1986), and the Levels of Client Perceptual Processing Classification System (LCPP; Toukmanian & Gordon, 2004). Critical shifts in client engagement in therapy were expected as clients successfully completed performance tasks. It was hypothesized that as injured and offending couple clients successfully moved through the AIRM steps, they would deepen their experiential involvement in therapy, perceptually process emotion information in a more internally differentiated, reflective, and integrated manner, and become more affiliative in their interpersonal responses. This shift in engagement was expected at Step 5 of the model.

The second objective of this study was to further empirically validate the AIRM. Following previous research by Makinen and Johnson (2006) who used task analysis to verify the model, this study aimed to examine AIRM components to validate the specific steps taken in the process of forgiveness in couples. Validation occurs through empirical verification of whether the presence or absence of model components discriminates successful from nonsuccessful performances. It was expected that the presence of model Steps 3, 4, 5, 6, 7, and 8 would discriminate

resolved from nonresolved couples. It was assumed that nonresolved couples would remain in Steps 1 and 2 of the AIRM; they would continue to be reactive and have difficulties completing cycle de-escalation of the injury-specific cycle. Nonresolvers would have difficulties moving into Step 3 and continuing onward to have access to and engage on the level of primary emotions and needs in the manner necessary for injury resolution.

The third objective was to specify EFT interventions associated with successful attachment injury resolution. This study uniquely linked client performance tasks and therapist behaviors at each stage of the model, which serves as a guide to the specific interventions used in particular tasks of the AIRM. It was expected that particular EFT interventions would be more frequently used at different stages of AIRM to support deeper emotional processing, shift negative interaction cycles, and promote more secure relatedness.

METHOD

Selection of Couple Cases and Clinical Process Events

Couple cases for this study were selected from audiotapes of an AIRM outcome study in which 24 heterosexual couples were given EFT ($M = 13$ sessions) for the purpose of resolving an attachment injury and alleviating general relationship distress (Makinen & Johnson, 2006). Couples were moderately distressed, with a mean couple score of 84 on the Dyadic Adjustment Scale (Spanier, 1976). Injury resolution was determined based on the following criteria: a 10-point mean couple score on the self-report Attachment Injury Measure (Millikin, 2000); the therapist perspective that the couple completed the resolution process; and the perspective of a clinical judge. Injured partners consisted of 19 women and five men. The majority of couples were Caucasian, with one East Indian couple. Ages ranged from 25 to 52 years ($M = 39.8$). Reported attachment injuries were actual abandonment ($n = 3$), perceived abandonment following a miscarriage ($n = 2$), infidelity ($n = 10$), flirtation ($n = 5$), Internet relationship or friendship with opposite sex ($n = 2$), insulting remark ($n = 1$), and financial deception/loss ($n = 1$). Nine of the resolved cases were randomly selected of the 15 available to enable the comparison of nine resolved to nine nonresolved cases.

Process Measures

Experiencing scale (Klein et al., 1986). The ES, a 7-point continuous rating scale used to rate in-session therapy talk turns, was used to assess couple partners' experiential and emotional involvement in therapy. At the lowest levels, clients engage in a detached manner. Level 1 and 2 are marked by impersonal and superficial content. As the scale increases, clients are more self-referential in their experiencing. Level 3 marks the beginning of internal self-referencing when personal reactions related to an event are integrated into the clients' discourse, but remain unexplored. Level 4 involves greater internal experiential descriptions. At higher levels, individuals are processing and exploring feelings and emotions. Level 5 consists of propositions about the self (i.e., feelings and emotions). Level 6 and 7 suggest in-depth exploration of inner experience to direct the self. Peak scores, the highest rating achieved on each transcript of a component, were used for this study. The scale validity of the ES has been explored in studies in which the client variables, introspection, and cognitive complexity were found to be correlated with the ES and predict client change (Orlinsky & Howard, 1986). Inter-rater reliability coefficients are reported as ranging from .76 to .91 (Klein et al., 1986).

Structural analysis of social behavior (Benjamin, 1974; Benjamin 1986). The SASB, a circumplex model of social interactions, was used to measure quality of couple client interpersonal responses. Behaviors are represented in terms of three two-dimensional grids, or focus (1 = self, 2 = other, 3 = introject), consisting of two axes. Interpersonal behaviors are assessed in terms of a horizontal axis representing degrees of affiliation (friendly-unfriendly) and a vertical axis representing degrees of interdependence (autonomous-submissive/controling). For this study, two grids, or focus, were used (1 = self, 2 = other). For each grid, there are four quadrants (i.e., affiliative, distant, hostile, friendly) that were used. Raters establish the focus and quadrant for each talk turn. Mode scores were used for the purpose of this study. Factor analysis, circumplex analysis, and dimensional ratings have established the validity of

the instrument. Kappa coefficients between .70 and .85 have also been achieved in previous studies (Benjamin et al., 1986).

Levels of client perceptual processing classification system (Toukmanian, 1986; Toukmanian & Gordon, 2004). The LCPP, a seven-category coding system, evaluates clients' processing of in-session experience (i.e., analyzing, organizing, and conveying thoughts and feelings), as opposed to the content of their discourse (Toukmanian, 1986; Toukmanian & Gordon, 2004). Seven mutually exclusive categories defining different mental operations are used to rate client discourse: (1) recognition, (2) elaboration, (3) externally focused differentiation, (4) analytic differentiation, (5) internally focused differentiation, (6) re-evaluation, and (7) integration. With Levels 1 and 2, an automated, habitual, undifferentiated, nonreflective manner of processing self or other experience is depicted. Levels 3 and 4 involve a more controlled but restricted mode of processing, as certain domains of experience are processed in client meaning making. Clients differentiate external aspects of experience or employ external frames of reference to construct meaning. Levels 5, 6, and 7 suggest a controlled mode of processing involving greater differentiation and integration of internal experience associated with self and other meaning structures. More flexible and adaptive responding at these levels promotes self and other schematic change. Mode scores are used for the purpose of this study. Inter-rater reliability for kappa range from .68 to .88 (Day, 1995; Levitt & Angus, 1999). The LCPP is sensitive to expected changes in clients' manner of in-therapy processing from early to late therapy in experiential and psychodynamic therapies (Toukmanian & McKee, 1998) and has been associated with symptom reduction (Missirlian et al., 2005).

Emotionally focused couple therapy coding scale (Bradley & Furrow, 2004). The EFT-CS was used to identify therapist interventions within each of the AIRM steps. The scale was devised to code EFT interventions used in EFT couple therapy. It consists of various codes that represent both experiential and systemic interventions in EFT. Bradley and Furrow (2004) reported kappa coefficients of .83 to .92 using the EFT-CS and construct validity when correlated with the Classification System for Counseling Responses.

Procedure

Transcript segment selection for rating. The primary researcher, who had previous training and experience with study process measures and the AIRM, was initially blind as to whether couples were resolved or nonresolved when reviewing audiotapes. All AIRM outcome study audiotapes were listened to by the primary researcher to identify steps until no more steps could be found and until no more sessions were available. Once a step was identified on the audiotape, a boundary of 4-minute segments was set for transcription. Transcribed therapy talk turns representing model components were identified and reviewed by an EFT expert clinician. The researcher and EFT expert clinician had to agree that the selected dialogue sequences were representative of a model component to be included in the study. Transcribed segments of steps were then given to independent raters in random order for rating.

Raters and reliability. Three clinical psychology graduate students were trained using process measure training manuals and standardized training procedures to rate therapy talk turns using the process measures (i.e., ES, SASB, LCPP). Raters were trained using practice segments and discussions of ratings until satisfactory reliability was achieved (i.e., kappa coefficient $\geq .70$ for LCPP and SASB, and intra-class correlation coefficient $\geq .80$ for ES). Talk turns were segmented according to unitizing rules set out in manuals for each measure. Peak scores were used for the ES, and modal ratings were used for the LCPP and SASB. Coders' mean scores were used when there were discrepancies between ratings. Two of the three trained raters coded each measure. For the EFT-CS, two clinical graduate students trained in EFT coded sample transcripts until a kappa coefficient $\geq .70$ was obtained. All therapist talk turns within each component were coded.

RESULTS

Inter-rater reliability coefficients exceeding acceptable standards were established for all three process measures and the EFT-CS. An intra-class correlation coefficient of .82 was achieved for the ES. A kappa coefficient of .72, .73, and .78 was achieved for the LCPP the

SASB cluster, and quadrant ratings, respectively. Inter-rater reliability for the EFT Coding Scale (EFT-CS) reached a kappa coefficient of .83.

Table 1 provides an overview of ratings of Steps 1–8 in terms of empirical criterion (e.g., the presence or absence of a step) in resolved versus nonresolved cases. As predicted, during earlier stages of the (AIRM; Steps 1–4), cycle de-escalation of the injury-specific cycle, each couple partner's manner of engagement involves lower levels of experiential involvement, automatic modes of perceptual processing, and nonaffiliative responding as partners remain stuck in an injury-specific, rigid, interaction cycle fueled by secondary emotional responses. From Phase

Table 1 Occurrence of Components in Resolved and Nonresolved Events				
Empirical criterion	Presence or absence of step	Resolved	Nonresolved	<i>p</i>
ES = Level 3; SASB 1-6, 1-7; LCPP ≤ Level 2	Step 1			1.00
	Present	8	9	
	Absent	1	0	
ES = Level 2; SASB 1-8, 2-7, 2-8; LCPP ≤ Level 2	Step 2			.47
	Present	7	9	
	Absent	2	0	
ES = Level 3; SASB 1-6, 1-7, 2-1; LCPP ≥ Level 3 ≤ 4	Step 3			.08
	Present	9	5	
	Absent	0	4	
ES ≤ Level 3; SASB 2-7, 2-8; LCPP ≥ Level 3 ≤ 4	Step 4			.13
	Present	8	4	
	Absent	1	5	
ES ≥ Level 4; SASB = 2-2; LCPP ≥ 5	Step 5			.00*
	Present	9	1	
	Absent	0	8	
ES ≥ Level 4; SASB = 1-2, 2-2; LCPP ≥ 5	Step 6			.00*
	Present	9	0	
	Absent	0	9	
ES ≥ Level 5; SASB = 1-2, 2-1, 2-2, 2-4; LCPP ≥ 5	Step 7			.00*
	Present	7	0	
	Absent	2	9	
ES ≥ Level 5; SASB = 1-2, 1-3, 2-2; LCPP ≥ 5	Step 8			.00*
	Present	7	0	
	Absent	2	9	
<i>*p</i> < .05.				
<i>Note.</i> ES = Experiencing Scale (1 = refusal to participate, 2 = behavioural/intellectual self-descriptions, 3 = personal reactions with limited self-descriptions, 4 = description of feelings and personal experiences, 5 = problems or propositions about feelings and personal experiences, 6 = felt sense of an inner referent, 7 = series of felt senses connecting the content); LCPP = Levels of Perceptual Processing Classification System (1 = recognition, 2 = elaboration, 3 = externally focused differentiation, 4 = analytic differentiation, 5 = internally focused differentiation, 6 = re-evaluation, 7 = integration); SASB = Structural Analysis of Social Behaviour (Quadrant 1 or 4—1-2 affirming and understanding, 1-3 nurturing and comforting, 2-1 asserting, 2-2 disclosing and expressing, 2-4 trusting and relying; Quadrant 2 or 3—1-6 belittling and blaming, 1-7 attacking and rejecting, 1-8 ignoring and neglecting, 2-7 protesting and withdrawing, 2-8 walling off and avoiding).				

I to Phase II of the AIRM for resolved partners, there is a critical shift in clients' manner of engagement at Step 5 of the AIRM.

In Phase II, increasing injured partner emotional accessibility is reflected in the injured partner's softer stance in relation to the injury. This softer stance is captured by process measures in terms of deeper experiential involvement, a more reflective, differentiating, and integrating mode of perceptual processing and more affiliative responding. The responsiveness of the injuring partner is also marked by a similar manner of engagement. Resolvers were able to complete Steps 5 and 6, in which new cycles of engagement related to the injury are created. However, nonresolved partners did not engage in such a way as to facilitate the completion of performance tasks in Phase II.

Optimal client in-session process associated with injury resolution involves a deepening of emotional involvement, more controlled and deliberate modes of perceptual processing, and more affiliative responding. This client manner of engagement coincides with partners differentiating and integrating primary attachment-related emotions and needs and engaging on this basis. In Phase III, consolidation of the bond in Steps 6 and 7, resolved couple partners continue to be experientially and emotionally involved in therapy, internally focused, re-evaluative, and integrative in their construal of experience related to the incident. More trusting interpersonal responses emerge as the injured partner shares attachment needs and the offending partner responds to these expressions.

In terms of hypotheses concerning model validation, using Fisher's exact test, there was a significant difference between resolved and nonresolved groups ($p < .01$) in the presence of Steps 5, 6, 7, and 8. As expected, the first two steps were present in both resolved and nonresolved cases. Steps 3 and 4 did not discriminate resolved and nonresolved cases as predicted, which suggests some of the nonresolved partners were able to de-escalate their injury-specific rigid, interaction cycle momentarily.

Interventions Used in Successful Cases of Injury Resolution

Frequency percentages of interventions employed at each step of the AIRM were identified by the EFT-CS for resolved couples (see Table 2). The most frequently used interventions (>10%) are identified to help facilitate clinical decision-making in terms of intervention options. In Phase I of the AIRM, EFT therapists used interventions common to cycle de-escalation in traditional EFT. In Steps 1 and 2 in this study, secondary emotion reactions were reflected and validated, and the defensive cycle tracked and reflected. The EFT therapist used a wide variety of interventions to unpack secondary emotional reactions and fears of processing more vulnerable emotions in Steps 3 and 4 of the AIRM. Secondary reactions were reframed to help the injured partner understand his or her attachment needs and concerns related to the injury. Empathic conjecture and interpretations about partners' emotional experience were also employed to facilitate partners' accessing of underlying emotional signals of distress related to attachment fears, loss, and sadness associated with the incident. Evocative responding and heightening interventions were used to access primary emotion and needs underlying each partner's position in the injury-specific cycle. Newly experienced primary emotional responses were reflected and validated, but not fully explored until Step 5.

In Phase II and III of the AIRM, EFT therapists used similar interventions to traditional EFT to promote a softening change event. In Step 5 of the AIRM, the therapist focused on processing the injured partner's primary emotional experience related to the injury. Evocative responding and heightening interventions were used to deepen experiential involvement and exploration of attachment-related emotion. Restructuring and shaping interactions were used to promote engagement on the basis of these expressions. Offending partners were supported to engage and reach out to the injured partner in an emotionally engaged manner in Step 6. Primary emotional expressions (i.e., regret, remorse) were supported through evocative responding, heightening, and reflections. Restructuring and shaping interactions were used to invite the offending partner to interact with the injured partner on the basis of these emotional experiences. Present and changing positions were heightened as partners entered into new cycles of engagement related to the injury. The therapist further supported the offending partner to

Table 2 <i>Therapist Focus and Percentage Frequencies of EFT Interventions</i>		
AIRM step	Therapist focus	EFT intervention
Step 1	Processing injured partner's account	Empathic reflection of secondary emotion reactions (31%); Validation of client emotional realities (36%); Track and reflect (20%); Other (13%)
Step 2	Processing offending partner's response and account	Empathic reflection of secondary emotion reactions (29%); Validation of client emotional realities (40%); Track and reflect (24%); Other (7%)
Step 3	Unpacking injured partner's secondary emotion reactions and accessing attachment significance of the injury	Reframing in the context of the cycle and/or underlying attachment emotion and needs (11%); Empathic conjecture, interpretation, inferences (14%); Evocative responding (27%); Heightening (14%); Validation of client emotional realities (15%); Empathic reflection of secondary emotion reactions (10%); Other (9%)
Step 4	Unpacking secondary emotion reactions and promoting withdrawer's accessibility to the attachment significance of the event for the injured partner	Reframing in the context of the cycle and/or underlying attachment emotion and needs (13%); Empathic conjecture, interpretation, inferences (13%); Evocative responding (28%); Heightening (16%); Validation of client emotional realities (15%); Reflection of underlying attachment-related emotions (11%); Other (4%)
Step 5	Processing injured partner's primary attachment-related emotional experience and expression to the offending partner	Empathic reflection of underlying attachment-related emotions (28%); Evocative responding (24%); Heightening (24%); Restructuring and shaping interactions (16%); Other (8%)
Step 6	Processing offending partner's primary emotional responses (i.e., sadness, remorse, regrets, emotional empathy for injured partner) and promoting offender's expression of responsibility and apology	Empathic reflection of underlying attachment-related emotions (24%); Evocative responding (26%); Heightening (24%); Restructuring and shaping interactions (18%); Other (8%)
Step 7	Processing injured partner's accessibility and responsiveness (i.e., acceptance of apology, empathy for offending partner's emotional experience) and expression of attachment needs related to the injury	Empathic reflection of underlying attachment-related emotions (40%); Restructuring and shaping interactions (38%); Validation of client emotional realities (13%); Other (9%)

Table 2 <i>Continued</i>		
AIRM step	Therapist focus	EFT intervention
Step 8	Processing offending partner's responsiveness to the injured partner's expression of need	Empathic reflection of underlying attachment-related emotions (42%); Restructuring and shaping interactions (42%); Validation of client emotional realities (12%); Other (6%)
AIRM = Attachment Injury Resolution Model. <i>Note.</i> Experiential interventions (empathic reflection of secondary emotion reactions, empathic reflection of underlying attachment-related emotions, validation of client emotional realities, evocative responding, heightening, empathic conjecture, interpretation, inferences); systemic interventions (track and reflect, reframing in the context of the cycle and/or underlying attachment emotion and needs, restructuring and shaping interactions).		

express responsibility and invited the offending partner to offer some type of response to the injured partner, including an apology.

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

DISCUSSION

Process of Forgiveness and Reconciliation

The steps of the AIRM were validated in this psychotherapy process study. The active ingredients of therapy presumed by EFT and attachment theory are the injury softening process that occurs in Steps 5 through 8 in the AIRM. Resolved couples completed the process steps in the expected manner. Critical shifts in engagement were captured by process measures. Partners processed primary emotions related to an injury in a highly emotional, differentiating, integrating, and affiliative manner. These shifts are critical in client engagement and have been associated with the softening process and positive outcomes in EFT (Johnson & Greenberg, 1988). The injury-specific softening process involves emotional processing of attachment-related emotions and needs for care and support and offending partner responsiveness to these core signals. This process facilitates emotional accessibility and responsiveness, which is crucial to restoring the offending partner and the relationship as a potential safe haven (Davila, Karney, & Bradbury, 1999; Johnson, 2008). These interactions are believed to be the building blocks of more secure attachment bonds (Bowlby, 1988). Partner responsiveness to the injured partner's emotional pain and attachment distress appears to serve as an antidote to the rupture in the bond and promote forgiveness and reconciliation. New cycles of emotional engagement related to the injury promote greater trust, relationship satisfaction, and forgiveness in resolved partners (Makinen & Johnson, 2006).

Nonresolved partners were unable to engage in therapy in a manner that enabled them to complete the performance tasks required for injury resolution. Contrary to study hypotheses

that assumed that de-escalation would not occur (i.e., Steps 3 and 4), some nonresolved partners were able to de-escalate their injury-specific cycle. However, they were unable to move through to Step 5, the beginning of the injury-specific softening process. Nonresolved partners' manner of engagement was mostly emotionally detached and reactive, the incident was processed in an automatic and habitual mode, and interpersonal responses were nonaffiliative. The primary emotional engagement required for resolution was impeded, and the injury remained unresolved.

The present study affirms the significance of attachment–caregiving interactions that involve emotional accessibility and responsiveness. These interactions appear to be the active ingredients underlying client change that promote forgiveness and reconciliation in resolved couples in EFT. This emphasis on attachment-related interactions is in contrast to a recently proposed model of forgiveness using emotion-focused therapy for couples, which is less attachment oriented and lacks a systemic approach to resolving attachment injuries and hurt in romantic relationships (Woldarsky Meneses & Greenberg, 2011). Forgiveness and reconciliation require that injured partners experience an internal experiential shift toward the offending partner (Enright & Coyle, 1998). An injury-specific softening process promoted such a shift in resolved partners. Without these interactions, couples are vulnerable to ongoing attachment distress when lingering unprocessed hurts and fears continue to seep into the relationship. In the AIRM, deep emotional experiencing and confiding lead to congruent apologies focused on the injury. This experiencing and confiding are the primary means by which the injured partner's emotional pain is healed. Attachment-oriented responsive interactions further promoted reconciliation, a restoration of an emotional connection (Rusbult, Hannon, Stocker, & Finkel, 2005) and relational trust (Haaken, 2002).

AIRM EFT Interventions

Process research was employed to link therapist foci at each step of the AIRM to EFT interventions. Experiential and systemic interventions enable the restructuring of attachment interactions and bring partner's attention to new cycles of engagement based on primary emotions and needs. Identifying clinical interventions associated with successful task resolution supports clinicians in promoting forgiveness and reconciliation of attachment injuries. This study suggests that EFT can be implemented in a systematic manner by linking client performance tasks with therapist interventions in the AIRM. Linking client process and therapist interventions in process research provides a systematic blueprint for clinicians to resolve cognitive–affective problems, such as an attachment injury (Johnson & Lebow, 2000; Pinsof & Wynne, 2000).

Interventions used to initiate and complete the injury-specific softening process were similar to those found in the general EFT model (Bradley & Furrow, 2004). In Steps 3 and 4 in the AIRM, the EFT therapist implemented a wide range of interventions to de-escalate the injury-specific cycle and begin to access primary vulnerable emotions. Key interventions used in Steps 5 through 8 to enter into the injury-specific softening process included reflection of primary emotion, evocative responding, and heightening. These interventions seem to facilitate deeper emotions and promote a more controlled mode of processing key primary emotional signals and attachment needs. EFT restructuring interventions and heightening were used to facilitate new cycles of engagement involving primary emotional responses. In Steps 7 and 8, offending partners were invited to respond to attachment needs and concerns about the injury at an emotional level. Primary attachment–related emotions and needs were reflected and interactions structured so that these needs are expressed in such a way as to elicit responsiveness. These interventions promoted new cycles of positive engagement and facilitated completion of the injury-specific softening.

General Discussion

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

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

The findings from this study may further expand current knowledge of the injury-specific softening process in resolved couples. A controlled mode of processing primary attachment-related emotions during the softening process seems to facilitate a more deliberate focused exploration of primary inner emotional experience and needs. This exploration may facilitate self and other schematic change (Toukmanian & Gordon, 2004). Research suggests that primary emotional processing and controlled modes of processing are associated with positive EFT outcomes and reduced depression symptoms (Missirlian et al., 2005).

Process research findings in this study contribute to an understanding of how clients engage in-session when an attachment injury has taken place and remains unhealed. Steps 1–4 are associated with reducing secondary reactive processing and self-protectiveness, anxious preoccupation, and emotional avoidance related to the injury. Nonresolved clients were self-protective, showed lower experiential involvement, processed information about the injurious incident in an externally focused manner, and responded in a nonaffiliative manner. Theoretically, insecure attachment resulting from multiple attachment injuries may impede access and exploration of internal experience. Sufficient emotional safety may be required for the injured partner to turn their attention inward toward core adaptive attachment-related emotional signals. In a successful injury-specific softening process, an EFT therapist is able to create emotional safety between partners and guide an injured client to tolerate and deepen their experience of an injury.

Process research findings further suggest that clients who initiated and completed an injury-specific softening process were engaging in-session in a manner associated with attachment security (Mikulincer, 1997). A shift from secondary reactive to deeper emotional processing of the incident is required. Clients who completed Steps 5–8 became increasingly flexible in their processing of a wide range of internal information, including attachment emotions and needs. Increased cognitive flexibility during this process was captured by the LCPP (Toukmanian & Gordon, 2004). Attachment security has been associated with cognitive flexibility (Main, 1991), and the ability to attend to and integrate new information with greater empathy (Mikulincer, 1997). Finally, more affiliative responses captured in the softening process suggest that resolved partners became increasingly more nurturing, comforting, trusting, and relying as measured by the SASB (Benjamin et al., 1986). These types of interpersonal responses on the SASB have also been associated with greater attachment security (Neumann & Tress, 2007).

Limitations and Next Steps

This process study has several limitations. By virtue of the intensive and lengthy nature of task analysis, a smaller sample size was used. As a result, particular types of injuries may have been underrepresented. In addition, nuances in the process of change between different types of attachment injuries were not noted in this study, but warrant further investigation. The external validity of this study is also limited as all couples were heterosexual, the majority were Caucasian, and most injured partners were women (79%). Gender and working models of attachment have been found to interact to predict forgiveness (Kachadourian, Fincham, & Davila, 2005), suggesting that there may be gender differences in the process of change and path to forgiveness. The change process may also differ on the basis of whether negative working models of attachment were reinforced by the attachment injury.

Study findings related to EFT interventions are also limited. Findings highlight frequency of use of interventions within each category across couples. However, infrequently used interventions may have contributed to the resolution of an attachment injury. Although the frequency of interventions used varied between therapists and couples, the interventions identified still provide a systematic framework for clinical training. Moreover, interventions within a step cannot be said to cause critical shifts, but do appear to facilitate a particular manner of processing that promotes resolution of the task at hand.

The client change process outlined in this study warrants further investigation to define performance tasks using other process measures. In addition, further review of audiotapes of

couple therapy sessions may uncover additional steps in the resolution path. Further research should investigate nonresolved cases and in-session therapist behaviors that may have contributed to difficulties in performance task completion. From a task analysis perspective, additional research should investigate potential different components and resolution paths with diverse populations (e.g., across race, or with gays and lesbians) and differences between gender, and explore whether anxiously attached versus avoidantly attached partners show variations in the AIRM process.

CONCLUSION

Couples beleaguered by an attachment injury often experience intense emotional reactions that are not easily relinquished. EFT appears to promote partner accessibility and responsiveness to deeper emotions and needs related to attachment injuries. An injury-related softening process within the AIRM is essential to healing these painful emotional injuries and moving couples toward forgiveness and reconciliation. Interventions that facilitate the deepening of emotional experience and processing of core emotional signals, including attachment needs, were also identified and provide a guide to healing these injuries.

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