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Enactments, Outcome, and Marital Therapy: A Pilot Study

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Enactments, Attachment, and Outcome in Marital Therapy: A Pilot Study

by

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As chair of the candidate's graduate committee, I have read the thesis of Cari Bacon Mitchell in its final form and have found that (1) its format, citations, and bibliographical style are consistent and acceptable and fulfill university and department style requirements; (2) its illustrative materials including figures, tables and charts are in place; and (3) the final manuscript is satisfactory to the graduate committee and is ready for submission to the university library.

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Abstract

Unfulfilled attachment related needs and wants are viewed by many therapists as the heart of couple distress (Johnson & Whiffen, 2003; Johnson, 2004). As a result, efforts to discover and utilize therapeutic processes that encourage couples to identify and appropriately respond to their partner's core attachment needs and wants continue to increase. This study served as a pilot study for a planned, larger-scale investigation examining enactments as a potential best-practice change mechanism to strengthen secure attachment in marital therapy. Twelve couples were randomly assigned to one of two possible experimental groups. Group 1 experienced three therapist-centered therapy sessions, followed by three enactment-centered sessions. Group 2 experienced three enactment-centered sessions followed by three therapist-centered sessions. Before each experimental session, both spouses independently completed a measure assessing their attachment security to their spouse over the past week. After each experimental session, both spouses independently completed a measure assessing how their attachment security to their spouse changed during the session. Each participant's scores were averaged and analyzed descriptively to explore possible trends and trajectories regarding the relationship between an enactment-focused clinical process and secure attachment and how it compared to a therapist-centered clinical process. The results of this pilot study provide preliminary support of enactments as an effective treatment protocol for therapists to help couples strengthen their secure attachment. Findings revealed trends suggesting that enactment-focused therapy sessions tended to increase overall couple secure attachment, perhaps superior to that of a solely therapist-centered approach.

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Introduction

"The business of couple therapy is essentially the business of addressing the security of attachment bonds" (Johnson, 2004, p. 37). Unfulfilled attachment related needs and wants are viewed by many therapists as the heart of couple distress (Johnson & Whiffen, 2003; Johnson, 2004). As a result, efforts to discover and utilize therapeutic processes that encourage couples to identify and appropriately respond to their partner's core attachment needs and wants continue to increase.

Enactments are one change mechanism therapists use to help couples learn to identify and better fulfill each other's attachment needs. Enactments provide intervention in behalf of couples' interaction process by facilitating couples to interact directly with each other, with guidance when necessary, instead of with the therapist. The therapist carefully coaches the interaction process, helping the couple develop new, healthier interaction patterns (Butler & Gardner, 2003). More disclosing, responsive interactions emerge which increase couples' attachment security—the foundation for overcoming and avoiding personal and couple distress (Johnson, 2004; Butler & Gardner, 2003). While enactment advocates propose that appropriately conducted enactments strengthen secure attachment, minimal direct empirical research (cf. Andersson, Butler, & Seedall, 2006; Butler & Wampler, 1999; Seedall & Butler, 2006) exists to support the theoretical claims. This study was a pilot test for a larger study which aims to quantitatively test the efficacy of enactments as a means of enhancing couples' sense of secure attachment and whether they are an important clinical operation for promoting couples' attachment security.

Review of Literature

Relationship Between Couples' Attachment Behaviors and Therapy Outcomes

Most significant relationship issues center around the security of the attachment bond between couples and their struggle to view the relationship as a safe and secure base (Johnson, 2003a). A secure couple attachment bond is recognized as an "active, affectionate, reciprocal relationship in which partners mutually derive and provide closeness, comfort, and security" (Johnson, Makinen, & Millikin, 2001, p. 145). Dimensions of secure attachment are related to more positive outcomes in couple therapy (Johnson & Greenberg, 1988; Johnson, 2004; Andersson, et al., 2006). For example, softening (Johnson & Talitman, 1997; Andersson, et al., 2006), open emotional expression (Feeney, 1995, 1999a; Johnson & Greenberg, 1988; Johnson, 2004), high levels of self-disclosure and the ability to elicit self-disclosure from one's partner (Keelan, Dion, & Dion, 1998), commitment, trust, and relationship satisfaction (Zitzman & Butler, 2005; Schachner, Shaver, & Mikulincer, 2003) are all dimensions of secure attachment that are empirically linked to better outcomes.

However, insecure attachment bonds are related to numerous harmful effects on couples' relationships. Relationship distress, negative relationship satisfaction and poorer therapy outcomes are all related to insecure attachment bonds (Schachner, Shaver, & Mikulincer, 2003; Davila, 2003). For example, couples who lack soothing and supportive responses and who feel that their relationship is not a safe place for emotional engagement experience severe relationship distress and potential for divorce (Gottman, 1994; Gottman, Coan, Carrere, & Swanson, 1998; Pasch & Bradbury, 1998). The isolation, separation, or disconnection from a partner that accompanies couples' feelings

of insecure attachment is inherently traumatizing and often accompanied by feelings of depression and anxiety (Johnson, Makinen, & Miliken, 2001). Couples without a secure bond often have one or both partners who suffer from a more negative view of self and partner while those who feel securely attached to their partners tend to have a more positive, coherent sense of self and personal identity (Mikulincer, 1995). The significant, empirically supported impact of attachment-related issues on therapy outcomes reveals the necessity for couple therapists to centralize their efforts around helping couples strengthen the security of their attachment bonds (Johnson, 2003a).

Adult Attachment Theory as a Means to Understand Change in Couple Relationships

Adult attachment theory provides a frame of reference that clarifies the relationship between couples' attachment issues and therapy outcomes (Johnson & Whiffen, 2003; Johnson, et al., 2001). The theory applies Bowlby's infant-caregiver attachment theory to adult romantic love relationships—or *pair bonds*, as evolutionary psychologists call them (Hazan & Zeifman, 1999). Bowlby's theory proposes that infants' attachment to primary caregivers influences their perception of self and others throughout life, especially in close relationships (Bowlby, 1988). Infants thrive in secure relationships with primary caregivers but can suffer emotional and social consequences into adulthood if denied secure attachment bonds during infancy. Ample research supports Bowlby's theory and now leads researchers to study its application to adult relationships as well (Cassidy & Shaver, 1999).

Adult attachment theory, consistent with Bowlby's theory, recognizes the importance of bonds formed between children and their caregivers and that attachment behavior plays a vital role throughout life (Feeney, 1999b). However, adult attachment

theory focuses on the importance of attachment bonds between adults in pair-bond relationships. It conceptualizes pair-bond connection as an attachment process that is influenced in part by earlier experiences with caregivers but also as a process that can change through learning and growth in relationships (Johnson, 2003b; Cassidy & Shaver, 1999).

Adult attachment theory maintains that numerous features of attachment process evident in infant-caregiver bonds also apply to marital and committed non-marital pair-bond relationships. In such relationships, adults derive comfort and security from their partner, want to be with their partner (especially during stressful times), and become distressed when their partner is unavailable—emotionally or otherwise—or threatens to become unavailable. Corresponding with Bowlby's theory, adult attachment states that a core human need is to have a secure emotional connection—an attachment—with significant others. Accessibility and responsiveness of a trusted other leads to greater social and emotional adjustment, more fulfilling intimacy, and catalyzes adult generativity (just as it enables exploration in infants). In romantic relationships, a secure couple attachment occurs when couples enjoy safe, emotional engagement and responsiveness. However, when emotional connection is threatened or lacking, couples' relationships deteriorate as does their overall functioning and generativity in life (Butler & Seedall, 2006; Butler, Seedall, & Harper, in press; Zitzman & Butler, 2005). It is this threatened or lacking emotional connection, and the fear of loss, isolation, and rejection that accompany it, that often serve as the primary issues couples bring to therapy (Johnson, 2003b). Therapists can help couples create a secure attachment of safe, emotional connection and responsiveness by helping couples improve how they "deal

with their emotions, process and organize information about the self and others, and communicate with loved ones" (Johnson, 2004, p. 36).

Emotionally focused therapy, an empirically validated therapy model (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Johnson, Hunsley, Greenberg, & Schindler, 1999; Johnson, 2004), is based entirely on helping couples learn to identify, express and properly fulfill each other's core attachment needs and longings. Focusing on attachment issues has enabled EFT to provide significant short and long-term positive outcomes in couple therapy (Johnson, et al., 1999; Clothier, Manion, Gordon-Walker, & Johnson, 2002). Its success has also awakened the attention and interest of therapists employing other models and led them to investigate attachment theory as a means for understanding and aiding couple change (Davila, 2003; Johnson & Whiffen, 2003).

Mounting evidence indicates that analyzing and assessing adult relationships through an attachment lens clarifies why couples experience distress and how to help them prevent and overcome it (Johnson, et al., 2001; Johnson & Whiffen, 2003). However, there is still need for further research demonstrating specific ways therapists can effectively promote secure attachment.

Enactments as an Effective Change Mechanism in Enhancing Couples' Sense of Secure Attachment

Enactments are one change mechanism used to promote and improve couples' emotional engagement and responsiveness, and are suggested by some as a possible common factor and best-practice in successful couple therapy (Butler & Bird, 2000; Butler & Gardner, 2003, Butler & Wampler, 1999; Minuchin & Fishman, 1981). Enactments consist of face-to-face couple interaction that is carefully guided by the

therapist. Though commonly used in a variety of relationship therapies (e.g., EFT, structural therapy, narrative therapy, behavior marital therapy), empirical investigations of the effectiveness of enactments (Butler & Wampler, 1999), and more specifically their utility in promoting couples' secure attachment, remain few (cf. Andersson, Butler, & Seedall, 2006; Seedall & Butler, 2006). The current study served as an initial pilot study to a larger empirical investigation of enactments as a means of enhancing couples' sense of secure attachment and to determine whether it is a defining clinical operation that is essential to promoting couples' attachment security.

Marriage and family therapists utilize relationships to bring about change in family processes. Recent therapeutic advances suggest that enactments are an effective means for change in couple therapy (Allen-Eckert, Fong, Nichols, Watson, & Liddle, 2001; Andersson, et al., 2006; Butler & Wampler, 1999; Butler & Bird, 2000; Butler & Gardner, 2003; Davis & Butler 2004; Nichols & Fellenberg, 2000)—independent of theory, model, or problem (Butler & Bird, 2000).

As previously defined, enactments consist of face-to-face couple interaction that is carefully guided by the therapist. The therapist coaches the couple to interact in a manner that promotes the sharing of emotions, partner softening and responsiveness, and the expression of attachment needs (Anderson, et al., 2006; Butler & Seedall, 2006; Johnson, 2004; Kerr & Bowen, 1988; Seedall & Butler, 2008). Couples are thus enabled to acknowledge and process emotion with the purpose of building secure attachment. As couples interact, therapists are able to identify couples' "functional and dysfunctional relationship processes and to engage the couple in a process of *experiential* discovery of the nature and consequences of their interaction patterns" (Butler, 1996, p. 28, emphasis

added). Couples' attitudes, attributions, emotions, and attachment are hypothesized to undergo deeper shifts or changes as they learn to improve their interaction patterns through enactments (Butler & Gardner, 2003).

As partners learn to identify, express and respond to each other's emotions and attachment needs, their attachment bonds are strengthened through their immediate experience in therapy. Consequently, couples better understand and perceive themselves, their partners, and their relationship. Enactments thus become an effective means through which couples are empowered to create the safe, secure connection necessary for secure attachment.

Empirical Support for Enactments' Effectiveness in Couple Therapy Outcomes

Many diverse therapy models embrace the use of enactments because of their efficacy in assisting couples to overcome distress. Emotionally focused therapy (EFT), an empirically supported treatment (Johnson, et. al., 1999), utilizes enactments to urge couple expression of and responsiveness to primary emotions and attachment needs with the intent that more positive, attachment-anchored interaction styles will develop (Johnson, 2004). Behavioral marital therapy, another empirically supported treatment, uses enactments to improve communication and conflict resolution skills such as listening or speaking non-defensively (Jacobsen, 2001). In marital enrichment programs such as Relationship Enhancement (RE), enactments are used for training new relationship skills (Scuka, 2005). Narrative couple therapy also incorporates enactment-like processes as they encourage couples to re-story their relationships and problems together (Brimhall, Gardner, & Henline, 2003). Structural couple therapists employ

enactments for clinical assessment purposes and to redirect the structure of family interactions (Keim & Lappin, 2002; Minuchin & Fishman, 1981; Simon, 1995)

Though widely endorsed by diverse therapy models, few empirical studies exist to show the relationship of enactments to therapy outcomes. However, the little empirical evidence to date indicates that enactments may indeed enhance couple therapy outcomes. A recent study investigating therapeutic processes that aid couples recovering from husband's addictive use of pornography found that enactments are effective for promoting couple self-reliance, healing and softening (Zitzman & Butler, 2005). After completing conjoint therapy for sexual addiction, each participating couple answered open-ended questions in an hour-long, structured interview. Questions followed a question-probe pattern that encouraged couples to relate the therapeutic processes which they found most helpful. All interviews were tape-recorded, transcribed, coded and analyzed. Couples specifically reported enactments as one of the most beneficial aspects of their therapeutic experience.

A study investigating proxy-voice (Seedall & Butler, 2006), a specific subcomponent of enactments, found further evidence supporting enactments. Proxy-voice occurs when the therapist briefly interrupts a relationship enactment—where the couple directly interacts with each other—to offer his/her proxy voice on behalf of the latent emotion and attachment experiences that the client struggles to recognize and articulate. The therapist listens "below" the superficial content of what the client is saying to identify the underlying primary emotion and attachment needs. The therapist then reframes what he/she hears the client saying in terms of primary emotion and attachment language and then encourages the client to turn and do the same with his or her partner.

Therapists may also provide "proxy listening" in the context of relationship enactments by helping an attending/listening spouse "hear" or recognize their partner's underlying primary emotions and reframe their words and meaning at a deeper attachment level. The therapist reframes clients' experience into primary emotion and attachment needs and then suggests that clients turn to their partner and attempt to do the same. In this manner, the therapist helps the client recognize and express primary emotion and link it to attachment. The study's results showed that proxy-voice (utilized during enactments) was inversely related to couple withdrawal and negativity and positively associated with couple softening (the ability to be receptive to one's partner's emotional and attachment expressions and to express his or her own in softer terms that invite closeness). Andersson et al. (2006) also found empirical support suggesting that appropriately conducted enactments are an effective tool for fostering client softening—even among more volatile couples. Butler and Wampler (1999) found that enactments not only predicted couples' increased sense of responsibility for their own therapeutic progress, but that enactments were also linked to more successful outcomes than those achieved by a therapist-centered approach.

Enactment versus Therapist-Centered Treatment Process

While enactments are viewed by some as just one of many stylized interventions used to promote successful change in couple therapy, some therapists consider enactments as a defining clinical operation that is essential to promoting healthy interaction patterns, relationship connection, and attachment security (Butler & Gardner, 2003; Butler & Bird, 2000). As explained previously, enactments are "therapist behaviors which stimulate and guide couple interaction as opposed to channeling interaction

through the therapist" (Butler, 1996, pp. 27-28). Consequently, couples are empowered to develop more healthy communication patterns, self-reliantly work through problems, and express and respond to emotions in a safe and secure manner (Butler & Wampler, 1999). Another treatment benefit enactments provide is that they encourage and increase couple participation and involvement during therapy. Substantial research related to different therapeutic models (e.g., behavioral marital therapy, Jacobson, 2001; emotionally-focused therapy, Johnson, 2004; narrative therapy, Brimhall, Gardner, & Henline, 2003) as well as research on therapy process generally suggests that client participation and engagement are essential elements for successful therapy (Butler & Bird, 2000; Butler & Wampler, 1999).

Conversely, therapist-centered approaches—characterized by therapist responsible patterns such as interaction channeled through the therapist, therapist interpretation and direct instruction—are linked to less successful clinical outcomes (Butler & Wampler, 1999; Chamberlain, et al., 1984; Butler & Bird, 2000; Shields, Sprenkle, & Constantine, 1991). Specifically, therapist behaviors that primarily channel in-session interaction through the therapist predict increased therapist-client struggle (Butler & Bird, 2000; Butler & Wampler, 1999; Patterson & Forgatch, 1985; Patterson & Chamberlain, 1988). Therapist interpretation along with general verbal activity level and confrontation are linked to treatment dropout (Postner, Guttman, Sigal, et al., 1971; Miller, Benefield, & Tonigan, 1993). Direct instruction, which includes therapist teaching, directives, and advice giving, is also associated with negative clinical outcomes (Beutler, 1994; Patterson & Forgatch, 1985; Patterson & Chamberlain, 1988). Gottman and Gottman discovered similar results and further warn that making the therapist

"irreplaceable . . . may maximize the couple's relapse once therapy terminates" (p. 310). Thus, a therapist-centered process may temporarily contain and structure interaction for volatile couples (Kerr & Bowen, 1988) but ultimately appears to be counterproductive and disempower couples' ability to progress toward successful and self-reliant interaction.

The appropriate use of enactments specifically guards against harmful therapist-centered behaviors and their related negative outcomes. For example, as noted earlier, Butler and Wampler (1999) found that enactments not only related to couples' greater sense of responsibility for their own therapeutic progress, but also predicted superior outcomes compared to those achieved by a therapist-centered approach. Twenty-five couples were exposed to couple-responsible verses therapist-responsible episodes during one therapy session. Couple-responsible episodes were defined by (1) the use of enactments to enable couple interaction and emotional connection, (2) accommodation to couple's worldview and interaction style, and (3) inductive processes for promoting self-reliant problem-solving. Therapist-responsible episodes were defined by (1) interaction primarily channeled through the therapist, (2) therapist interpretation, and (3) direct instruction. Immediately following the session, couples reviewed their videotapes and completed measures of responsibility, struggle, and cooperation. Results showed that couples' significantly perceived their responsibility as higher and their therapy resistance as lower during the enactment-based, couple-responsible episodes. The findings confirm that couples prefer a clinical process characterized primarily by couple interaction, as facilitated through enactments, to a primarily therapist-centered process. It also indirectly shows enactments' effectiveness in promoting optimal couple therapy outcomes.

The Effective Execution of Enactments

While enactments are endorsed by many relational therapies, the success of enactments depends on how effectively they are conducted (Nichols & Fellenberg, 2000; Andersson et al. 2006; Butler, Davis & Seedall, 2008; Butler and Gardner, 2003). Nichols and Fellenberg (2000) found that therapists who do not understand how to effectively use enactments can promote unproductive outcomes. Eighteen video-taped therapy sessions with different families were used to compile descriptions of various therapist enactment techniques and client responses. The data was then analyzed to identify elements of enactments that differentiated successful from less successful therapy outcomes. Results showed that enactments require much more than simply directing couples to talk to one another and that such oversimplification risks destructive escalation of couple interaction and less successful clinical outcomes.

To enhance therapists' effective utilization of enactments, and therefore clinical outcomes, Butler and Gardner (2003) crafted a developmental model that carefully calibrates enactment structure and process to couples' presenting and changing levels of distress, interactional volatility, and emotional reactivity. The first stage, shielded enactments, accommodates highly volatile, distressed, and reactive couples. It involves 100% therapist-channeled interaction to shield or protect spouses from experiencing volatile, escalating couple interaction. The second stage, buffered enactments, requires that therapists buffer or filter spouses' interactions—using coaching, proxy voice, and listening—to reframe couples' expressed experience and meaning. This promotes couple softening along with understanding of, and responsiveness to, each other's core attachment needs. The model recommends that therapists transition from stages one and

two into stage three as quickly as possible in order to help couples learn self-reliant, positive interaction on their own as soon as possible.

Though stages one and two structurally resemble a therapist-centered approach (due to all interaction being channeled through the therapist), a critical distinction at the process level exists and must be carefully sustained. The differentiation of stage one and stage two enactments from therapist-centered process consists principally in the fact that therapist-spouse interaction is not the focal point of therapy process. The therapist is not transacting their own relationship with either partner, but through their proxy-like interaction, focuses instead on reframing and conveying the couple relationship and exchanges in a positive manner that brings the relationship to the attending partner in a way that can more readily be received. The therapist acts as a genuine conduit, facilitating and conveying each partner's emotion and experience to the other—filtering, buffering, and reframing partner exchanges to promote and model positive interactional experience. By conveying positive exchanges, the therapist facilitates softening and helps prepare the couple for direct, face-to-face enactments which occur in the ensuing stages. Thus, the enactment-anchored therapist always focuses on facilitating the couple relationship instead of developing and utilizing his or her own, independent, stand-alone relationship with each partner.

Enactment stages one and two help couples soften and prepare for face-to-face interaction in all later stages. They increase their willingness to empathize, listen without interruption, seek understanding of each others' perspective, and relate to each other in a more receptive, conciliatory manner. These developments reveal readiness for stage three or face-to-face talk-turn enactments. In stage three, therapists carefully coach couples as

they talk face-to-face with each other instead of to the therapist. This stage includes talk-turn-by-talk-turn intervention with the therapist guiding couples to express and identify personal and partner primary emotions and attachment needs and/or distress. Stage three creates space for deeper connection and attachment security to evolve between the partners themselves as they learn to have meaningful, attachment-strengthening interactions with each other. Stage four, episode enactments, continues to involve 100% couple interaction, but therapist involvement decreases. Spouses interact for extended periods without therapist coaching, followed by therapist-guided couple evaluation of their interaction. Stage five, autonomous relationship enactments, occurs when the couple consistently interacts in a relationship-enhancing manner that satisfies both partners in terms of process and outcome, especially attachment outcomes. Success at this stage indicates that couples are ready for therapy closure.

Andersson et al. (2006) tested the five stage model and found that enactments which were carefully calibrated each session to spouses' distress and reactivity levels maximized consistent, positive outcomes. Using qualitative methodology, couples were administered a semi-structured interview after experiencing enactment stages according to Butler and Gardner's model (2003). During one session, couples first experienced the structured, safeguarded enactments characterized by stages one and two followed by the free-form, coached enactments of stages three and four. Immediately following the session, each participant individually met with an interviewer. The interview entailed viewing a videotape of themselves experiencing the first two, structured and safeguarded enactment stages and answering a series of questions about their perceptions. Each participant then viewed their experience with the third and fourth, free-form enactment

stages and answered the same series of questions regarding their perceptions. The interview ended with questions comparing their experience of each. Findings showed that more volatile couples felt that "free form" enactments were premature and felt more comfortable with therapist-regulated and therapist-conveyed relationship enactments (enactment stages one and two). Less volatile couples, however, appreciated the "free-form" enactments more. The findings suggest preliminary support for Butler and Gardner's theoretical assertion (2003), based on clinical observation, that enactments appear most effective when adapted to couples' levels of distress, interactional volatility, and emotional reactivity.

Adding to Butler & Gardner's (2003) five-stage longitudinal and developmental model of enactments, Davis and Butler (2004) conceptualized the core components of a single enactment focusing specifically on using enactments to strengthen couples' emotional connection and attachment. They divided the execution of enactments into three components—*initiation, intervention,* and *evaluation.* The first phase, initiation, consists of preparatory instruction and explanation for clients. The therapist describes the nature of enactments, the content to be discussed, and clearly delineates the therapist's and clients' roles. The therapist also uses the initiation phase to encourage softened emotional expression and listening throughout the enactment. The first phase ends as the therapist directs the couple to face each other while removing him or herself from the interaction. The purpose of the second phase, intervention, is to give the couple guided experience communicating with each other in a manner that brings the emotional experience of the relationship into the open. It also allows the couple to uncover and work through attachment issues and needs and resolve problems. The therapist carefully

coaches the couple to express primary emotions in a softened manner, focus on attachment needs and threats, and empathically listen for their partner's emotions and attachment needs. The third phase, evaluation, completes the enactment with the therapist helping the couple to evaluate their interaction experience. Couples are asked to evaluate what they perceived went well, express their appreciation to each other for what went well, and make commitments to try what went well during interaction at home. The current study follows Butler and Gardner's (2003) five-stage, developmental model and Davis and Butler's three-component conceptualization to promote effective enactment execution in promoting couples' secure attachment.

Summary

The current study was a pilot investigation preceding a larger empirical investigation to examine enactments as an effective means of enhancing couple therapy outcomes—particularly outcomes relating to couples' secure attachment. It also investigates enactments as a potentially best-practice clinical process that empowers couples to become more capable of strengthening their secure attachment in a self-reliant manner independent of clinical assistance.

The purpose of the current study was to examine enactments as a specific, potential best-practice change mechanism that promotes secure attachment by helping marital couples learn how to safely, emotionally engage and respond to each other. The study served as a pilot study to future quantitative research. Specifically, the study's main objectives were (a) to investigate the relationship between enactment-centered therapy and couples' sense of secure attachment; (b) to examine whether differences exist

between enactment-centered and therapist-centered approaches in their ability to strengthen secure attachment in marital therapy.

Hypotheses

Hypothesis 1: Regarding objective (a), we expected that enactment interventions would be associated with marital couples' increased sense of secure attachment.

Hypothesis 2: Regarding objective (b), we expected that enactments would demonstrate greater shifts towards marital couples' sense of secure attachment than a therapist-centered approach.

Methods

Participants

Couples. The sample consisted of twelve married couples (12 husbands, 12 wives) who presented for marital therapy at a clinic in the Western United States. Presenting problems included such issues as pornography addiction, communication problems, anxiety, and depression. Participants ages were 18-25 (30%), 26-35 (33%), 36-45 (30%), and 46-55 (8%). Participants' length of marriage averaged 9 years and ranged from 3.5 to 27 years. All participants had children. The number of children each couple had ranged from one to two children (58%), three to four children (34%), and five to six children (8%). Participants' ethnicity included white (92%), and Hispanic (8%). Participants' income distribution was $0-14,999 per year (8%), $15-29,999 per year (42%), $30-44,999 (25%), and $60,000 per year (25%). The participants' highest educational degree included a high school degree (29%), some college (25%), a college degree (38%), and a graduate degree (8%).

Therapists. Four student-interns from an AAMFT-accredited Marriage and Family Therapy graduate program executed the experimental therapy conditions. The therapists were 2 male and 2 female caucasion first-year MFT master's students with an average age of 26.

Procedure

Couple recruitment. Clinic intake workers recruited couples to participate in the study whose primary focus of coming to therapy was to improve their marital relationship. Couples who expressed interest were then randomly assigned to one of four MFT therapist-interns trained to execute the study. All interested couples signed an informed consent letter (see Appendix A) prior to participating. Each participating couple was informed of the following: 1) the purpose of the study; 2) risks and benefits associated with their participation in the study; 3) their right to withdraw their participation at any time; 4) the nature of their participation in the study; 5) the confidentiality of all received information; 6) entitlement to compensation in the form of a $45 gift certificate or free therapy. Demographic information (see Appendix F, *Demographics Questionnaire*) was also collected for all recruited couples.

Therapist training and proficiency. As part of their clinical practicum, participating therapists received 12 hours of specific training from a licensed marriage and family therapist and an AAMFT approved supervisor proficient in both enactments and therapist-centered approaches. The supervisor had also published extensively regarding enactments. Training for both therapy approaches included readings and didactic instruction describing each therapy condition, viewing of videotaped examples, experiential practice through role-play, proficiency tests, and, as needed, reviews of their

results. They also received specific training of the descriptive criteria for both therapy conditions used in the study (as listed in Appendices C and D). Following training, therapist proficiency in each therapy process protocol, was tested by video recording each therapist executing each therapy condition (separately) in an experiential role play. These proficiency tests were then coded by one of the study's principal investigators according to the criteria for enactment and therapist-centered protocol as listed in Appendix C and D. Proficiency for the therapist-centered approach was determined if therapists exhibited at least four of five key therapist-centered indicators (see Appendix C). During the study, therapists were instructed to review the criteria for the appropriate therapy condition that they were to execute before each experimental session. Proficiency for the enactment-centered therapy process was attained if therapists executed at least eight of nine key enactment indicators (see Appendix D).

Experimental Condition

The study employed a pre-test post-test, repeated measures design with a treatment and alternate treatment comparison. Each participating couple experienced six experimental therapy sessions—three sessions of therapist-centered therapy and three sessions of enactment-centered therapy. The sequencing was alternated across participant couples. During therapist-centered sessions, the couples were exposed to therapist-centered clinical process wherein the therapist channeled all couple interaction through him or herself and refrained from conducting any enactments (see Appendix C for therapist-centered criteria). During enactment sessions, participant couples were exposed to enactment-centered clinical process wherein the therapist coached the couple through sustained interaction with each other following Butler and Gardener's model (2003) and

Davis and Butler's single-episode conceptualization (2004) of enactments (see Appendix D for enactment-focused criteria).

To assess the relationship between therapy treatment type and couples' secure attachment, each participant (both husband and wife) completed a secure attachment measure (SAM) directly preceding (SAM1) and following (SAM2) each therapy session over the course of six experimental sessions. Thus, pre and post secure attachment measures were administered before and after six consecutive therapy sessions during which each couple was exposed to three sessions of therapist-centered as well as three sessions of enactment-centered therapy treatment. Pre-post measurement enabled direct assessment of the subtle shifts in couple-perceived attachment security over the course of a single session as well as between sessions and how they related to therapy modality (enactment verses therapist-centered). Couples and therapists were randomly assigned to begin with either the therapist-centered or enactment-centered treatment first. This provided an adjunct to randomization in helping control for possible effects related to sequencing of experimental conditions. Random alternation of treatment sequence also helped control for the effects of one experimental condition upon the other. Couples were randomly assigned to participating therapists.

To ensure that therapists executed the designated therapy condition over each of the six sessions, each session was video-recorded and later coded by a research assistant. The coder viewed each session and assessed whether the appropriate treatment type was conducted using the same key indicators used in the therapist training and proficiency tests (see Appendix C). Though all therapists were trained in the entire conceptualization of both treatment types to enable them to have multiple skills from each treatment type at

their disposal, the verification coding of each session followed a minimalist approach and measured only the most fundamental operational criteria for each modality. The coder verified therapist-centered sessions if the therapist channeled all interaction through him/her and prevented or interrupted any direct couple interaction with each other. The coder verified enactment sessions if the therapist directed the couple to speak to each other, rather than to the therapist, and sustained and coached their interaction at least once during the session. A minimalist coding approach allowed for fluid application of treatment modalities to each couple's varying needs. This fluidity and lieberality, however, means that the coding process did not assess the precise quality of treatment executed. Therapists could have provided the most rudimentary execution of either modality, and yet the session would still have qualified as an appropriately conducted experimental session. In this manner, though, execution of the correct experimental treatment modality was verified for each session, while the quality of execution was not. This limitation might have resulted in less clinically meaningful differences and is discussed later.

None of the experimental treatment processes or interventions in any way represented any departure from what clients might normally be exposed to in the typical course of marital therapy. Additionally, treatment alternation designs such as the method proposed have been shown to provide clear clinical benefit for clients (Hayes, Barlow, & Gray, 1999). For the current study, a two group comparison of two treatment modalities permitted investigation of whether couples' sense of secure attachment remained the same, improved, or deteriorated in relation to enactment- versus therapist-centered treatment process.

Measures

Secure Attachment Measures (SAM1 and SAM2). Secure attachment was assessed using a questionnaire adapted from the Experiences in Close Relationships measure (ECR; Brennan, Clark, & Shaver, 1998). The ECR is a 36-item self-report attachment measure where respondents use a 7-point Likert scale to indicate how much they disagree or agree with items such as "I worry about being abandoned by my partner" and "I tell my partner just about everything." The ECR is empirically considered the best quantitative self-report adult attachment measure currently available. Statistical analyses of current adult attachment measures reveal that the ECR's multi-item dimensional nature statistically demonstrates the greatest precision and validity among existing adult attachment measures (Fraley, Waller, & Brennan, 2000).

The current study adjusted the ECR by utilizing only questions relating to secure attachment and by slightly rewording the questions in an effort to achieve within- and between-session sensitivity and partner-specificity. The adjusted measures were called the Secure Attachment Measure 1 and 2 (SAM1 and SAM2). The measures consisted of 19 questions each and utilized a 7-point Likert scale, with 1 reflecting weak secure attachment and 7 reflecting strong attachment. The SAM1 was administered immediately preceding each therapy session and asked subjects to rate how they felt towards their partner concerning each item over the past week (e.g., "Over the past week, I felt comfortable sharing my private thoughts and feelings with my partner"). The SAM2 was administered immediately after each session and asked subjects to rate how they felt towards their partner during and after the session compared to how they felt at the beginning of the session (e.g., "During today's session, I became more comfortable

sharing my private thoughts and feelings with my partner"). As the example items illustrate, the items were the same for the SAM1 and the SAM2 with only slight wording differences to solicit reflection on any within-session and between-session changes, thus allowing direct comparison of how the different therapeutic approaches might influence couples' sense of secure attachment. Cronbach's alpha for the SAM1 was .96 and for the SAM2 it was .95.

Confidentiality

Several steps were taken to protect confidentiality. All information was stored in a locked container. The only people to have access to the locked container were the principal investigators and research assistants. Each case was assigned a case number and information to ensure that couple's information would only referred to by case number. Any and all other identifying information was removed from collected research data.

Results

This small-sample investigation served as a pilot study to a planned, larger-sample study to follow. Thus, analyses of data obtained thus far were not statistical, but instead consisted of trends and trajectories in the data through an examination of a preliminary subset of a later participant sample. Data was analyzed by averaging raw secure attachment scores for each participant from each session. Possible significant trends and trajectories were examined using graphical mapping of the data overlaid with regression lines. Though regression lines can oversimplify rich growth process and change, they highlight overall trends and were used in analyses to more clearly illustrate the overall pattern of the data. We describe the data both in terms of real-life growth

patterns and also in terms of trends determined by forced linear simplification of those rich growth patterns.

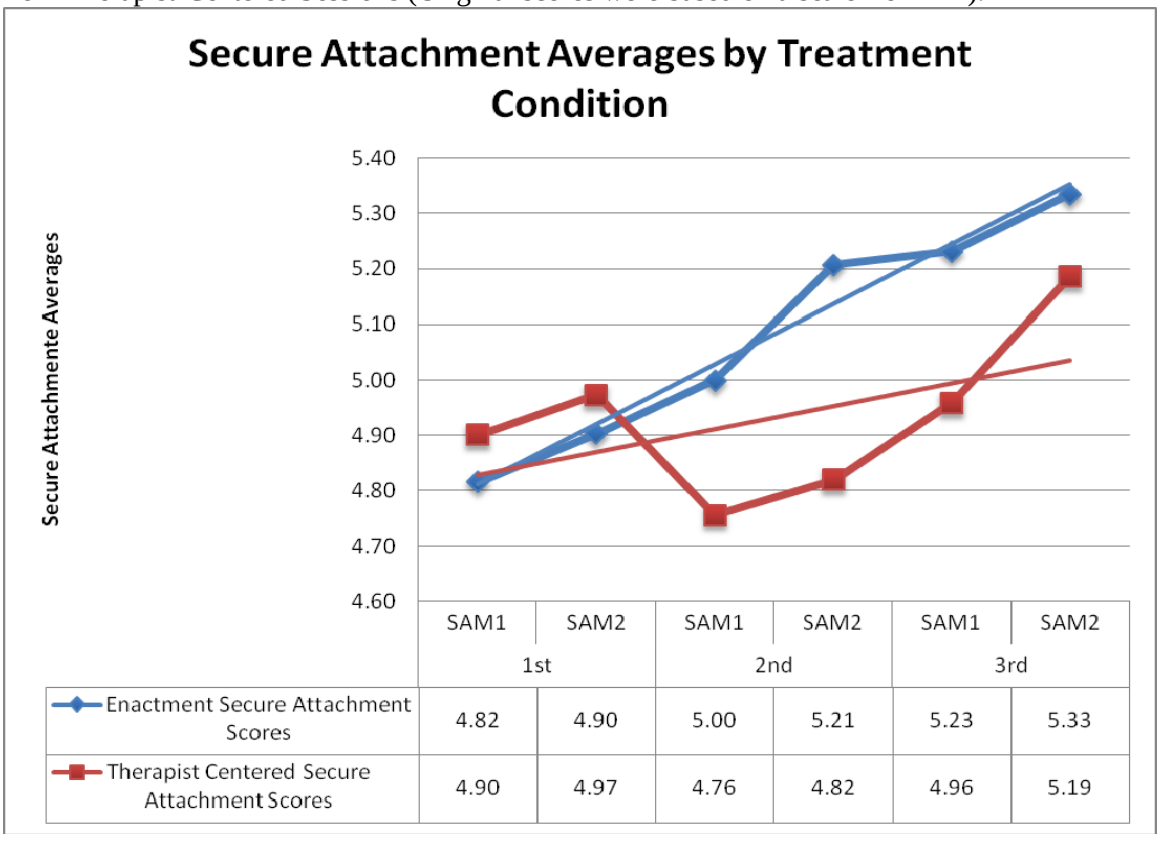
Secure Attachment Scores Related to Therapy Condition

We hypothesized that enactment-centered sessions would result in higher secure attachment (SAM) scores than therapist-centered sessions. We tested this hypothesis by comparing participants' secure attachment scores before and after each enactment-centered session with those from before and after each therapist-centered session (see Figure 1). We first summed each participant's SAM1 scores from before their first enactment session and computed an average score for each of the 24 spouses. These averages represented how secure each spouse felt towards his or her partner before experiencing the first enactment session. Next, we took the SAM1 averages from each of the 24 participants before their first enactment session, summed them with the other participants' averages, divided that sum by the number of participants (24) to compute a total average for all participants combined. This created one overall average score (M=4.82) to represent the total secure attachment score before the first enactment session experienced, for all participants combined. This calculation procedure was then repeated to compute a combined pre-session secure attachment score for the second and third enactment sessions as well. The same process was executed to compute the total pre-session secure attachment scores for each of the three therapist-centered sessions. Post-session secure attachment (SAM2) average scores for each of the six experimental sessions were computed in the same manner as the pre-session scores.

As Figure 1 indicates, the data revealed a consistent rise in secure attachment scores over the course of the enactment sessions in terms of within-session and between-

session change. The average secure attachment scores before and after each enactment session were, respectively, 4.82, 4.90 (Session 1), 5.00, 5.21 (Session 2), and 5.23, 5.33 (Session 3). Therapist-centered sessions also showed an overall, though less dramatic, increase in secure attachment. For therapist-centered, however, the increase was not consistent, with a decrease in secure attachment scores between the first and second sessions, followed by an increase over the second and third sessions. The average secure attachment scores before and after each therapist-centered session were, respectively, 4.90, 4.97 (Session 1), 4.76, 4.82 (Session 2), and 4.96, 5.19 (Session 3). Both treatment conditions were associated with overall improvement in couples' secure attachment, with enactment scores slightly higher than therapist-centered change by the end of each condition.

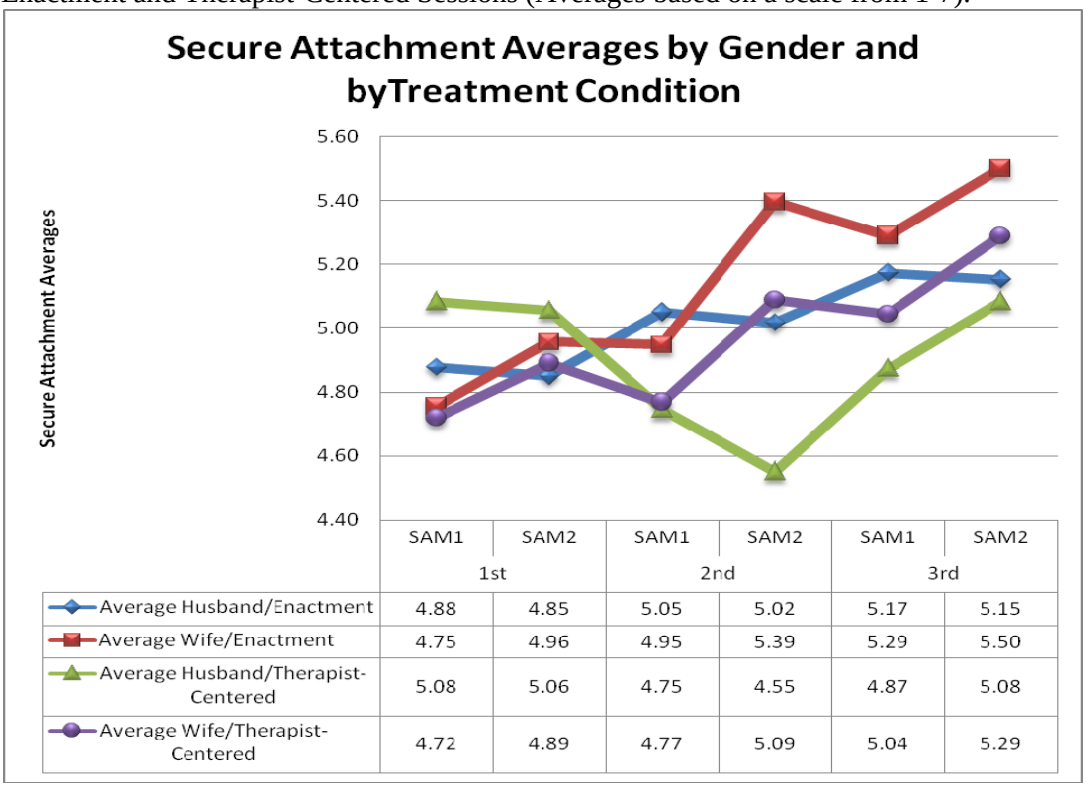
Figure 1: Participants' Secure Attachment Scores from Enactment Sessions Compared with those from Therapist-Centered Sessions (Original scores were based on a scale from 1-7).



Gender Differences

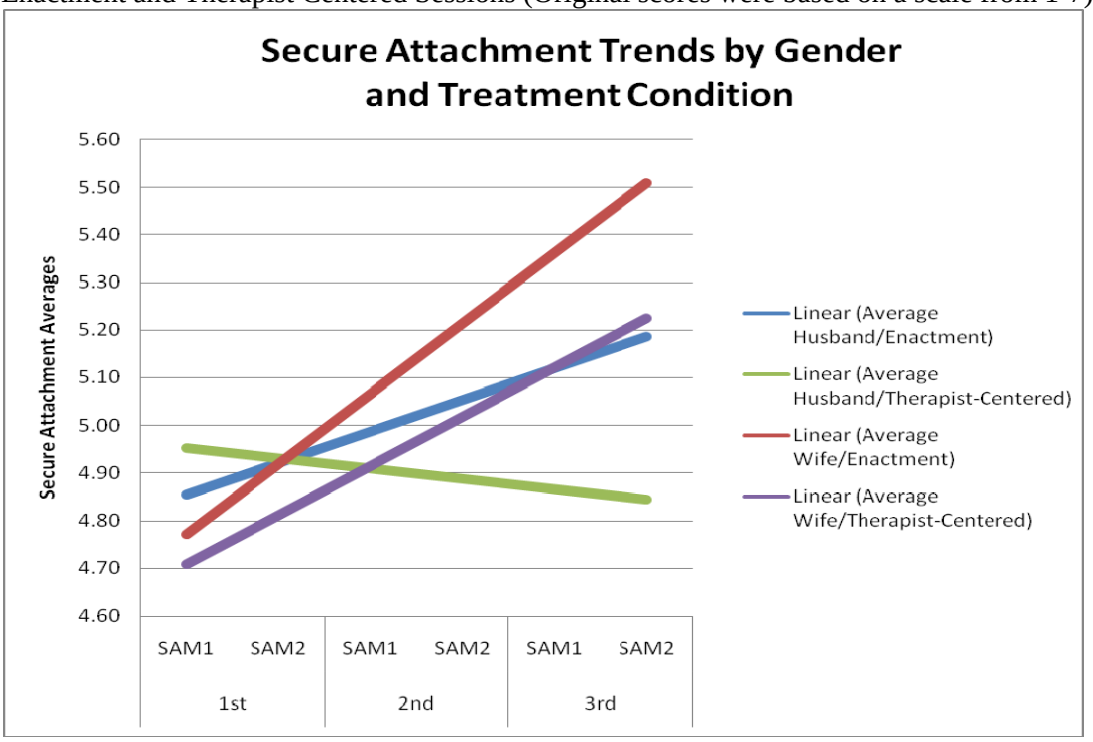
We also examined our results by gender, separating husbands' average SAM1 and SAM2 scores from wives', to assess whether husbands and wives experienced the enactment-focused and therapist-centered treatment modalities differently. We analyzed gender differences by separating husbands' average SAM scores from wives' average SAM scores. Figure 2 shows the average secure attachment scores for each gender and each therapy session by treatment condition, both numerically and graphically. Figure 3 shows the linear regression representation of the data to illustrate the overall trends. The data showed that both husbands' and wives' secure attachment scores increased over the course of the enactment sessions, with wives' scores increasing at a higher rate than husbands' (see Figure 3). Therapist-centered sessions also showed an increase in wives' secure attachment scores, but the linear model suggests that it was not as great an increase as with enactment-centered sessions. Interestingly, husbands' secure attachment scores decreased over the course of therapist-centered sessions according to the best-fitting linear model of the data (see Figure 3).

Figure 2: Comparison of Husband and Wife Secure Attachment Averages over the Course of Enactment and Therapist-Centered Sessions (Averages based on a scale from 1-7).



	SAM1	SAM2	SAM1	SAM2	SAM1	SAM2
	1st		2nd		3rd	
Average Husband/Enactment	4.88	4.85	5.05	5.02	5.17	5.15
Average Wife/Enactment	4.75	4.96	4.95	5.39	5.29	5.50
Average Husband/Therapist-Centered	5.08	5.06	4.75	4.55	4.87	5.08
Average Wife/Therapist-Centered	4.72	4.89	4.77	5.09	5.04	5.29

Figure 3: Trend Comparison of Husband and Wife Secure Attachment Scores over the Course of Enactment and Therapist Centered Sessions (Original scores were based on a scale from 1-7).

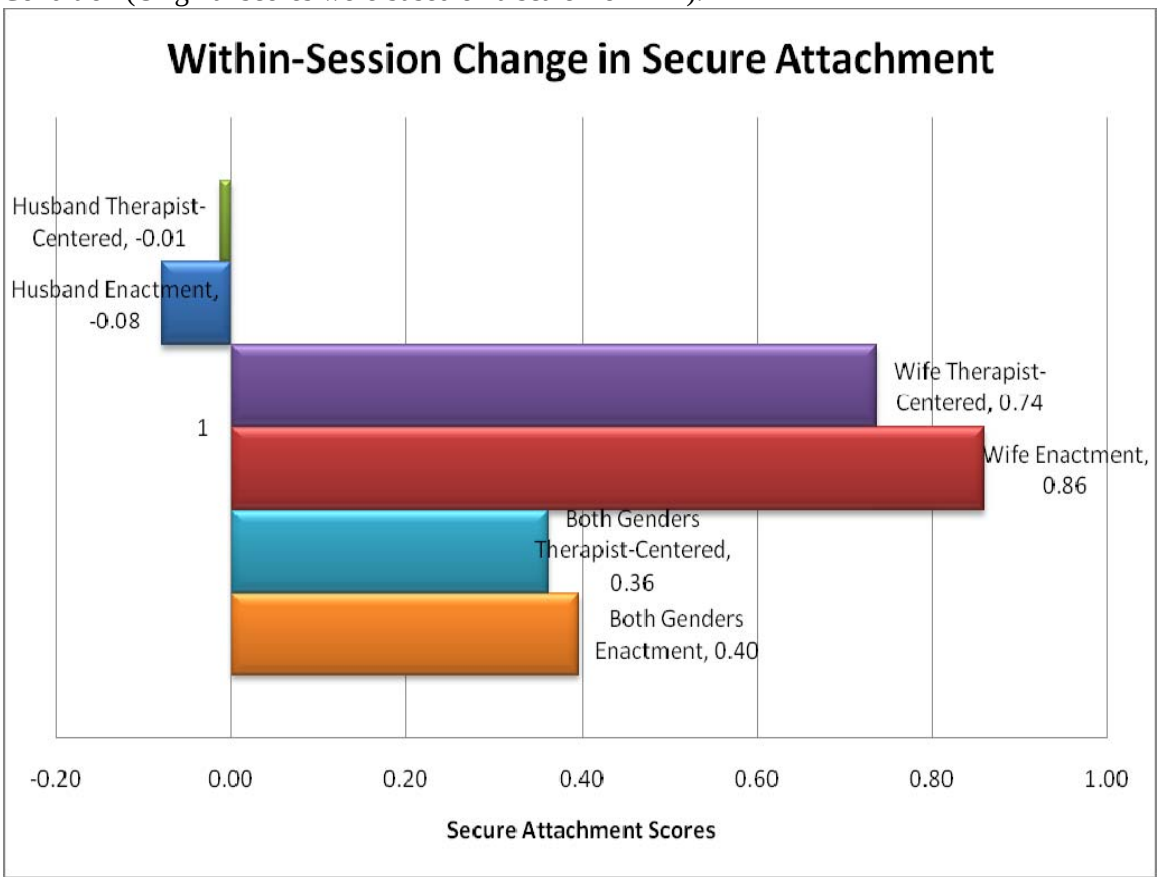


Within-Session, Between-Session and Overall Change Scores

We also looked at how within- and between-session change, as well as overall change, related to treatment condition and gender. Within-session change scores were obtained by computing the difference in SAM1 scores from SAM2 scores for each experimental session (see Figure 4). Between-session change scores for enactment sessions were obtained by subtracting the total average SAM1 score from each enactment session from the total average SAM1 scores of the enactment session immediately following (see Figure 5). The same process was repeated to compute between-session change scores for the therapist-centered sessions. Overall change in SAM scores was calculated by creating a sum of the within and between session differences for the three sessions comprising each experimental therapy treatment modality (see Figure 6).

As indicated in Figure 4, wives experienced increasing secure attachment scores within each session for both treatment conditions, but enactments (.86) slightly exceeded those of therapist-centered (.74). Husbands appeared to experience no within-session change for either therapy process modality (-.08 during enactment-focused sessions and -.01 during therapist-centered sessions). Thus, as compared to husbands', wives alone experienced positive change within sessions, and only slightly more positive within-session change from enactment treatment than from therapist-centered process. When husbands' and wives' within session scores were combined, there was very little difference between the two therapy types, with therapist-centered session change totaling .36 and enactment session change only slightly higher at .40.

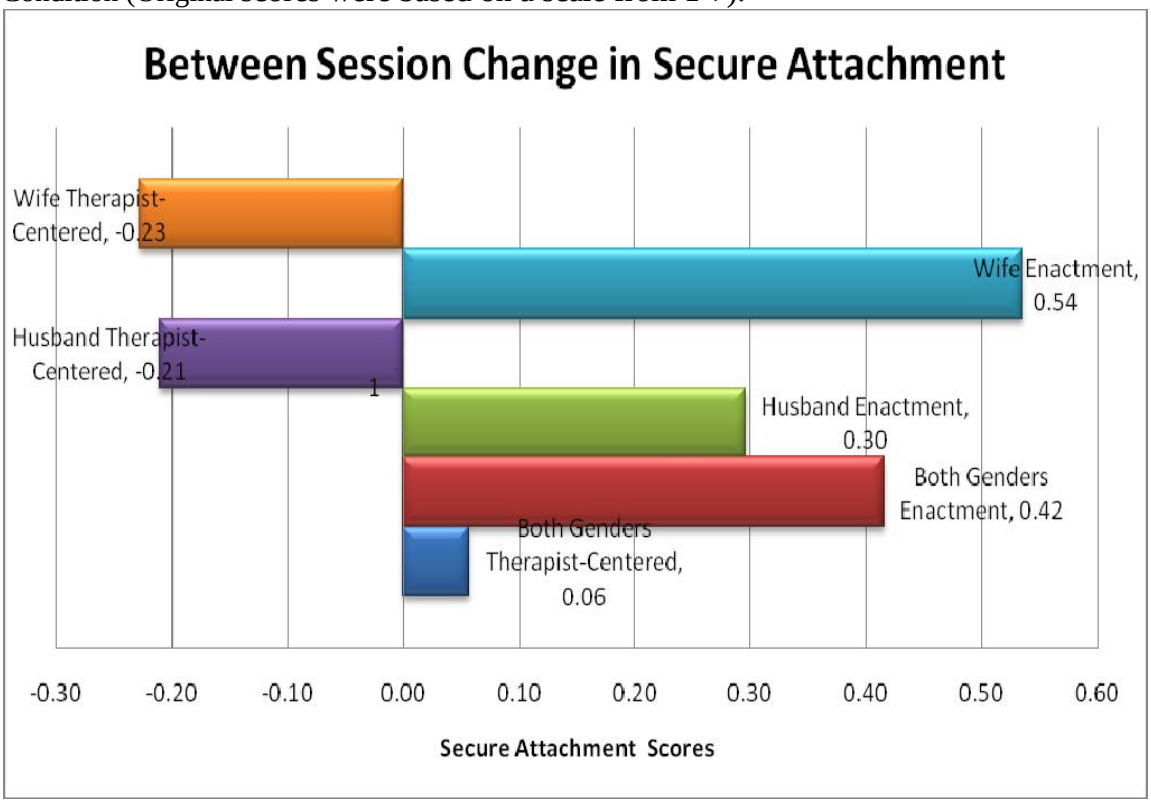
Figure 4: Within-Session Change Scores in Secure Attachment by Gender and by Treatment Condition (Original scores were based on a scale from 1-7).



Between-session change scores revealed a bit more interesting story (see Figure 5). As previously mentioned, total change between sessions with both genders combined showed a .42 improvement in secure attachment scores from enactment sessions, but only a .06 improvement from therapist-centered sessions. Gender analyses revealed similar patterns. Wives experienced a .54 increase in secure attachment between enactment sessions, but a -.23 decrease between therapist-centered sessions. Unlike within-session change husbands exhibited some change between sessions, with a .30 improvement between enactment sessions, but a -.21 decrease in secure attachment between therapist-centered sessions. When husbands' and wives' between session scores were combined, therapist-centered sessions yielded a total change score of .06 while enactment sessions

yielded a total change score of .42. Thus, there is a preliminary indication of a trend toward enactment sessions producing higher between-session change scores for both husbands and wives than did therapist-centered sessions.

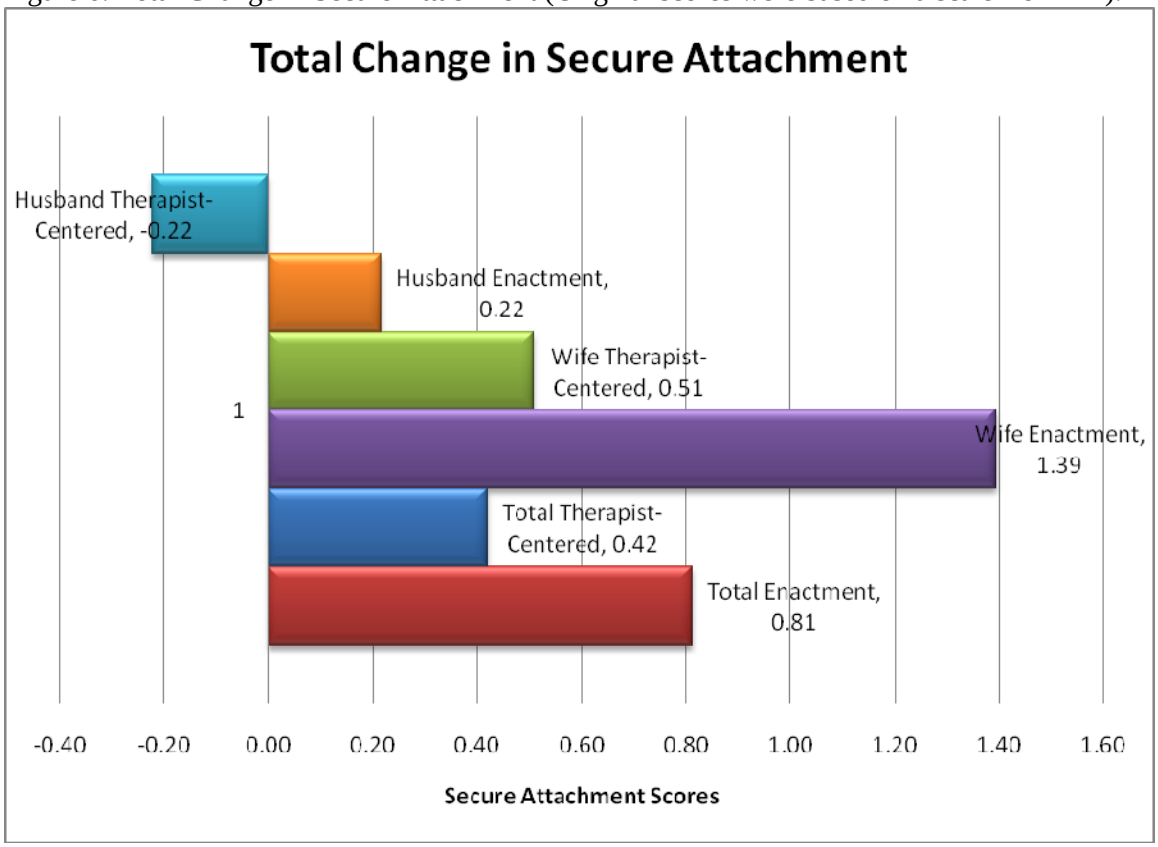
Figure 5: Between Session Change Scores in Secure Attachment by Gender and by Treatment Condition (Original scores were based on a scale from 1-7).



Total secure attachment change scores for each therapy process modality were created by summing the within- and between-session scores (see Figure 6). Wives showed a .51 overall increase in secure attachment over the course of therapist-centered sessions and a 1.39 overall increase over enactment-centered sessions. Husbands showed a -.22 overall decrease in secure attachment over the course of therapist-centered sessions and a .22 overall increase over enactment sessions. Thus, wives' secure attachment appeared to benefit from both therapist-centered and enactment-centered treatment, but

the positive effect of enactment sessions was substantially greater than that for therapist-centered sessions. Husbands' secure attachment also appeared to benefit marginally from enactment sessions, while their secure attachment scores actually deteriorated over the course of therapist-centered sessions. Wives' and husbands' combined scores showed a .42 overall increase for therapist-centered sessions and an overall .81 increase for enactment-centered sessions.

Figure 6: Total Change in Secure Attachment (Original scores were based on a scale from 1-7).

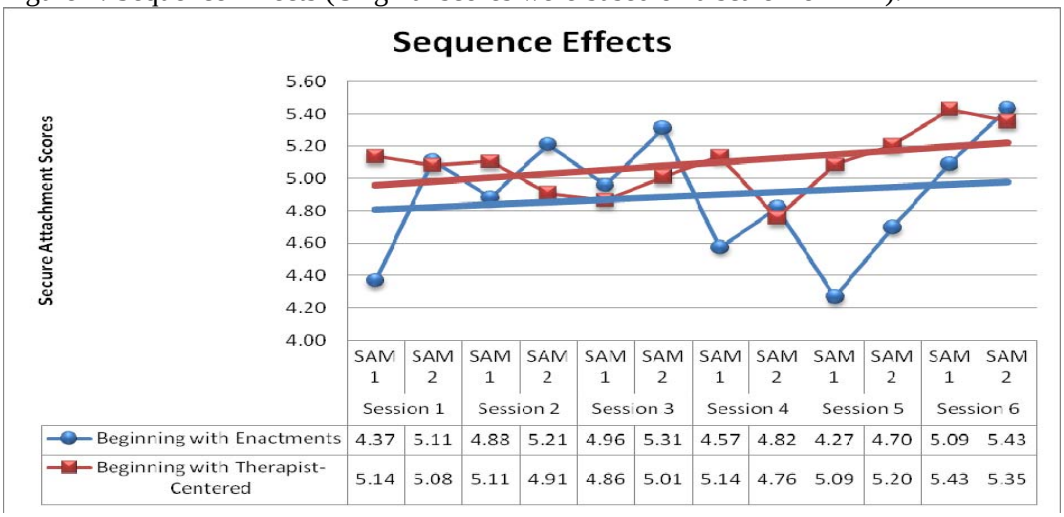


Sequence Effects

We also examined whether any sequence effects occurred from receiving enactment- versus therapist-centered treatment first (see Figure 7). We compared the secure attachment (SAM) averages over all six sessions for both groups—those beginning with therapist-centered and those beginning with enactment-centered. No

major differences are apparent in terms of the best-fitting linear model of the data. Both graphs followed the same trend over the course of the six sessions, irrespective of which therapy condition was introduced first. However, observation of the averages hints at the possibility of some interesting sequencing consequences. For couples who began with enactment sessions, the switch to therapist-centered sessions led to an increase in SAM scores during the initial therapist-centered session. By the next session, however, SAM scores had dropped lower than when the couples began the experiment. Couples who began with therapist-centered sessions and then switched to enactments reported an opposite experience. Their scores decreased during their first enactment session, but increased by the next session. Thus, it appears that switching to enactment-centered therapy process is initially disruptive to attachment progress (within the first enactment session), but afterward appears to consistently predict growth. Alternatively, switching to therapist-centered process from enactment-based process appears to produce a within-session improvement followed by between-session deterioration, but then a consistent trend toward growth thereafter, with an overall outcome endpoint equal to that for enactment process sessions.

Figure 7: Sequence Effects (Original scores were based on a scale from 1-7).



	SAM 1	SAM 2	SAM 1	SAM 2	SAM 1	SAM 2	SAM 1	SAM 2	SAM 1	SAM 2	SAM 1	SAM 2
	Session 1		Session 2		Session 3		Session 4		Session 5		Session 6	
Beginning with Enactments	4.37	5.11	4.88	5.21	4.96	5.31	4.57	4.82	4.27	4.70	5.09	5.43
Beginning with Therapist-Centered	5.14	5.08	5.11	4.91	4.86	5.01	5.14	4.76	5.09	5.20	5.43	5.35

Discussion

This study served as a pilot study for a planned larger-sample investigation examining enactments as a potential best-practice change mechanism to strengthen secure attachment in marital therapy. The results of this study provide preliminary, trend-based evidence in support of enactments as an important and impactful treatment tool for therapists to help couples strengthen their secure attachment. The trends revealed in this pilot-study also suggest that enactments may help improve couples' secure attachment between therapy sessions, thus helping couples learn to strengthen their secure attachment on their own. This is significant given that a fundamental theoretical and clinical assertion of enactment proponents is that they facilitate self-reliant, positive couple interaction. However, it is important to note that, given the small sample size, the results of this study represent only descriptive trends and trajectories and cannot conclusively inform therapy practice.

We hypothesized that enactment-centered sessions would reveal evidence of increased secure attachment scores. Observed trends suggest preliminary support for this hypothesis. Enactment-centered sessions did reveal a trend towards an overall increase in secure attachment scores for both husbands and wives. These findings are consistent with previous research supporting enactments as an effective change mechanism in couple therapy (Allen-Eckert, Fong, Nichols, Watson, & Liddle, 2001; Seedall & Butler, 2006; Andersson, et al., 2006; Butler & Wampler, 1999; Butler & Bird, 2000; Butler & Gardner, 2003; Davis & Butler 2004; Nichols & Fellenberg, 2000), particularly in strengthening couples' secure attachment.

Enactments allow couples to develop new interaction patterns that promote emotional sharing, partner softening and responsiveness, and the expression of attachment needs (Andersson, et al., 2006; Seedall & Butler, 2006). Couples are thus enabled to acknowledge and process emotion and make relationship-enhancing changes in their attitudes, attributions, emotions, and attachment (Butler & Gardner, 2003). The current research research provides preliminary indication supporting enactments as a potentially effective means whereby therapists can help couples create a secure attachment consisting of safe, softened, emotional connection and responsiveness.

We also hypothesized that enactment-centered sessions would produce greater shifts towards couples' secure attachment than therapist-centered sessions. Our data showed preliminary support for this hypothesis as well. Enactments showed a trend toward promoting greater couples' secure attachment than a therapist-centered approach for wives and husbands, but with clearly greater effects evident for wives. These results relate to previous research findings that show active client participation and engagement is essential for successful therapeutic outcomes (Hotlzworth-Munroe, Jacobson, DeKlyen & Whisman, 1989; Johnson, 2004; Butler & Bird, 2000; Butler & Wampler, 1999; Brimhall, Gardner, & Henline, 2003). Distinguished from a therapist-centered approach, enactments most actively engage and involve couples in their own therapeutic process. As therapists carefully coach couples to experience healthier interaction patterns, couples create their own relationship strengthening and healing journey, rather than relying on the therapist to do so for them. Consequently, couples are more likely to become self-reliant and able to work through their own conflicts, safely express their needs and emotions, and respond to each other in a relationship-enhancing, attachment-securing way—with or

without the therapist (Butler & Wampler, 1999; Butler & Gardner 2003). Though the results showed trends in this direction, future research needs to test these preliminary trends statistically, with a larger sample of couples.

Between-session differences especially highlighted the potential for enactments to help couples' increase their secure attachment in a self-reliant context. Between-session assessments were collected at the beginning of each session to assess how the therapy process condition might affect couples' secure attachment over the week between each therapy session. For both husbands and wives, substantial improvement occurred in between-session secure attachment scores over the period enactment sessions were received, but decreased during the period of therapist-centered sessions. The between-session increase in secure attachment from enactment sessions, especially for wives, suggests the potential for greater long-term positive effects from enactment-focused therapy. We judge that perhaps the interactive, experiential nature of enactments within session better equips couples with the ability and confidence to successfully carry out the same emotion and attachment focused work out of session. Enactments may be better at enabling couples to learn to self-reliantly work through their problems and connect emotionally without the need of therapist assistance. The potentially superior out-of-session and post-termination couple interaction gains from enactment-focused therapy process, as compared to therapist-centered process, is certainly an important question for future research to address.

Within-session differences revealed some gender differences in couples' experiences during each therapy session. Females appeared to benefit during both therapist and enactment-centered sessions, with enactment sessions showing slightly

greater improvement in secure attachment. Males, however, experienced a slight decrease in secure attachment during both enactment- and therapist-centered sessions. Thus, while overall secure attachment scores seemed to improve over time for males over the course of enactment sessions, males' secure attachment did not appear to respond favorably to either treatment process during the sessions themselves. Perhaps these differences occur because males experience some overall discomfort from the candid openness, intense processing, and demanding interaction during therapy sessions. The increase in secure attachment between sessions may result from the overall positive results that flow from their therapy experiences in their relationship at home. Alternatively, perhaps the wives' improvement in secure attachment, during and then between therapy sessions, exerts enough influence on males' secure attachment that it overrides their slightly negative or neutral reaction during therapy sessions.

It is important to note that though enactment-focused sessions showed a greater trend toward greater secure attachment scores than therapist-centered sessions, both therapy types showed a trend towards overall increased secure attachment scores for females. However, while males' secure attachment scores showed a growth trajectory to increase over enactment-centered sessions, they appeared to deteriorate over therapist-centered sessions. Thus both types of therapy show potential to benefit females' sense of secure attachment, while males' scores revealed a growth trend only from enactments. Yet, as previously noted, within enactment-focused sessions, males' attachment scores showed a tendency to decrease slightly during the session. Thus a paradoxical dynamic might exist where, for males at least, enactments may be the difficult medicine (challenging emotional interaction) that nonetheless produces recognizable and essential

healing and gains in overall relationship interaction and attachment. If accurate, this dynamic suggests a caution to novice and experienced therapists alike: namely, therapists may miss out on important benefits of enactments if they assess their utility in terms of in-session outcomes alone. In order to obtain a complete picture of the therapeutic potential of enactments, therapists should perhaps asses for between-session impact of in-session enactment process. In fact, gains through self-reliant couple ineteraction outside of therapy are perhaps the most significant indicator of postivie and potentially enduring change. Enactments may be challenging in session, yet prove beneficial to relationship functioning and attachment just the same.

One possible explanation for this gender difference could be linked to the fact that among couples who present for marital therapy, females are typically the instigators and present with more marital dissatisfaction than males. Thus, females might experience any therapeutic effort to strengthen the marital relationship as beneficial, whether the therapy approach is using enactments, therapist-centered, or some other approach. Perhaps just the fact that their husband is willing to come to therapy and work on the relationship is enough to increase females' secure attachment scores, regardless of the therapy process. Still, though both therapy types appeared to increase females' secure attachment scores, enactment sessions were associated with greater increases than were therapist-centered sessions. Thus, while both therapy types appeared to benefit females' sense of secure attachment, enactment sessions may have the greater potential to do so.

While the gains and trends found herein may seem less than highly clinically significant, we should bear in mind that these results were produced by fairly novice, inexperienced therapists. We can surmise that with growing experience and practice, the

effects potentially produced by enactments—especially in terms of facilitating couple growth toward self-reliant attachment interaction—could be far greater still and yield highly clinically relevant results.

The overall decrease in male scores across therapist-centered sessions could be related to the fact that therapist-centered sessions are typically more directive and require less client participation than enactment sessions. Men may be more reactive than women to directive therapy and instruction (Butler & Bird, 2000). Perhaps they perceive their position in this type of therapy as less autonomous and less in control. Such feelings might influence males to feel less capable of strengthening their own marriage and an increased sense of inadequacy. Decreased secure attachment might result as such worrisome feelings of inadequacy tend to make husbands want to withdraw instead of draw close to their wife. Conversely, while initially difficult and challenging, the active client participation and interaction encouraged by enactments might inspire males' confidence that they can personally help their marriage to progress, rather than needing to rely on a therapist's help to do so. It may bet that the conclusive realization of this prospect and confidence through positive out-of-session interaction is what accounts for between-session gains in males' attachment security. Perhaps males are more likely to experience an increased sense of secure attachment when they are the ones actively, successfully interacting and engaging with their spouse, rather than the therapist. Men also tend to value themselves as the provider and protector for their families—more so than females. The more directive nature of therapist-centered sessions might challenge males in this perspective, leading them to feel less capable than the therapist and therefore less connected with their spouse.

Limitations and Future Research

Some important limitations must be considered when interpreting the pilot-observations of this study. Because this was a small-sample pilot study, results cannot be interpreted as conclusive in any way. Instead, all results are simply preliminary observations designed to bring to a sharper focus the most relevant questions to attend to in future, full-scale research. Nevertheless, given the intensive time, labor, and financial costs associated with process-outcome research, a pilot-study approach is clearly warranted as a way to refine and warrant subsequent full-scale investigations. Painstaking, full-scale research is now called for to investigate if the same observations will be replicated as statistically significant findings in a larger sample where statistical power is sufficient.

This study also debuted new measures to assess secure attachment scores which have not been tested for statistical validity. Future research is necessary to statistically test the validity of these instruments to assure that they actually do measure partners' sense of secure attachment and do so accurately. A larger-scale study is also needed to examine the SAM1 and SAM2 items individually to discover which, if any, are actually sensitive to change at between-session and within-session intervals. Process-outcome research related to attachment, as well as numerous other variables, is desperately in need of instruments sensitive to fine-grained change over brief intervals. The current study also lacked a randomized control group. Thus it is difficult to determine how much of the difference observed for either enactment or therapist-centered sessions was due to mere chance, natural growth, or regression to the mean. The time between sessions was also a limitation to this study. Some couples experienced significant periods between each

session (several weeks as opposed to the typical one week interim). Thus the chances of such couples experiencing important influences upon secure attachment from outside of therapy was increased.

It is also important to note that the therapists used to execute the different experimental types were unlicensed, first-year graduate students training to become marriage and family therapists. The study revealed some benefits from utilizing graduate student MFT interns. For example, first-year students are open and willing to be trained in particular treatment styles. Thus, the student-therapists were quick to learn and accept both types of therapy treatment as legitimate. They also expressed a willingness and readiness to execute both experimental treatments in their therapy according to the strict research criteria. More experienced therapists might have shown less willingness to learn and accept treatments that might be outside their realm of comfort or familiarity. Their experience might also have led them to tweak the treatment styles and thus not execute them true to the designated criteria.

However, utilizing first-year MFT students also showed some less desirable effects. For example, the therapists were still trying to figure out their own self-as-therapist, what therapy consists of, and their own theory of how people change. Thus, the new therapists often showed tentative behavior that might have diminished the effectiveness of their treatment execution. The therapists used were still learning how to identify underlying primary emotions and attachment needs—an essential skill for enactments to be executed effectively. For these reasons, as previously suggested, licensed professional marriage and family therapists with more experience might yield significantly different results. Additionally, as earlier acknowledged, the current study

did not utilize a fine-grained approach to coding the quality of therapists' execution of the two therapy-process modalities. On the one hand, this allowed for flexibile application of each treatment to each couple's needs. However, it is also possible that therapists could have provided only the most rudimentary execution of either treatment and thus failed to execute the modalities in a manner that would highlight differences and thereby lead to more discriminating results.

Another important limitation of the study is that it only analyzed participants' secure attachment scores based on combined averages. Such analyses could minimize or mask variability and heterogeneity among couples. Research examining individual couple differences might reveal a more accurate and rich story of how enactments relate to couples' secure attachment.

Finally, the gender differences shown by our data suggest that males and females might experience enactment- and therapist-centered therapy sessions differently. Future research examining how both genders experience different therapy conditions would help therapists better understand how gender differences affect each partner's experience of therapy and what is most effective for each. Additionally, our study examined enactments on secure attachment outcomes among married, Caucasian couples only. Future research is needed to examine the impact of enactments on couples' secure attachment from a variety of ethnic, religious, SES, and marital status couples.

Conclusion

The current study's observations suggest the possibility of larger-scale research generating conclusive findings with significant implications regarding the potential efficacy of enactments as a best practice in couple therapy. Attachment threats and

injuries are at the heart of most relational distress (Johnson, 2004). Thus, it is imperative that therapists learn and use effective tools to maximize their efforts to strengthen couples' secure attachment. This study shows preliminary support for enactments as an effective change mechanism therapists can use to help couples strengthen their secure attachment—perhaps more effectively than by using a therapist-centered approach. Results suggest that enactment sessions showed a trend to increase overall secure attachment scores for both males and females above and beyond therapist-centered therapy sessions. These results support previous research that enactments are not merely some stylized intervention, but perhaps superior to promoting lasting healthy interaction patterns, relationship connection, and attachment security in couples' therapy (Butler & Gardner, 2003; Minuchin & Fishman, 1981). While EFT (Johnson, 2004) identifies enactments as a useful change mechanism in couple therapy, it does not and has not centralized them. Enactments do not appear to have been discerned or advocated as a processual key to emotionally focused attachment work. This study supports a call for more extensive investigation of the comparative utility of enactment-focused therapy process verses therapist-centered process alone. Our pilot findings suggest the possibility that enactments may ultimately prove to be not just a stylized approach to EFT and other relationship therapies, but an essential approach—through their direct access to relationship experience, emotion, interaction, and change—to help couples strengthen their attachment security. Thus, this study's preliminary growth trend observations suggest the importance for therapists to familiarize themselves with effective enactment execution (Nichols & Fellenberg, 2000; Davis & Butler, 2004; Butler & Gardner, 2003)

and utilize enactments in order to most effectively enable couples to strengthen their secure attachment.

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Appendices

Appendix A: Consent Form

Informed Consent to Participate as a Research Subject

Introduction
Dr. Mark Butler, Associate Professor in Brigham Young University's School of Family Life, and Graduate Programs in Marriage and Family Therapy, is conducting research focused on understanding the role of the therapy process in helping couples improve their marital relationship and overall experience in therapy.

You have been recommended as a couple who may be willing to participate in this research. You were selected for participation in part because your therapist identified you as seeking therapy for couple related issues. Your participation is completely voluntary. Declining to participate in the research will not affect any therapy you are currently receiving or might receive in the future.

Procedures and Participation
Participation involves completing four normal therapy sessions with your therapist at the BYU Comprehensive Clinic. Before and after each session, you will be asked to complete a questionnaire assessing your feelings about your relationship with your spouse. The added questionnaires will require an additional five to ten minutes to complete. No additional fees will be incurred aside from those you contract to pay with the BYU Comprehensive Clinic according to their sliding scale system ($0-15 per session).

Risks/Benefits
There are minimal risks for participation in this study. There is the potential for discomfort associated with providing information about your experience in therapy. There are known benefits anticipated in consequence of your experience of couple interaction based therapy. Additionally, society and people in general will likely benefit from the knowledge gained regarding what couples perceive as helpful therapist behaviors. Therapists and other distressed couples will especially benefit from the knowledge gained concerning what improves couples' relationship quality.

Your participation in the study will assist in understanding clients' perceptions of certain therapist behaviors and allow us to discover ways to improve couples' experiences in therapy. The results of this research may specifically help other couples who come to therapy with couple related issues. As this study is completed, the conclusions and benefits will be released to the public in hopes of providing assistance for all therapists who work with couples.

You may refuse to continue your participation in the study at any time.

Confidentiality
Although the video tape used to record the therapy session becomes property of Brigham Young University's School of Family Life, reasonable and appropriate actions will be taken to keep your information confidential. No identifying information will accompany any materials, and only research project staff will have access. We will not use your names when analyzing the information.

Questions about the Research
For questions about this research study, please contact Dr. Mark Butler, who is the primary researcher in this study.

Mark H. Butler, Ph.D
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Marriage and Family Therapy Graduate Programs
Brigham Young University
262 TLRB, P.O. Box 28601
Provo, UT 84602-8601
(801) 422-8786

Questions about your Rights as Research Participants
If you have questions regarding your rights as a participant in a research project, you may contact IRB Chair, Renea Beckstrand, 422, 3873, renea_beckstrand@byu.edu, 422 SWKT, Provo, UT., 84602.

By signing this form, you acknowledge that your participation in this research study is voluntary.

I have read, understood, and received a copy of the above consent, and desire of my own free will and volition to participate in this study.

_____

Research Participant Date

_____

Witness Date

Appendix B: Instruments

Demographic Questionnaire

To begin, we have a few general questions about you:

1. What is your gender?
    a. female
    b. male

2. What is your age?
    a. 18-25
    b. 26-35
    c. 36-45
    d. 46-55
    e. 56 or above

3. What is your relationship status?
    a. Single
    b. Married
    c. Separated
    d. Divorced
    e. Other _____ (please specify)

4. How many times have you been married? _____

5. How many years have you been in your current relationship? _____

6. How many children do you have?
    a. 0
    b. 1-2
    c. 3-4
    d. 5-6
    e. 7 or more

7. What is your religious affiliation?
    a. Buddhist/Hindu
    b. Christian
    c. Islamic
    d. Jewish
    e. Latter-day Saint
    f. Other: _____

8. What is the highest level of education you have completed?
    a. junior high school
    b. high school
    c. some college
    d. college
    e. graduate degree

9. What is your annual income?
    a. 0-14,999
    b. 15,000-29,999
    c. 30,000-44,999
    d. 45,000-59,999
    e. 60,000 or above

10. What is your race/ethnicity?
    a. White/Caucasian
    b. African American
    c. Asian
    d. Pacific Islander
    e. Hispanic
    f. Other (specify): _____

11. How many therapy sessions have you had? _____

SAM1

Couple ID Number:_____ **Date:**_____

Please respond to each statement by indicating how much you agree or disagree with it.
Circle the appropriate number in the box provided, using the following rating scale:

	Strongly Disagree 1	Disagree 2	Somewhat Disagree 3	Neither Disagree nor Agree 4	Somewhat Agree 5	Agree 6	Strongly Agree 7
OVER THE PAST WEEK,							
1. I felt comfortable being close to my partner.	1	2	3	4	5	6	7
2. I felt comfortable sharing my private thoughts and feelings with my partner.	1	2	3	4	5	6	7
3. I preferred not to show my partner how I felt deep down.	1	2	3	4	5	6	7
4. I worried about my relationship with my partner.	1	2	3	4	5	6	7
OVER THE PAST WEEK,							
5. I turned to my partner for many things, including comfort and reassurance.	1	2	3	4	5	6	7
6. I found it relatively easy to get close to my partner.	1	2	3	4	5	6	7
7. I worried that my partner didn't care about me as much as I care about him/her.	1	2	3	4	5	6	7
8. I worried about being abandoned by my partner.	1	2	3	4	5	6	7
OVER THE PAST WEEK,							
9. I felt comfortable telling my partner just about everything.	1	2	3	4	5	6	7
10. I didn't worry about being abandoned by my partner.	1	2	3	4	5	6	7
11. I didn't feel comfortable opening up to my partner.	1	2	3	4	5	6	7
12. I wished that my partner's feelings for me were as strong as my feelings for him/her.	1	2	3	4	5	6	7
OVER THE PAST WEEK,							
13. I discussed my problems and concerns with my partner.	1	2	3	4	5	6	7
14. I felt comfortable depending on my partner.	1	2	3	4	5	6	7
15. It was difficult to allow myself to get close to my partner.	1	2	3	4	5	6	7
16. I felt that my partner didn't want to get as close as I would like.	1	2	3	4	5	6	7
OVER THE PAST WEEK,							
17. I felt comfortable asking my partner for comfort, advice, or help.	1	2	3	4	5	6	7
18. It helped to turn to my partner in times of need.	1	2	3	4	5	6	7
19. I worried about losing my partner.	1	2	3	4	5	6	7

SAM2

Couple ID Number:_____ **Date:**_____

Please respond to each statement by indicating how much you agree or disagree with it. Circle the appropriate number in the box provided, using the following rating scale:

	Strongly Disagree 1	Disagree 2	Somewhat Disagree 3	Neither Disagree nor Agree 4	Somewhat Agree 5	Agree 6	Strongly Agree 7
DURING TODAY'S SESSION,							
1. I became more comfortable being close to my partner.	1	2	3	4	5	6	7
2. I became more comfortable sharing my private thoughts and feelings with my partner.	1	2	3	4	5	6	7
3. I became less willing to show my partner how I felt deep down.	1	2	3	4	5	6	7
4. I became more worried about my relationship with my partner.	1	2	3	4	5	6	7
DURING TODAY'S SESSION,							
5. I became more comfortable turning to my partner for many things, including comfort and reassura	1	2	3	4	5	6	7
6. I found it easier to get close to my partner.	1	2	3	4	5	6	7
7. I became more worried that my partner doesn't care about me as much as I care about him/her.	1	2	3	4	5	6	7
8. I became more worried about being abandoned by my partner.	1	2	3	4	5	6	7
DURING TODAY'S SESSION,							
9. I became more comfortable telling my partner just about everything.	1	2	3	4	5	6	7
10. I became less worried about being abandoned by my partner.	1	2	3	4	5	6	7
11. I became less comfortable opening up to my partner.	1	2	3	4	5	6	7
12. I wished even more that my partner's feelings for me were as strong as my feelings for him/her.	1	2	3	4	5	6	7
DURING TODAY'S SESSION,							
13. I became more comfortable discussing my problems and concerns with my partner.	1	2	3	4	5	6	7
14. I became more comfortable depending on my partner.	1	2	3	4	5	6	7
15. It was difficult to allow myself to get close to my partner.	1	2	3	4	5	6	7
16. I felt that my partner didn't want to get as close as I would like.	1	2	3	4	5	6	7
DURING TODAY'S SESSION,							
17. I didn't mind asking my partner for comfort, advice, or help.	1	2	3	4	5	6	7
18. It helped to turn to my partner in times of need.	1	2	3	4	5	6	7
19. I worried about losing my partner.	1	2	3	4	5	6	7

Observational Assessment of Therapist-Centered Proficiency (OATCP)

Macro	Micro	Frequency Count
Narrative Behaviors =>	Encourages and invites partners to share their "story" or perspective with him/her	
	Empathically listens as one or both partners share their story, feelings, or thoughts	
	Reflects the partners' feelings	
	Validates the partnrs' feelings	
	Reframes negative comments	
	Third-person voice	
Physical Gestures Channeling Interaction through theTherapist =>	Sets partners' chairs to face the therapist rather than each other	
	Hand gestures that invite/encourage couple interaction with the therpiast	
	Verbal instructions for the couple to interact with or directly talk to the therapist	
Creating Insight/Understanding =>	Offers appropriate advice, suggestions, or potential solutions	
	Encourages clients to think of suggestions or solutions	
	Socratic Dialogue	
	Suggests new ways of looking at things	
	Helps partners discover new ways of looking at things	
	Offers interpretations or insights ito couple behavior	
	Points out negtavie consequences of dysfunctional interaction patterns, ideas about relationships, etc.	
	Offers feedback, interpretations, thoughts or feelings regarding clients' comments	
	Gives communication skill suggestions (e.g., "speak in I terms instead of criticizing or blaming your partner"	
Active Involvement =>	Engages in a separate dialogue with one or both partners	
	Actively participates in therapy conversation (either verbally or through attentive listening	
Encouragment of Attachment/Emotion Expression =>	Requests a partner to reframe a statement in terms of how it made him/her feel	
	Offers alternative, more softened statement for partners to repeat	

Appendix D: Criteria Indicating an Enactment-Centered Approach