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The Effects of Couple-Centered and Therapist-Centered Process on Dyadic

Attachment of Distressed Therapy Seeking Couples:

A Multilevel Longitudinal Analysis

Justin Zamora

A thesis submitted to the faculty of
Brigham Young University
in partial fulfillment of the requirements for the degree of

Master of Science

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ABSTRACT

The Effects of Couple-Centered and Therapist-Centered Process on Dyadic Attachment of Distressed Therapy Seeking Couples: A Multilevel Longitudinal Analysis

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Master of Science

This study is an empirical investigation of 35 clinically distressed therapy seeking couples receiving sequential sessions of both therapist-centered and, alternatively, couple-centered, enactment-based therapy processes. Using a mixed-level longitudinal analysis with a repeated measure design, analysis of secure attachment, and the interrelated dimensions of attachment anxiety and attachment avoidance were examined demonstrating that couple-centered, enactment-based sessions produced higher levels of post-session and within-session attachment gains than therapist-centered process for both males and females. Couple-centered, enactment-based process was observed to have a unique treatment effect after the second session, where both partners experienced higher levels of attachment followed by levels returning to pre-experiment levels. Clinical implications and future research considerations are suggested.

Keywords: enactments, attachment, process-outcome, couple-centered therapy, marital therapy

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Introduction

After considerable theoretical and conceptual work, empirical investigations into the effectiveness of enactments as a common factor of couple-centered therapy process are beginning to emerge (cf. Butler, Harper, & Mitchell, 2011; Woolley, Wampler, & Davis, 2012). These efforts continue to push marriage and family therapy (MFT) away from the competing models approach towards investigating therapeutic factors common among relational therapy models (Lebow, 1997; Johnson & Lebow, 2000). As compliment to *de facto* therapist-centered process, which is rooted in individual psychotherapy, enactments have been suggested as the “intuitive [venue] for relationship work” that utilizes a couples’ interaction as both the “vehicle and focal point for change work” (Seedall & Butler, 2006, p. 422) that is not tied to, or dependent upon, a couple’s presenting problem, or a therapist’s clinical orientation.

This study seeks to add to the emerging process-outcome literature investigating couple-centered, enactment-based process versus therapist-centered process by examining the within- and post-session attachment outcomes of clinically-distressed couples who receive both therapy process modalities (cf. Butler, Harper, & Mitchell, 2011) at the partner-level (i.e. gender). Understanding how these two therapy process modalities affect attachment outcomes may better inform clinicians and couples therapy researchers how each process is experienced by each partner and provide clinical insights into a potentially rich area of clinical research largely unexplored in conjoint marital therapy.

In order to begin such an examination, it is beneficial to review how contemporary attachment researchers conceptualize secure attachment in romantic pair-bond relationships and present what the clinical literature has found regarding the role of attachment in therapeutic outcomes. A review of therapist-centered process literature will discuss the role and maintenance

of therapeutic alliance in conjoint couple's therapy, and factors that may adversely affect the alliance hindering positive therapeutic outcomes. Similarly, a review of couple-centered, enactment-based process will be presented and discuss how proponents propose to resolve the process impasses inherent in therapist-centered process, how enactments propose to increase partner secure attachment, and discuss the recent findings from enactment process-outcome research.

Literature Review

Attachment Theory in Romantic Pair-Bond Relationships

The trend toward viewing individual and dyadic change through the lens of attachment theory continues to grow in MFT literature (cf. Obegi & Berant, 2009). Within the context of romantic pair-bond relationships, Hazan and Shaver (1987) are credited with extending Bowlby's (1969, 1973, 1980) concept of infant attachment to adult dating and marital partners, which has since transformed the study of the nature and maintenance of adult romantic relationships (cf. Cassidy & Shaver, 2010).

From a clinical perspective, adult attachment theory has awakened the attention and interest of therapists and researchers employing other models to investigate attachment as a means for understanding and aiding couple change (Davila, 2003; Johnson & Whiffen, 2003). One such clinical application of adult attachment theory to couple's therapy has been the development of emotionally-focused therapy (EFT), an empirically validated therapy model that seeks to help partners learn to identify, express and properly fulfill each other's core attachment needs (cf. Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Johnson, Hunsley, Greenberg, & Schindler, 1999; Johnson, 2004)

At the broadest level, adult attachment theory suggests that the goal of romantic relationships is “felt security” (cf. Sroufe & Waters, 1977), which has been conceptualized as secure attachment bonds that are “active, affectionate, [and] reciprocal [...] in which partners mutually derive and provide closeness, comfort, and security” (Johnson, Makinen, & Millikin, 2001, p. 145). Essential to this sense of felt security is the ability to see one’s partner as a *safe haven* and a *secure base* while concurrently being able to serve in those roles for one’s partner as well (Feeney & Collins, 2004).

Dimensional view of attachment. Decades of observational and self-reported data indicate that adult partners seeking romantic pair-bond relationships exhibit distinct categorical attachment patterns, or styles, to their partners, similar to how infants seek safety with their caregivers (cf. Ainsworth, Blehar, Waters, & Wall, 1978; Hazan & Shaver, 1987; Fraley & Shaver, 2000; Zeifman & Hazan, 1997; Waters, Merrick, Treboux, Crowell, & Albersheim, 2000). In general terms, these styles were identified as either *secure*, or *insecure*, which was further differentiated into *anxious*, *avoidant*, and *ambivalent*. However, contemporary adult attachment theorists have since moved away from this categorical typology in favor of taxonomies characterized as a function along two orthogonal dimensions—*attachment anxiety* and *attachment avoidance*.

According to Mikulincer and Shaver (2007), attachment anxiety is “concerned with a strong desire for closeness and protection” (p. 27). Fraley (2010) noted that individuals with high levels of attachment anxiety worry if their partner is available, responsive, and attentive. Such individuals intensely worry about their value to their partner and the relationship; whereas, individuals with low levels of attachment anxiety are more secure in their partner’s responsiveness. Conversely, attachment avoidance is “concerned with discomfort with closeness

and depending on relationship partners” (Mikulincer & Shaver, 2007, p. 27).” Fraley (2010) noted that individuals with high levels of attachment avoidance prefer not to rely on or open up to their partners and often rely on emotional distance and self-reliance to deal with insecurity and distress; whereas individuals with low levels of attachment avoidance are comfortable with being, and allowing others to be intimate with and depend upon them.

Empirical investigations have consistently documented high levels of attachment anxiety and attachment avoidance as negatively affecting marital satisfaction (Carnelley, Pietromonaco, & Jaffe, 1996; Cobb, Davila, & Bradbury, 2001; Davila & Bradbury, 2001; Davila, Bradbury, & Fincham, 1998) and contributing to poor communication and conflict management skills in relationships (Pietromonaco & Carnelley, 1994; Feeney, 1994; Marchand, 2004). Clinical investigations have linked attachment avoidance with divorce and multiple marriages (Ceglian & Gardner, 1999; Hill, Young, & Nord, 1994); however attachment anxiety has been linked to staying in unhappy marriages (Davila & Bradbury, 2001).

Using the orthogonal dimension construct, Brennan, Clark, and Shaver (1998) defined secure attachment as a function of low levels of attachment anxiety and low levels of attachment avoidance. A partner’s sense of secure attachment to their partner has been identified as a major variable explaining the quality of marital relationships (Feeney, 1999; Shaver & Hazan, 1993). Individuals described as securely attached to their partners demonstrated more self-disclosing behaviors (Keelan, Dion, & Dion, 1998) and exhibited greater emotional expression with their partners (Feeney, 1995, 1999; Johnson & Greenberg, 1988; Johnson, 2004). Empirical investigations of married couples have linked secure attachment to increased levels of marital intimacy (Mayseless, Sharabany, & Sagi, 1997) and marital satisfaction (Alexandrov, Cowan, & Cowan, 2005; Charania & Ickes, 2007), decreased marital ambivalence (Volling, Notaro, &

Larsen, 1998), and an increase in positive marital climate (Diehl, Elnick, Bourbeau, & Labouvie-Vief, 1998). Perhaps most important, during instances of couple conflict, securely attached partners have been found to be better communicators who constructively resolve their problems (Hazan & Shaver, 1987; Levy & Davis, 1988; Shi, 2003). Self-reports of a secure pair-bond attachment have been linked with positive aspects of relationship functioning, including high levels of trust, commitment, interdependence, and dyadic satisfaction (Kirkpatrick & Davis, 1994; Mikulincer, 1998). Thus, when partners feel secure in their relationships they are more satisfied and behave in ways that enhance the relationship (Mikulincer & Shaver, 2007).

Secure attachment requires a profound level of dynamic interdependence between partners as they simultaneously occupy the attachment-seeker and the attachment-provider roles for each other. This dynamic attachment interdependence requires attachment-seekers to seek their partner sensitively, while attachment-providers must be attuned to and in synchrony with their partner's needs (cf. Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969; Hazan & Shaver, 1987; Hazan, Gur-Yaish, & Campa, 2004). Because of this interdependence, incidents in which one partner fails to respond appropriately adversely affects the quality of an attachment bond between partners (Simpson & Rholes, 1994). Consequently, relational distress ensues as the attachment-seeker fails to feel secure in the relationship or the attachment-provider fails to meet attachment needs resulting in attachment injuries (Johnson, Makinen, & Millikin, 2001).

Attachment behaviors and therapeutic outcomes. Research continues to identify unmet attachment needs and attachment injuries as central components of distress in adult pair-bond relationships (Hazan & Zeifman, 1999; Johnson, Makinen, & Millikin, 2001; Feeney & Collins, 2004; Millings & Walsh, 2009), which potentially can bring a couple to therapy. Although spouses may describe the problem in terms of content, the underlying problem,

however, is the threat to attachment security (cf. Davis & Butler, 2004), and may become a clinically recurring theme that has the potential to create a therapeutic impasse that blocks relationship repair in couple's therapy (Johnson, Makinen, & Millikin, 2001).

Complimentary Therapy Processes in Conjoint Marital Therapy

At the onset of therapy, each partner attempts to enlist the therapist to understand his or her experience within the relationship to the extent that they feel the therapist accepts his or her version of the presenting problem or therapy goals (Symonds & Horvath, 2004; see Butler, Harper, & Brimhall, 2011; Brimhall & Butler, 2011). As a means of mediation, therapists have two distinct process modalities to rely upon in order to foster and increase secure attachment, that is, decrease partner levels of attachment anxiety and attachment avoidance—*therapist-centered process*, where couples interact directly with the therapist, and very little with each other, and *couple-centered, enactment-based process*, where couples interact directly with each other, with the therapist indirectly involved.

Therapist-centered process in the context of conjoint marital therapy. Therapist-centered process relies on the strength of the therapist's alliance with each partner individually, and with the couple system collectively. Initially conceptualized by Bordin (1979, 1994), the therapeutic alliance is a collaborative relationship between the client(s) and the therapist characterized "by an emotional bond based on mutual trust and positive regard, shared goals, and clearly defined tasks" (Garfield, 2004, p. 458).

Decades of empirical evidence confirm that the development and maintenance of a productive therapeutic alliance is a strong predictor of outcome in individual (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000; Horvath & Bedi, 2002) and marital therapy, regardless of theoretical model (cf. Johnson & Greenberg, 1985; Gurman, Kniskern, & Pinsof,

1986; Heatherington & Friedlander, 1990; Bourgeois, Sabourin, & Wright, 1990; Johnson & Talitman, 1997; Quinn, Dotson, & Jordan, 1997; Knobloch-Fedders, Pinsof, & Mann, 2004; Knobloch-Fedders, Pinsof, & Mann, 2007; Anker, Owen, Duncan, & Sparks, 2010); however, in contrast to establishing a therapeutic relationship within individual psychotherapy, the therapeutic alliance within conjoint marital therapy is seen as a “unique, complex, and multilayered” phenomena (Friedlander, Escudero, Heatherington, & Diamond, 2011, p. 25; cf. Butler, Harper, & Brimhall, 2011; Brimhall & Butler, 2011; Kneer, Bartle-Haring, McDowell, Adkins, Ostrom Delaney, & Gangamma, 2011; Bartle-Haring, Knerr, Adkins, Ostrom Delaney, Gangamma, Glebova, Grafsky, McDowell, & Meyer, 2012) that occurs “between the *therapeutic system* and the *patient system* that pertains to their capacity to mutually invest in, and collaborate on, the therapy” (Pinsof & Catherall, 1986, p. 139, emphasis added).

Couples presenting to therapy often begin with one distressed partner desperate to save their relationship. Recent research has found that distressed females may quickly develop a strong alliance with the therapist, which has the potential to be perceived as collusion by their male partners (Knerr, Bartle-Haring, McDowell, Adkins, Ostrom Delaney, Gangamma, Glebova, Grafsky, & Meyer, 2011; Porter & Ketring, 2011). Unfortunately, this behavior may adversely “split” (Pinsof & Catherall, 1986) or “unbalance” (Minuchin & Fishman, 1981) the therapeutic alliance, potentially hindering therapeutic progress and outcomes (Heatherington & Friedlander, 1990; Quinn, Dotson, & Kordan, 1997; Mamodhousen, Wright, Tremblay, & Poitras-Wright, 2005; Muñiz de la Peña, Friedlander, & Escudero, 2009).

Although clinical suggestions to avoid split alliances exist (cf. Garfield, 2004; Symonds & Horvath, 2004), therapist-centered process only allows partners to indirectly interact with each other through the therapist. As the therapist encourages each partner to share his or her story,

partners may experience the therapist as more sensitively responsive to their emotional needs than their partners (Symonds & Horvath, 2004), which could cause partners to look to their therapist as an alternative attachment provider (cf. Ainsworth, 1989; Amini, Lewis, Lannon, & Louie, 1996; Farber, Lippert, & Nevas, 1995; Mallinckrodt, Gannt, & Coble, 1995; Vogel & Wei, 2005; Janzen, Fitzpatrick, & Drapeau, 2008).

Although the components of attachment prominent in romantic pair-bond relationships differ from those within the therapeutic relationship, Parish and Eagle (2003) noted that the therapeutic relationship “[has] every feature of [romantic pair-bond] attachment identified in the theoretical literature with the sole exception [of...] protesting separation from the therapist” (p. 280). More recently, Obegi (2008) and Mallinckrodt (2010) presented convincing clinical illustrations of individual psychotherapy clients who exhibited attachment-like patterns to their therapist that warrants concern when working with distressed couples through a therapist-centered process modality.

Interestingly, despite being distressed, partners tended to view the attachment to their partner as stronger than the attachment to their therapist, and were more likely to turn to their partner in times of distress as their attachment provider (Parish & Eagle, 2003), a phenomena similar to what Symonds and Horvath (2004) termed as couple “allegiance.” Consequently, partners experiencing therapist-centered process are unable to act as each other’s attachment provider, as their primary interactions are with the therapist, whose empathic responses and attentive listening may move the therapist from a concerned mediator to an alternative attachment provider (cf. Obegi & Berant, 2009; Mallinckrodt, 2010; Parish & Eagle, 2003; Obegi, 2008). Clearly, then what partners seek and need from their pair-bond partner are attachment availability, responsiveness, and engagement. Therefore, a more effective process

modality may consist of the therapist facilitation and coaching of partners' secure attachment interaction, rather than the therapist attempting to be that provider. As such, an alternative couple-centered, enactment-based process has been suggested for alleviating this tension by focusing the therapy process on helping couples reestablish and restore their own secure attachment bonds by using each other as attachment providers.

Enactment-based, couple-centered process in the context of conjoint marital therapy. Enactment-focused therapists operate under the assumption that relational distress can be attributed to couple process more than the identified presenting problem (Davis & Butler, 2004). By facilitating and assisting direct, semi-structured couple-centered engagement (Andersson, Butler, & Seedall, 2006; Butler, Davis, & Seedall, 2008), enactments purport to act as an effective intervention that creates a space whereby the expression and resolution of unmet attachment needs, or the repair of damaged attachment bonds, can be actualized *within the couple system* (Andersson, Butler, & Seedall, 2006; Butler, Harper, & Mitchell, 2011).

Operating within the conceptual framework of attachment theory (Bowlby, 1969, 1973, 1980), enactment-anchored therapy, or more broadly, couple-centered process, seeks to provide a semi-structured dyadic process that promotes spousal secure attachment that actively engages partners in the therapy process by facilitating new interactional and emotional experiences within the couple relationship (i.e. couple system) that may potentially help couples move beyond the impasse of their attachment injuries and heal their relationship (cf. Andersson, Butler, & Seedall, 2006; Butler & Bird, 2000; Butler & Gardner, 2003; Davis & Butler 2004; Gardner & Butler, 2009).

Conceptually, enactments provide a clinical process framework or modality for investigating how couple-centered process can increase dyadic secure attachment, thereby

decreasing marital distress. Under the guidance and coaching of the therapist, enactments are designed to utilize dyadic “interaction[al] experiences to effect deeper attitudinal, attribution, and attachment shifts or changes” (Butler & Gardner, 2003, p. 312) and create a space where partners learn how to identify and express their attachment-seeking needs and behaviors to their attachment-provider, who learns how to attune and respond to their partner’s needs. Thus, by facilitating effective attachment interactions, positive communication skills, and constructive dialogue within the safe environment of therapy, couple-centered, enactment-based process encourages partner- and couple-level change that can extend into situations outside of therapy as partner interactions become associated as being “relationship enhancing and satisfying in terms of both process and outcome” (Butler & Garner, 2003, p. 326).

Enactments as a process intervention to increase secure attachment. Scholarly conceptualization and empirical investigations suggest couple-centered, enactment-based process is a clinically effective modality that facilitates the expression of partner emotions, responsiveness, and the expression of attachment needs (Andersson, Butler, & Seedall, 2006; Butler & Seedall, 2006; Johnson, 2003; Kerr & Bowen, 1988; Seedall & Butler, 2006), which promote the healing of secure attachment bonds (Johnson & Greenman, 2006), help resolve attachment injuries (Makinen & Johnson, 2006), and enhance the expression of partner intimacy (Weeks & Fife, 2009).

Enactments as process intervention to implementing positive change in dyadic relationships. Through direct, semi-structured couple engagement, enactments may be an effective intervention that promotes partner softening conducive to the expression and resolution of unmet attachment needs or damaged attachment bonds in order to create the safe, secure

connection necessary for secure attachment superior to therapist-centered process (cf. Andersson, Butler, & Seedall, 2006; Butler, Davis, & Seedall, 2008; Butler, Harper, & Mitchell, 2011).

From a theoretical perspective, enactments proffer to be an effective intervention that promotes couple self-reliance, interactional confidence, hope, and the expectancy for attitudinal- and behavioral-levels of change (Seedall & Butler, 2006) by reducing attachment anxiety and avoidance. By facilitating effective communication skills and dialogue within the safe environment of therapy, attachment avoidance may be reduced through successful positive interactional experiences, which encourage spousal and couple change that can be implemented in situations outside of therapy. Additionally, as a couple-constructed and therapist-facilitated process, enactments “represent an important interactional context in which partners may develop new meanings regarding themselves, their partners, and their relationship” (Seedall, 2009, p. 103), whereby couples experience “healthy interaction[al] patterns, relationship connection, intimacy, healing, self-reliance, problem-solving, and resolution” (Andersson, Butler, & Seedall, 2006, p. 302) thereby reducing attachment anxiety and avoidance.

In sum, couple-centered, enactment-based process may be the “intuitive [venue] for relationship work” that utilizes a couples’ desire to change as the “vehicle and focal point for change work” (Seedall & Butler, 2006, p. 422). By placing the couple at the center of the therapy process, with the therapist indirectly involved, enactments have the potential of increasing secure attachment in therapy seeking couples.

Enactment outcome research. Although clinical investigations examining the effects of couple-centered, enactment-based process on attachment behaviors at the partner- and couple-level remain few, the corpus of literature suggest that enactments generate positive outcomes and increase couple responsibility by promoting couple self-reliance, healing, softening, and

attachment repair (cf. Butler & Wampler, 1999; Andersson, Butler, & Seedall, 2006; Seedall & Butler, 2006; Butler, Harper, & Mitchell, 2011; Woolley, Wampler, & Davis, 2012).

The first empirical study (Butler & Wampler, 1999) to investigate the clinical utility of enactments found increased couple-levels of responsibility conducive towards positive therapeutic outcomes than those achieved by traditional therapist-centered approach. Later, studies examining the applicability of enactments to specific couple problems were found to be successful in promoting couple self-reliance, healing, softening, and attachment repair (Zitzman & Butler, 2005; Andersson, Butler, & Seedall, 2006). Recently, Woolley et al. (2012) found that therapists who actively engaged the couple system during enactments helped increase the amount of positive couple communication expressed, which in turn most likely improved secure attachment (cf. Feeney, Noller, & Roberts, 2000; Guerrero, 2008). At the partner-level, Woolley and colleagues suggested that males were more likely to respond to change-oriented interventions, such as enactments, as males focus on the “here and now” with their partners. Conversely, women were found to respond more positively to insight-oriented interventions, which although not explicitly identified, has been associated with therapist-centered process (cf. Snyder, Wills, & Grady-Fletcher, 1991; Snyder & Wills, 1989; Wills, Faitler, & Snyder, 1987).

Recently, Butler and colleagues (2011) presented preliminary results of self-reported levels of secure attachment from 16 couples who received sequential treatments of three therapist-centered and three couple-centered, enactment-based therapy sessions and found moderate support for employing enactments early in therapy. Females’ self-reported measures of secure attachment increased with both types of therapy; however, only males who received enactment-based therapy first increased in secure attachment more than males whose therapy began with therapist-centered process. Although gender differences did not achieve statistical

significance, the participant sample recruited by Butler and colleagues (2011) has grown to a level where further investigation into partner effects of the two processes is now possible.

Purpose of the Study

Although the findings from Butler and colleagues (2011) were preliminary, they were the first to contrast couples receiving therapist-centered and couple-centered, enactment-based processes with attachment outcomes. Building upon these preliminary findings, this study sought to examine how each therapy process modality affects the two constituent components of secure attachment, namely, attachment anxiety and attachment avoidance, in distressed therapy-seeking couples. Specifically, this study examined the effects of therapist-centered and enactment-based, couple-centered therapy processes on self-reported measures of secure attachment, as a function of attachment anxiety and attachment avoidance, within-session (i.e. post-session minus pre-session) and post-session outcomes over the course of treatment.

Hypotheses

In context of the findings presented by Butler and colleagues (2011) and Woolley and colleagues (2012), we hypothesized that (H1) couple-centered, enactment-based sessions will produce high levels of secure attachment gains (i.e. post-session scores minus pre-session scores), defined as lower levels of attachment anxiety and attachment avoidance than therapist-centered process for both males and females; (H2) couple-centered, enactment-based sessions will be associated with higher levels of post-session secure attachment, defined as lower levels of attachment anxiety and attachment avoidance than therapist-centered process for both males and females. Additionally, in line with Woolley and colleagues' (2011) assertion, (H3) we hypothesize that males will be more responsive to change-oriented interventions, such as enactments, and females prefer insight-oriented interventions, which we associate with therapist-

centered process, by testing for interaction effects between spouse gender and therapy process modality.

Methods

Procedure and Design

The researchers administered self-report attachment measures in a pretest-posttest, repeated measures experimental design (cf. Cook & Campbell, 1979) where partners were administered the same measure prior to and directly after each experimental session (see Figure 1). Participating couples ($N = 35$) experienced a total of six therapy sessions—three sessions defined as “therapist-centered” and three sessions defined as “couple-centered, enactment-based.” Each couple provided a matched participant sample, experiencing both therapist-centered and couple-centered, enactment-based process modalities. Two treatment groups were created based on the sequencing of the therapy process modalities, with one group of couples beginning with three therapist-centered process sessions ($n = 18$) and the other group beginning with three couple-centered, enactment-based process sessions ($n = 17$). The two contrasting treatment groups were created in order to counterbalance and control for any potential sequencing effects the two therapeutic processes may have (see Figure 1).

After the first three sessions, participating therapists transitioned to the alternate treatment process for the last three sessions. Transition between therapy process modalities that occurred between sessions 3 and 4 was not disclosed to the participants during treatment.

Prior to the experimental phase of the study, therapists spent an average of three sessions (range: 1 to 6, $SD = 1.4$) focused on assessment, joining, and establishing a therapeutic alliance.

Participating Couples

Couples recruited for the study consisted of 35 heterosexual couples (married, $n = 33$; engaged, $n = 1$; separated, $n = 1$) that presented for couples therapy at a community clinic in the Western United States volunteering for a university study focused on “improving couple communication.” For their participation, couples were offered either six sessions of free therapy or gift cards of comparable value.

Demographic questionnaires were administered to each spouse prior to treatment. The mean age for males and females was 38 ($SD = 16.99$) and 35 ($SD = 16.88$), respectively. The mean length of relationship was 7.50 years ($SD = 7.79$), and the average number of children was 2.33 ($SD = 1.03$).

The ethnic identity of participants was Caucasian (88.6%), Hispanic (5.7%), Asian (1.4%), with 4.3% not reporting. The level of education attained by participants included high school (22.9%), some college (32.9%), college degree (34.3%), graduate degree (5.7%), with 4.3% not reporting. Participants reported an annual household income of under \$14,999 (20%), between \$15,000-\$29,999 (28.6%), between \$30,000-\$44,999 (28.6%), between \$45,000-\$59,999 (5.7%), and >\$60,000 (12.9%), with 4.3% not reporting.

Self-identified presenting problems for therapy included communication problems (80%; males, $n = 27$; females, $n = 29$; couple agreement, $n = 27$), depression and/or anxiety (10%; males, $n = 3$; females, $n = 4$; couple agreement, $n = 3$), behavioral addictions (4.3%; males, $n = 2$; females, $n = 1$; couple agreement, $n = 1$). Three males and one female (5.7%) left the presenting problem blank on the demographic questionnaire.

Treatment duration of the six sessions ranged between 4.86 and 20.0 weeks (mean = 8.6, $SD = 3.53$). The mean length of time required to complete the experimental sessions was 8.33

weeks ($SD = 2.77$; range: 4.86 to 14.29) for couples beginning with therapist-centered process modality, and 8.9 weeks ($SD = 4.27$; range: 5.0 to 20.0) for couples beginning with couple-centered, enactment-based process. An independent-samples t -test was conducted to compare the difference in treatment length between the two treatment groups and showed no statistically significant difference between the two treatment conditions ($t(33) = 1.556, p = .221$, two-tailed). The magnitude of the differences in the means (means difference = -0.57 , 95% CI : -3.03 to 1.89) was very small ($\eta^2 = .006$). In other words, only 0.6% of the variance was attributed to differences in the treatment length couples received between treatment groups.

Participating Therapists

Therapists participating in the study consisted of 17 MFT Master's-level student therapists—7 males and 10 females—enrolled in a COAMFTE-accredited marriage and family therapy graduate program who were supervised by licensed doctoral-level AAMFT-approved supervisors. Ages of the participant therapists ranged from 24 to 53, with a mean age of 30 ($SD = 6.6$).

Participating therapists received 12 hours of study-specific training from an AAMFT-approved supervisor proficient in both the enactment-based, couple-centered process modality and the therapist-centered modality (cf. Butler, Harper, & Mitchell, 2011). Training in each therapy process modality followed the procedure outlined by Butler et al. (2011), which included instructional reading and didactic training describing the process and protocol of each treatment condition. Therapists were instructed to employ the two contrasting modalities as a process overlay to their own theoretical orientation or clinical model. In other words, therapists only altered interaction processes while employing their preferred clinical model.

Throughout their participation in the study, participating therapists were instructed to review the criteria for the appropriate treatment condition prior to conducting experimental sessions. Therapist proficiency was assessed through experiential role-plays that were video recorded and later observationally coded using Davis and Butler's (2004) Relationship Enactment-Based Clinical Process–Observational Assessment of Proficiency instrument (REBCP-OAP; see Figure 2) for the couple-centered, enactment-based process modality, and the Person-of-the-Therapist-Based Clinical Process Observational Assessment of Proficiency instrument (PoTCCP-OAP; Butler, unpublished instrument; see Figure 3) for the therapist-centered process.

Process proficiency was attained when therapists exhibited at least eight of nine mid-level therapist tasks for couple-centered, enactment-based process, and seven of eight mid-level tasks for therapist-centered process. Intraclass correlation coefficients of the mid-level therapist tasks were conducted on the video recorded role plays that were observationally coded by 1 MFT graduate and 1 undergraduate video coder. Results achieved strong agreement between coders for therapist-centered ($ICC = 0.7$; 95% CI : .51 to .81, $df(56)$, $p < .001$) and couple-centered, enactment-based process and achieved strong agreement ($ICC: 0.7$; 95% CI : .32 to .83, $df(56)$, $p < .001$).

Institutional Review Board and Experimental Compliance

This study was conducted with Institutional Review Board (IRB) approval, reviewed annually (2007-2012). Study-specific informed consents were obtained from each partner prior to participating in the experiment. At the conclusion of the sixth session, a graduate research assistant debriefed each partner separately through a semi-structured qualitative interview and explained the scope, purpose, and procedures of the experiment per IRB guidelines.

Measures

Revised dyadic adjustment scale (RDAS). Prior to each of the six experimental sessions, spouses were administered the Revised Dyadic Adjustment Scale (RDAS; Busby, Christensen, Crane, & Larson, 1995), a 14-item Likert-scale measure used to assess each partner's level of marital distress. Internal reliability of the RDAS has been established at $\alpha = .80$, and was replicated with the participant sample of the study ($\alpha_{\text{Males}} = .87$; $\alpha_{\text{Females}} = .86$). Clinical distress was indicated using the cutoff score of 48 (Crane, Middleton, & Bean, 2000).

Prior to the first experimental session, the range of RDAS scores for the entire participant sample was between 16 and 58, with a mean RDAS score of 40.67 ($SD = 7.76$) with 28 males (84.8%) and 30 females (90.9%) indicating clinical levels of distress. Mean RDAS scores for couples beginning the experiment with the therapist-centered process were 41.29 ($SD = 7.37$, range: 27 to 58) and 39.94 ($SD = 7.07$, range: 18 to 51) for males and females, respectively; with 15 (83.33%) males and 16 (94.1%) females identified as clinically distressed. Mean RDAS scores for couples beginning the experiment with couple-centered, enactment-based process were 41.88 ($SD = 9.46$, range: 16 to 56) and 39.56 ($SD = 7.51$, range: 26 to 52) for males and females, respectively; with 13 (81.30%) males and 14 (87.50%) females identified as clinically distressed. An independent-samples t-test was conducted to compare the difference in marital distress prior to the experimental phase of treatment for males ($t(31) = -.197$, $p = .399$, two-tailed) and females ($t(31) = .149$, $p = .882$, two-tailed) between the two treatment groups and yielded no statistically significant difference. The magnitude of the differences in the means for males (means difference = -0.58, 95% CI : -6.58 to 5.42) and females (means difference = 0.38, 95% CI : -4.80 to 5.56) was very small ($\eta^2 < .001$) for both partners.

Secure attachment measure (SAM). Partner attachment was measured using the SAM,

a 19-item questionnaire adapted from the 36-item Experiences in Close Relationships measure (ECR; Brennan, Clark, & Shaver, 1998), which has been used to assess attachment styles in clinical and non-clinical samples (Fraley, Waller, & Brennan, 2000; Halchuk, Makinen, & Johnson, 2010; Parker, Johnson and Ketring, 2011). Consisting of the two subscales—attachment anxiety (12 items) and attachment avoidance (7 items)—the SAM measured self-reported levels of attachment anxiety (Cronbach's $\alpha_{\text{Males}} = .93$, $\alpha_{\text{Females}} = .92$) and attachment avoidance (Cronbach's $\alpha_{\text{Males}} = .96$, $\alpha_{\text{Females}} = .97$).

Recently, Parker and colleagues (2011) published results of an exploratory factor analysis (EFA) on the ECR using a therapy-seeking couple sample and presented a clinically-informed version of the ECR. This version was internally reliable for both males and females on both the attachment anxiety ($\alpha_{\text{Males}} = .91$, $\alpha_{\text{Females}} = .90$) and attachment avoidance ($\alpha_{\text{Males}} = .90$, $\alpha_{\text{Females}} = .90$) subscales that were representative of the non-clinical sample presented by Fraley and colleagues (2000).

In addition to identifying separate factors for males and females that were unobserved in the non-clinical sample, several items were found not to load for males and females, and a separate *dependence* factor was identified for both partners as contributing to unexplained variance. Upon the recommendation of Parker and colleagues (2011) these items were removed from statistical analysis. Consequently, 5 items associated with the attachment anxiety and 5 items associated with attachment avoidance were used for statistical analysis, with a total of 10 items examined for secure attachment.

When completing the SAM, couples were asked to reflect in terms of their relationship “over the past week” (pre-session SAM) and “during the session” (post-session SAM).

Respondents used a 7-point Likert scale to indicate the level of agreement with items such as “I worry about being abandoned by my partner” and “I tell my partner just about everything.”

Following Butler et al.’s (2011) scoring scheme, items were positively coded to indicate greater levels of self-reported spousal secure attachment. Additionally, we calculated mean scores for the attachment anxiety and attachment avoidance subscales separately (cf. Fraley, Waller, & Brennan, 2000). Possible scores for the secure attachment ranged from 10 to 70; for the attachment anxiety subscale, 5 to 35; and for the attachment avoidance subscale, 5 to 35. Following the recommendations of Fraley and colleagues (2000), secure attachment composite and attachment anxiety and avoidance subscales were not averaged in order to more accurately identify changes in attachment styles over time. Thus, two possible scores were extrapolated from the data—(1) a positively coded *secure attachment* composite score (cf. Butler, Harper, & Mitchell, 2011) and (2) separate *attachment anxiety* and *attachment-avoidant* scores (cf. Fraley, Waller, & Brennan, 2000; Parker, Johnson, & Ketring, 2011).

Prior to the experimental phase of the study, the mean secure attachment composite scores for couples beginning with the therapist-centered process were 45.48 ($SD = 13.75$; range: 26 to 68) for males and 47.55 ($SD = 13.55$; range: 23 to 70) for females. Mean scores for males and females along the attachment anxiety subscale were 18.41 ($SD = 8.91$ range: 5 to 33) and 17.14 ($SD = 7.91$; range: 5 to 32), respectively. Along the attachment avoidance subscale, mean scores for males and females were 18.41 ($SD = 7.29$; range: 5 to 31) and 15.32 ($SD = 7.29$; range: 5 to 27), respectively.

Secure attachment composite scores for couples beginning with the couple-centered, enactment-based process for males and females were 51.8 ($SD: 11.77$; range: 30 to 70) and 53.15 ($SD: 9.8$; range: 34 to 65), respectively. Mean scores for males and females along the attachment

anxiety subscale were 16.35 ($SD = 8.05$; range: 6 to 30) and 20.3 ($SD = 8.14$; range: 7 to 33).

Along the attachment avoidance subscale, mean score for males and females were 16.35 ($SD = 5.84$; range: 8 to 25) and 19.1 ($SD = 6.66$; range: 9 to 31), respectively.

An independent-samples t-test was conducted to compare the difference in self-reported SAM composite score, and attachment anxiety and attachment avoidance subscales prior to the experimental phase of treatment for males and females in each of the two treatment groups. No statistically significant difference was found in the SAM composite score between the two treatment groups for both males ($t(39) = -.43, p = .669$, two-tailed) and females ($t(40) = 1.81, p = .079$, two-tailed). The magnitude of the differences in the means for males (means difference = -1.82, 95% CI : -10.39 to 6.74) and females (means difference = 6.95, 95% CI : -.83 to 14.72) was very small for males ($\eta^2 = .005$) and moderate for females ($\eta^2 = .075$).

Additionally, there was no statistically significant difference for the attachment anxiety subscale for both males ($t(39) = -.06, p = .952$, two-tailed) and females ($t(40) = -1.28, p = .209$, two-tailed). The magnitude of the difference in the means for males (means difference = -.159, 95% CI : --5.53 to 5.21) and females (means difference = -3.16, 95% CI : -8.17 to 1.844) was very small for males ($\eta^2 < .001$) and moderate for females ($\eta^2 = .04$). Lastly, no statistically significant difference was found for the attachment avoidance subscale for both males ($t(40) = .658, p = .514$, two-tailed) and females ($t(40) = -0.03, p = .976$, two-tailed). The magnitude of the difference in the means for males (means difference = 1.19, 95% CI : -2.48 to 4.87) and females (means difference = -0.59, 95% CI : -4.08 to 3.98) was small for males ($\eta^2 = .011$) and females ($\eta^2 = .001$). In sum, no non-systematic differences were identified between couples in the two treatment groups.

Protocol Validation

To ensure protocol validity and therapist fidelity to the experimental design, five undergraduate research assistants were recruited to independently code each session using the Enactment-Based Clinical Process-Observational Assessment of Proficiency instrument (see Figure 2) for the couple-centered, enactment-based process modality, and the Person-of-the-Therapist-Based Clinical Process Observational Assessment of Proficiency instrument for the therapist-centered process (see Figure 3).

Coder training consisted of a 30 minute overview of the study's goals, experimental design, and procedure followed by an in-depth explanation of the conceptualization and operationalization of couple-centered, enactment-based process (as detailed in REBCP-OAP, see Figure 2) by the principal investigator and a graduate research assistant. Coder's then observationally coded three 15-minute video recorded enactment role-plays conducted by Master's- and Doctoral-level students with the principal investigator in order to review the coder's understanding of the couple-centered, enactment-based coding instrument and therapy process. A final "live session" coding of a participating couple determined coder proficiency. This training process was repeated for therapist-centered videos using the therapist-centered coding instrument (see Figure 3). Thus, coders received a total of 4 hours of training.

A total of 210 sessions were included as part of the study, with 105 therapist-centered and 105 couple-centered, enactment-based sessions video recorded. The mean session length for therapist-centered sessions was 48:44 minutes ($SD = 14:57$ minutes) and 46:50 minutes ($SD = 18:14$) for couple-centered, enactment-based sessions.

Couple-centered, enactment-based sessions were included for analysis if the spouses were observed as being each other's in-session attachment-providing figure. Operationally,

therapist-specific tasks were broadly divided into three mid-level tasks defined as *sustaining and monitoring couple interaction*, *coaching*, and *facilitating couple-centered attachment interaction* with three micro-level tasks in each of the three mid-level therapist tasks. Within the sustaining and monitoring couple interaction task, the three micro-level therapist tasks were: (1) sustaining couple interaction and avoiding unnecessary interruption; (2) commending positive couple interaction; and (3) interrupting negative couple interaction. Within the coaching task, the three micro-level tasks were (1) coaching positive spouse expression; (2) coaching positive spouse attending; and (3) assisting positive attending/expression (proxy voice; cf. Butler & Gardner, 2003). Within the facilitating couple-centered attachment interaction, the three micro-level therapist tasks were: (1) promoting couple expression; (2) promoting couple a listening; and (3) promoting couple responses (see Figure 2).

These micro-level tasks were coded as an extension of three mid-level tasks, thus therapists observed performing one of the micro-level tasks were also scored as performing the corresponding mid-level task and respective macro-level task. In other words, therapists were not required to perform all of the corresponding micro-level tasks to certify a mid-level task. For the purposes of this study, sessions where one mid-level task was observed, the macro-level “Intervention” task was considered satisfied, and was included for analysis.

Therapist-centered sessions were included for analysis if the therapist was observed to be the in-session attachment-providing figure. Operationally, couple-centered, enactment-based therapists tasks were broadly divided into three mid-level tasks defined spouse *sharing*, therapist *listening*, and therapist *validating*. Within the spouse sharing task, one micro-level therapist task was included: encouraging and inviting couples to share their “story” with the therapist. Within the therapist listening task, one micro-level therapist task was included: empathically listening as

one or both partners share their story, feelings, or thoughts. Within the therapist validating task, the three micro-level therapist tasks coded were: (1) reflecting partners' feelings; (2) validating the partner's feelings; and (3) reframing negative comments (see Figure 3). Therapists who performed one micro-level task were also scored as performing the corresponding mid-level task and macro-level tasks, and thus were not required to perform all of the corresponding micro-level tasks to certify a mid-level task.

For both therapy processes, fidelity was tested at the macro- and mid-level tasks. For therapist-centered process, all three macro-level tasks were adhered to 103 sessions (98.1%) and only two macro-level tasks were observed in 2 sessions (1.9%). Therapists were observed to adhere to the two *structure* mid-level tasks in 91 sessions (86.67%) and only one mid-level task was observed in 14 sessions (13.33%). Sessions with all three mid-level *attachment* tasks were observed in 100 sessions (95.23%) and 5 sessions only adhered to two mid-level tasks (4.76%). Lastly, all three mid-level *substance* tasks were observed in 90 sessions (85.7%), 15 sessions were observed to adhere to two (14.29%), and 5 sessions (4.76%) were observed to adhere to one.

For couple-centered, enactment-based process, all three macro-level tasks were adhered to 87 sessions (82.85%), only two macro-level tasks were observed in 12 sessions (11.43%), and only one macro-level task was observed in 6 sessions (5.71%). Therapists were observed to adhere to all three mid-level *initiation* tasks in 37 sessions (35.24%), only two mid-level tasks were observed in 43 sessions (40.95%), and only one mid-level task was observed in 25 sessions (23.81%). Sessions with all three mid-level *intervention* tasks were observed in 87 sessions (82.85%) and only two mid-level tasks in 18 sessions (17.14%). Lastly, all three *evaluation* mid-

level tasks were observed in 8 sessions (7.62%), two mid-level tasks were observed in 29 sessions (27.62%), and only one mid-level task was observed in 68 (64.76%) sessions.

Statistical Analysis

Analysis of the attachment outcomes of each partner over the six sessions of the study required a repeated measures approach capturing the attachment levels and marital distress of each partner during the three therapist-centered versus three couple-centered, enactment-based portions of treatment. Accordingly, longitudinal data was hierarchically structured and required a multilevel nested approach (Bryk & Raudenbush, 1987, 1992; Raudenbush, 2001).

Due to the study's complexity, a $2 \times 2 \times 3 \times 2$ ANOVA was employed to account for the multifactorial design of the experiment (see Figure 4). Factors included for analysis were treatment group (0 = AAA-BBB, 1 = BBB-AAA; see Figure 4, Part A), therapy process modality (0 = therapist-centered, 1 = couple-centered, enactment-based; see Figure 4, Part B), the 3 sessions for each segment of the study for a total of 6 sessions (see Figure 4, Part C), spouse (0 = wife, 1 = husband; see Figure 4, Part D). Such analysis allowed for a robust model and in-depth examination into the correlates and predictors of partner (i.e. gender) differences in the parameters of change (i.e. treatment modality) under investigation.

Results

Before proceeding with the data analysis, the data were examined for possible code and statistical assumption violations, as well as for missing values, and outliers, using SPSS Frequencies, Explore, and One-Way ANOVA procedures. The RDAS had a total of 10 (2.4%), missing scores, and for the SAM, 6 (1.4%) pre-session and 10 (2.4%) post-session scores were not reported. Several univariate outliers were detected and isolated to two couples over the course of the study as having an RDAS less than two standard deviations from the mean;

however, they were not considered extreme or unusual enough to require deletion, as one couple was in each of the two treatment groups, and their responses, over the course the experiment, returned within the normal distribution range. Because there was a random assignment of participants to treatment groups and random assignment of couples to participating therapists, independence was assumed to be appropriate between treatment groups.

Kolmogorov-Smirnov, Shapiro-Wilk tests of normality of all of the dependent variables were not found to be statistically significant ($p > .05$) and Levene's test for homogeneity of variance was performed on each dependent variable, and none were found to be statistically significant ($p > .05$); thus assumptions of normality and heterogeneity were not violated..

Longitudinal Multilevel Model with Repeated Measures

In order to account for both random and fixed variables, a longitudinal mixed model with repeated measures approach (Heck, Thomas, & Tabata, 2010) was employed to analyze the post-session changes in secure attachment, and the subscales of attachment anxiety and attachment avoidance over the duration of treatment.

Treatment group effects. The experimental design of the study placed participating couples in one of two randomly assigned treatment groups in order to counterbalance any effects the sequencing of the two therapy process modalities could potentially have on the results. Using the MIXED command in SPSS, a mixed model analysis was conducted on the treatment groups and any interaction effects it would have on partners. Results revealed that treatment groups, that is, receiving one therapy process modality before the alternate process, did not have a statistically significant main effect on post-session reports of secure attachment ($F(1, 39.98) = 0.060, p = .807$; see Table 2), attachment anxiety ($F(1, 39.93) = .048, p = .828$; see Table 3), or attachment avoidance ($F(1, 39.93) = .082, p = .776$; see Table 4) subscales. Within session

differences (i.e. post-session and pre-session differences) were not statistically significant for secure attachment ($F(1, 39.072) = .116, p = .735$; see Table 5) or for the attachment-anxiety ($F(1, 39.73) = .131, p = .719$; see Table 6) and attachment avoidance ($F(1, 39.039) = .107, p = .746$) subscales (see Table 7).

Although treatment groups did not have a significant main effect on the dependent variables, treatment groups and partner interaction effects were observed to be significant for post-session secure attachment composite scores ($F(1, 436.253) = 6.231, p = .013$; see Figure 2) and post-session attachment avoidance ($F(1, 443.055) = 10.111, p = .002$; see Figure 4). These results indicate that beginning conjoint couples therapy with therapist-centered process reduced female post-session attachment avoidance, and produced higher levels of secure attachment than beginning therapy with couple-centered, enactment-based process. Conversely, couple-centered, enactment-based process reduced attachment avoidance for males, and produced higher levels of secure attachment than beginning therapy with therapist-centered process.

Therapy process effects over time. Therapy process modality effects were found to have a statistically significant main effect on post-session secure attachment ($F(1, 436.263) = 3.706, p = .055$) and within-session attachment avoidance ($F(1, 438.495) = 5.221, p = .002$); however no statistically significant main effect was observed within or after each session. Statistically significant interaction effects were observed for therapy process over the three sessions for both post-session secure attachment ($F(2, 436.357) = 3.074, p = 0.047$; see Figure 7) and post-session attachment avoidance ($F(2, 443.122) = 2.861, p = .058$; see Figure 8).

Plots of estimated marginal means revealed a treatment effect unique to couple-centered, enactment-based process. This treatment effect placed post-session 1 secure attachment 1.25%

higher than therapist-centered process; followed by post-session 2 secure attachment 8.11% higher than therapist-centered; and then 0.61% lower than therapist-centered process after session 3. This effect is also observed along the attachment avoidance subscale, where the post-session 1 measure is relatively equal; followed by a 16.25% decrease in attachment avoidance after session 2; and post-session 3 attachment avoidance finishing nearly equal. In sum, we find that therapist-centered process is characterized by a gradual increase of secure attachment and decrease of attachment avoidance over the three observed sessions, and couple-centered, enactment-based process is characterized by a greater increase of secure attachment after session 2, which are subsequently lost after session 3..

Partner receptivity of therapy process modality. Last, we tested Woolley and colleagues (2012) assertion that females may be more receptive to insight-oriented process, which we identified as therapist-centered process; and males may be more receptive to change-oriented process, which was associated with couple-centered, enactment-based process. Earlier, we presented evidence for this assertion when testing for treatment group effects, and stated that females receiving therapist-centered process first, experienced higher levels of secure attachment, and lower levels of attachment avoidance than females who experienced couple-centered, enactment-based process first. Similarly, males receiving couple-centered, enactment-based process first experienced higher levels of secure attachment and lower levels of attachment avoidance than males who received therapist-centered process first.

Statistically significant main effects were observed for within-session secure attachment ($F(1, 429.162) = 10.043, p = .002$; see Table 5), within-session attachment anxiety ($F(1, 435.56) = 7.616, p = .006$; see Table 6), and within-session attachment avoidance ($F(1, 438.46) = 4.555, p = .033$; see Table 7); however, interaction effects between partner gender and therapy process

were not found to be statistically significant for either post- or within-session attachment measures. These results add to Woolley et al.'s assertion that females may be more receptive to insight-oriented interventions, such as therapist-centered process, and males may be more receptive to change-oriented process, such as enactment by finding that respective therapy processes experienced early on in therapy may prove beneficial for each spouse; however, our results indicate that within the context of conjoint marital therapy, spouses react differently to each approach, and it may be difficult for therapists to properly balance the two processes within a conjoint session.

Discussion

This study was the first to examine and contrast the effects of therapist-centered, and couple-centered, enactment-based process on distressed couples seeking conjoint couple's therapy and their related post-session and within-session attachment outcomes. These results add to growing empirical literature examining attachment outcomes contrasting the effects therapist-centered and couple-centered, enactment-based processes have on the same couple, particularly between genders.

First, we hypothesized that (H1) couple-centered, enactment-based sessions would be associated with higher levels of secure attachment gains (post-session scores minus pre-session scores), defined as lower levels of attachment anxiety and attachment avoidance, than therapist-centered process for both males and females. Results indicated that couple-centered, enactment-based process did produce statistically higher levels of secure attachment than therapist-centered process for both males and females, particularly after the second session; however, these gains disappear after the third couple-centered, enactment-based session. Couple-centered, enactment-

based process was discovered to have a unique process effect that was unobserved in the therapist-centered process.

This effect could be explained by a number of factors inherent in the couple-centered, enactment-based process. One possible explanation is that couple-centered, enactment-based process presents a qualitatively different experience than therapist-centered process. For example, the first couple-centered, enactment-session could be perceived by partners as an orientation or introduction to the process, as the therapist explains the purpose of enactments and the role of each partner and the therapist. This session could increase anxiety in partners as they cautiously attempt to engage each other, with the therapist in an unfamiliar role (i.e. indirectly involved). The second couple-centered, enactment-based session was observed to be the session associated with greatest level of positive change, characterized by markedly higher levels of secure attachment and low levels of attachment avoidance. During this session, it is possible that couples are familiar with the process, and are able to begin to process attachment injuries for the first time, or to be able to process what was brought up during the first session. Curiously, this dramatic change in secure attachment is lost after the third session, as couples appeared to return to their level of attachment homeostasis. Possible explanations for the decrease in secure attachment after the third session may be linked with the dramatic rise in attachment avoidance, that is, the couple's inability to talk appropriately by potentially "running out of things to say," leaving partners not saying anything.

Another potential answer for the enactment process effect could be explained by therapist behaviors during the intervention, or perhaps therapist gender as a whole. Currently, the process of observationally coding the experimental sessions are concluding; however, preliminary data anecdotally suggests that therapists varied in intervention behaviors over the course of the three

couple-centered, enactment based sessions; principally with coaching positive spousal expression and promoting couple emotional expression. These two tasks maintain the therapist's involvement in the couple-centered, enactment-based process, and may be a form of validation or the reassurance partners need from the therapist as they endeavor to express themselves to their partners.

Undoubtedly, therapist in-session behaviors will help clarify the "quality" of couple-centered, enactment-based process. In an early investigation, Butler, Davis, and Seedall (2008) assessed the in-session enactment behaviors of 26 beginning therapists from COAMFTE-accredited programs. Results indicated that more than half of beginning therapists were considered statistically non-proficient in conducting enactments. With the participant therapist sample derived from beginning therapists, further investigation into therapist in-session behaviors could explain what factors contribute to the enactment process effect. As the length of the experiment only encompassed three sessions of each modality, it is impossible to determine the trajectory of enactment process effect in subsequent sessions. It could very well be that couples return to, and maintain, pre-treatment levels of secure attachment, or if the rebound trajectory maintains its course toward higher levels of secure attachment.

The second hypothesis tested was that (H2) couple-centered, enactment-based sessions would be associated with higher levels of post-session secure attachment, defined as lower levels of attachment anxiety and attachment avoidance than therapist-centered process for both males and females. Similar to the response of secure attachment, couple-centered, enactment-based process was associated with lower levels of attachment anxiety and avoidance; however, the same enactment process treatment effect was observed. Partners achieved lower levels of

attachment anxiety and avoidance than partners in the therapist-centered process after the second session before returning to homeostatic, pre-treatment levels, after the third session.

Lastly, we tested Woolley and colleagues (2011) assertion that females prefer insight-oriented interventions, which we associated with therapist-centered process, and males prefer change-oriented interventions, such as enactments. We found statistical support for this assertion, in that females experiencing therapist-centered process first demonstrated higher levels of secure attachment than females who experienced couple-centered, enactment-based process first. Similarly, we found statistical support for males being more receptive to couple-centered, enactment-based process early as evidenced in higher levels of secure attachment than males who experienced therapist-centered process first. Anecdotally, we find qualitative support for these findings as interviews from participant couples have found that females express preference to therapist-centered process more than couple-centered, enactment-based process, as females feel they have tried to talk with their spouse about their presenting problem before coming to therapy. Males on the other hand preferred speaking with their partners, and have expressed that doing so in a safe environment with a third party present was helpful. However, further investigations need to more carefully examine these qualitative differences.

In sum, we found evidence that couple-centered, enactment-based process did produce higher levels of secure attachment and lower levels of attachment avoidance observed after the second session, but these gains returned to levels comparable to therapist-centered process after the third session. The discovery of the enactment treatment effect is an interesting finding in and of itself. Conceptually, therapists wishing to employ enactments will not want to do so without considering the presenting problem and relationship factors. However, this analysis demonstrated that enactments can be successfully implemented with clinically-distressed couples and foster

secure attachment by decreasing attachment anxiety and avoidance. Three clinical suggestions are offered in light of these findings:

First, this analysis should not obviate the importance of the therapeutic relationship occurring at the onset of therapy, which is typically established via therapist-centered process. Indeed, participant couples experienced an average of three sessions focused on establishing a therapeutic relationship with spouses, largely through therapist-centered process. With the three alliance-building, therapist-centered sessions, partners could see the introduction of enactments as actual couple therapy, or “couple work,” as sessions become almost exclusively couple-centric. Thus, it is recommended that therapists properly and adequately introduce the seemingly unfamiliar couple-centered, enactment-based process by explaining the purpose of the intervention and roles of each participant (see Davis & Butler, 2003). With the therapeutic alliance established, and an explanation of the couple-centered, enactment-based process, couples embarking in enactments may feel safe enough to engage each other toward actual “couple work.”

Second, enactments should be viewed as an effective means of decreasing attachment anxiety and avoidance; however, these changes are prone to homeostatic resistance. Thus, acknowledging the enactment process treatment effect and educating the couple that levels of attachment could potentially become destabilized after enactment sessions may require additional homework, such as, at-home interventions (e.g. couple caring days, relationship-specific conversations, etc.) that can help maintain and strengthen each partner’s level of secure attachment and solidify the attachment gains between sessions.

Third, with the couple-centered, enactment-based therapy process properly explained to each partner, clinicians are cautioned to maintain a therapeutic presence by interrupting negative

interactions between partners while commending, encouraging, and coaching partners in attachment-based expression. As couples begin to process the attachment injuries that brought them to therapy, both partners may need third-party validation at potential process impasses from the therapist. Additionally, encouraging and commending positive attachment-based expression may also help partners learn new interactional patterns and processes that may be unfamiliar to them and their relationship.

A combination of these suggestions may alleviate the treatment effect couple-centered, enactment-based process was observed to have on couples through a therapist-facilitated-enactment as the therapist may provide each spouse with the security for each partner to become attached to their partner. Through continuous leveraging of the strengths in the three relationships present in couples therapy, with the therapist acting as the third-party to strengthen and encourage each spouse in reducing their attachment avoidance and attachment anxiety, couples have the potential to strengthen their secure attachment through the appropriate execution of enactments.

Limitations and Suggestions for Future Research

This study builds upon the study design and protocol initially presented by Butler and colleagues (2011), and consequently experienced similar limitations. In addition to not having a control group, conclusive generalizability contrasting the two processes is untenable. Additionally, therapists participating in the study were unlicensed MFT graduate students, with limited clinical experience. The clinical confounds introduced by clinical inexperience presents a number of challenges to future process-outcome literature as they may not be generalizable to more experienced clinicians. Lastly, the strict treatment protocols, necessary for replicable

comparisons, are generally not representative of practices typical of most therapists (cf. Gurman, Kniskern, & Pinsof, 1986; Jacobson & Addis, 1993).

Limitations within the study design also extend into the very practice of couples and marital therapy. Given that attachment injuries have been likened to trauma (Johnson & Makinen, 2001), restoring trust in couples with compound injuries require longer treatment than the six sessions offered in this study, or three sessions of any particular therapy process modality. The resolution process may involve more extensive treatment to work through the emotional wounds and rebuild trust not captured in the study's design. Without a sample of couples completing therapy or post-treatment follow-up, it is difficult to know how each therapy process modality might translate into individual and dyadic change over an entire course of therapy.

Considerations for future research include increasing the number of sessions within the study's design and include other test groups for comparison. Increasing the number of sessions for each modality can potentially address the couple-centered, enactment-based process treatment effect observed within the present study. Additionally, increasing the number of sessions will better address any correlations between the two therapy processes and attachment outcomes. Future investigations should consider including an enactment-only group, therapist-centered only group, an alternating/mixed process group, and potentially a waitlist control group.

Measurement sensitivity continues to be another limitation for the study as the SAM may not be sensitive enough to capture "fine-grained change over brief intervals" (Butler, Harper, & Mitchell, 2011, p. 218). Although Parker and colleagues (2011) are credited with identifying various constructs applicable to clinically distressed couples and items contributing to unexplained variance, the SAM unfortunately may need to be revised or reconsidered. Future researchers may consider using the full ECR, or the State Adult Attachment Measure (SAAM;

Gillath, Hart, Nofhle, & Stockdale, 2009), which was designed to account for situational factors, such as therapy.

Additionally, assessing the client's stage of change may be beneficial in assessing the level of therapeutic alliance and willingness to change (cf. Principe, Marci, Glick, & Ablon, 2006; Connors, DiClemente, Dermen, Kadden, Carroll, & Frone, 2000). Prochaska and Norcross (2001) noted that research in the area of client stage of change is still relatively limited, with no existing research in couple therapy. Examining the client's stage of change may be able to identify the therapy "customer" and therapy "visitor" hypothesis suggested by De Shazer (1988) as research has noted that females are typically the initiators of therapy (Delaney, 2006; Garfield, 2004), which may attribute to females entering into therapy at a higher stage of change than male partners (Porter & Ketring, 2011). Assessing each partner's stage of change may prove to be an important factor in assessing the use and effectiveness of couple-centered, enactment-based process.

In addition to revising the applicability of the SAM, reconsideration of using the RDAS may be warranted. Although the RDAS is a widely used measure for measuring marital distress, its inherent robustness, that is, broad and generalizable categories may be too broad to capture other nuances of marital distress. Alternative measure of marital distress that may be more sensitive to micro-processes should be investigated.

Lastly, and perhaps most important, the therapeutic relationship remains to be tested in this experimental design. With the SAM measuring the attachment between spouses across therapy modalities, a similar measure needs to be employed to capture the strength of the therapeutic relationship, or perhaps, the attachment a spouse may have to their therapist. Pinsof and Catherall (1989) have developed the Couple Therapy Alliance Scale—Revised (CTAS-R),

an empirically tested measure for assessing the unexamined therapeutic alliance in the present study, which has been revised to include within- and between-person factors (Pinsof 1994). Additionally, Mallinckrodt, GAnnt, and Coble (1995) developed the Client Attachment to Therapy Scale (CATS; 1995) that may be administered concurrently with measures assessing individual attachment responses to their partner.

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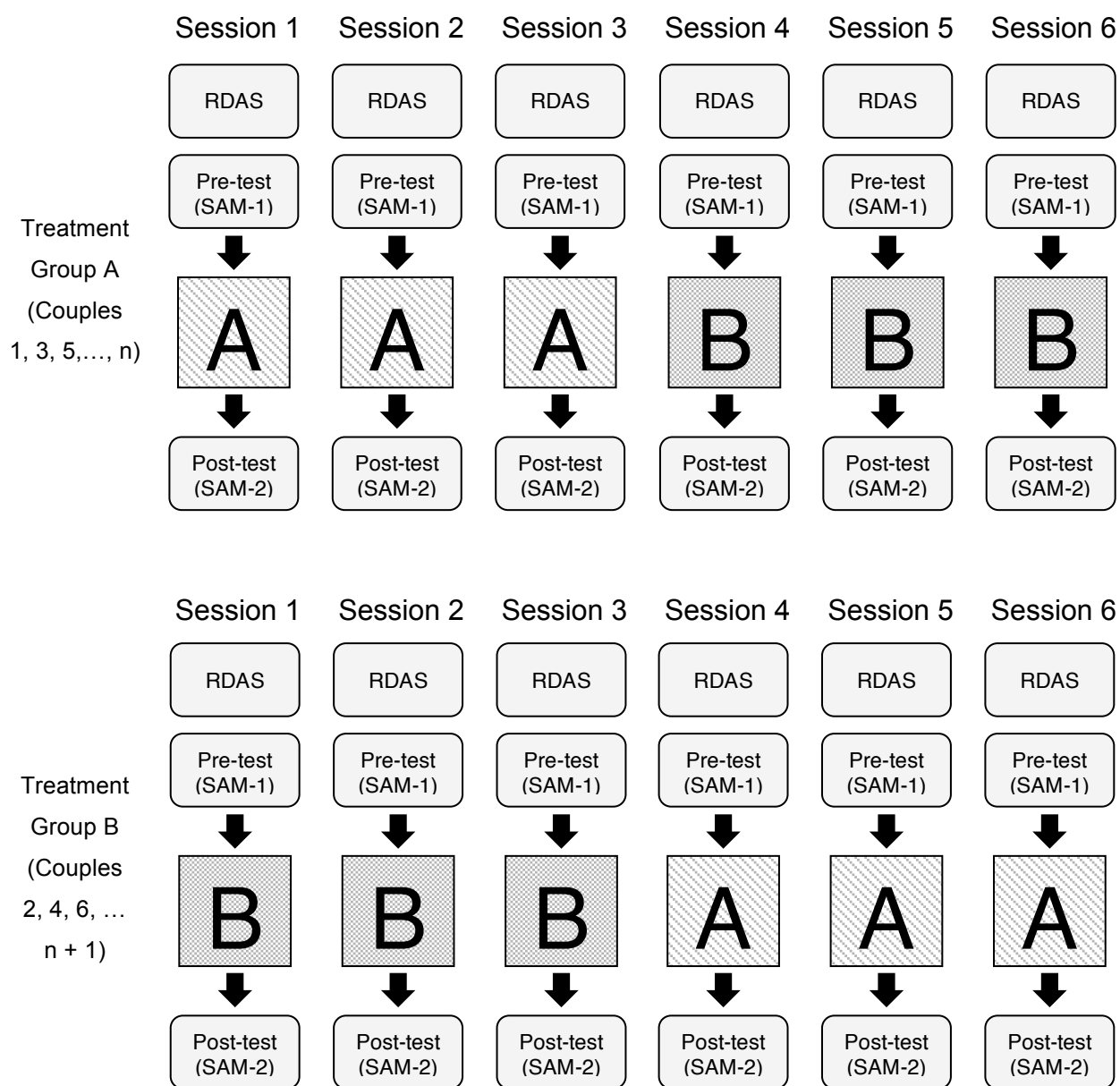
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Figure 1. Alternating Treatment Design for Treatment Groups



Note: A = Therapist-Centered Process; B = Couple-Centered, Enactment-Based Process; RDAS = Revised Dyadic Adjustment Scale; SAM-1 = Secure Attachment Measure (Pre-session test); SAM-2 = Secure Attachment Measure (Post-session test).

Figure 2. Couple-Centered, Enactment-Based Video Coding Instrument
**Relationship Enactment Based Clinical Process
 Observational Assessment of Proficiency (REBCP-OAP)**

clinical process focused on orchestrating/coaching relationship interaction
 for emotional/attachment providing

(Emotion & Attachment Focused) Adapted from Davis & Butler (2004). Used with permission.

Macro	Mid	Micro	Frequency Count
<input type="checkbox"/> Initiation =>	<input type="checkbox"/> Introduce Roles/Goals =>	<input type="checkbox"/> Explain Purpose of Enactment	<input type="text"/>
		<input type="checkbox"/> Explain Spouses' Roles	<input type="text"/>
		<input type="checkbox"/> Explain Therapist's Role	<input type="text"/>
	<input type="checkbox"/> Specify Topic =>	<input type="checkbox"/> Specify Content Focus	<input type="text"/>
		<input type="checkbox"/> Set Expectations for Positive Comm/Interx Process	<input type="text"/>
		<input type="checkbox"/> Set Expectations for Positive E/A Process	<input type="text"/>
	<input type="checkbox"/> Establish Structure =>	<input type="checkbox"/> Arrange Spouses for Couple Interaction	<input type="text"/>
		<input type="checkbox"/> Request First-Person Language	<input type="text"/>
		<input type="checkbox"/> Remove Self from Couple Interaction	<input type="text"/>
		<input type="checkbox"/> Sustain Interaction/Avoid Unnecessary Interruption	<input type="text"/>
<input type="checkbox"/> Intervention =>	<input type="checkbox"/> Sustain, Monitor, Structure Interaction =>	<input type="checkbox"/> Commend Positive Couple Interaction	<input type="text"/>
		<input type="checkbox"/> Interrupt Negative Couple Interaction	<input type="text"/>
		<input type="checkbox"/> Coach Positive Spouse Expression	<input type="text"/>
	<input type="checkbox"/> Coach Interaction =>	<input type="checkbox"/> Coach Positive Spouse Attending	<input type="text"/>
		<input type="checkbox"/> Assist Positive Attending/Expression (Proxy Voice)	<input type="text"/>
		<input type="checkbox"/> Promote Couple E/A Expression	<input type="text"/>
	<input type="checkbox"/> Facilitate E/A Interaction =>	<input type="checkbox"/> Promote Couple E/A Listening	<input type="text"/>
		<input type="checkbox"/> Promote Couple E/A Responses	<input type="text"/>
		<input type="checkbox"/> Invite Review of Enactment Goals	<input type="text"/>
		<input type="checkbox"/> Invite Review of Enactment Roles	<input type="text"/>
<input type="checkbox"/> Evaluation =>	<input type="checkbox"/> Recall Goals =>	<input type="checkbox"/> Invite Recall of Therapy Goals	<input type="text"/>
		<input type="checkbox"/> Invite Couple to Notice What Went Well	<input type="text"/>
		<input type="checkbox"/> Invite Couple to Commend Each Other for Successes	<input type="text"/>
	<input type="checkbox"/> Assess/Evaluate =>	<input type="checkbox"/> Invite Couple to Identify Needed Changes	<input type="text"/>
		<input type="checkbox"/> Invite Content Commitments	<input type="text"/>
		<input type="checkbox"/> Invite Process Commitments	<input type="text"/>
	<input type="checkbox"/> Commit to Change =>	<input type="checkbox"/> Invite E/A Commitments	<input type="text"/>

Figure 3. Therapist-Centered Coding Instrument

**Person-of-the-Therapist Based Clinical Process
Observational Assessment of Proficiency (PoTBCP-OAP)**

clinical process focused on person-of-the-therapist interaction
for emotional/attachment providing

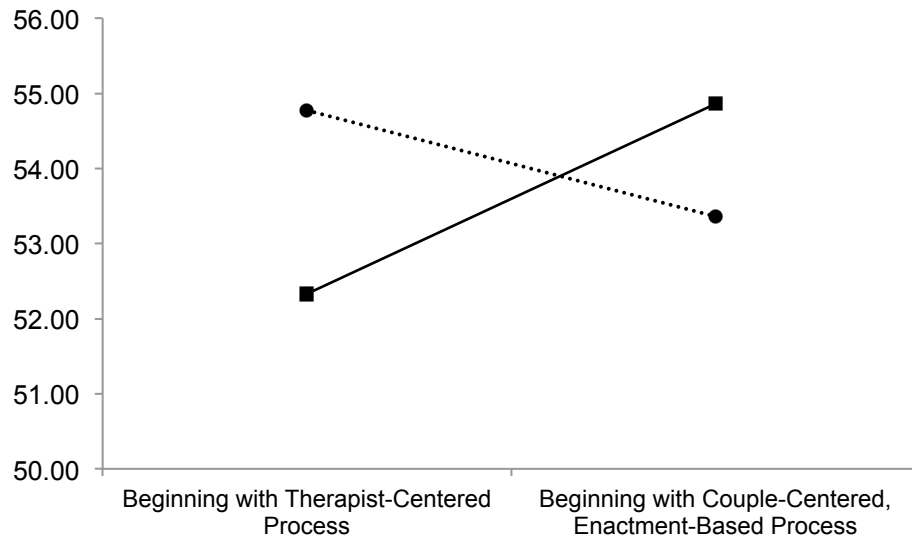
(Emotion & Attachment Focused)

Macro	Mid	Micro	Frequency Count
<input type="checkbox"/> Verbal & Physical Gestures Channeling Interaction Through the Therapist (Structure) =>	<input type="checkbox"/> Physical Gestures Channeling Interaction Through the Therapist	<input type="checkbox"/> Set partners' chairs to face the therapist rather than each other	<input type="text"/>
		<input type="checkbox"/> Hand gestures that invite/encourage couple interaction with the therapist	<input type="text"/>
	<input type="checkbox"/> Verbal Gestures Channeling Interaction Through the Therapist	<input type="checkbox"/> Verbal instructions for the couple to interact with or directly talk to the therapist	<input type="text"/>
		<input type="checkbox"/> Engage in a separate dialogue with one or both partners	<input type="text"/>
		<input type="checkbox"/> Actively participates in therapy conversation (3-way dialogue, full participant)	<input type="text"/>
		<input type="checkbox"/> Third-person voice	<input type="text"/>
<input type="checkbox"/> Attachment-Providing Narrative Behaviors =>	<input type="checkbox"/> Sharing	<input type="checkbox"/> Encourages and invites partners to share their "story" or perspective with him/her	<input type="text"/>
	<input type="checkbox"/> Listening	<input type="checkbox"/> Empathically listens as one or both partners share their story, feelings, or thoughts	<input type="text"/>
		<input type="checkbox"/> Reflects the partners' feelings	<input type="text"/>
		<input type="checkbox"/> Validates the partner's feelings	<input type="text"/>
		<input type="checkbox"/> Reframes negative comments	<input type="text"/>
<input type="checkbox"/> Creating Insight/Understanding (Substance) =>	<input type="checkbox"/> Processing	<input type="checkbox"/> Socratic dialogue	<input type="text"/>
	<input type="checkbox"/> Interpretation	<input type="checkbox"/> Offers interpretations or insights into couple behavior	<input type="text"/>
		<input type="checkbox"/> Helps partners discover new ways of looking at things	<input type="text"/>
		<input type="checkbox"/> Highlights negative consequences of dysfunctional interaction patterns, ideas about relationships, etc.	<input type="text"/>
	<input type="checkbox"/> Solutions	<input type="checkbox"/> Offers appropriate advice, suggestions, or potential solutions	<input type="text"/>
		<input type="checkbox"/> Encourages clients to think of suggestions or solutions	<input type="text"/>

Figure 4. Multifactorial Design of Present Study

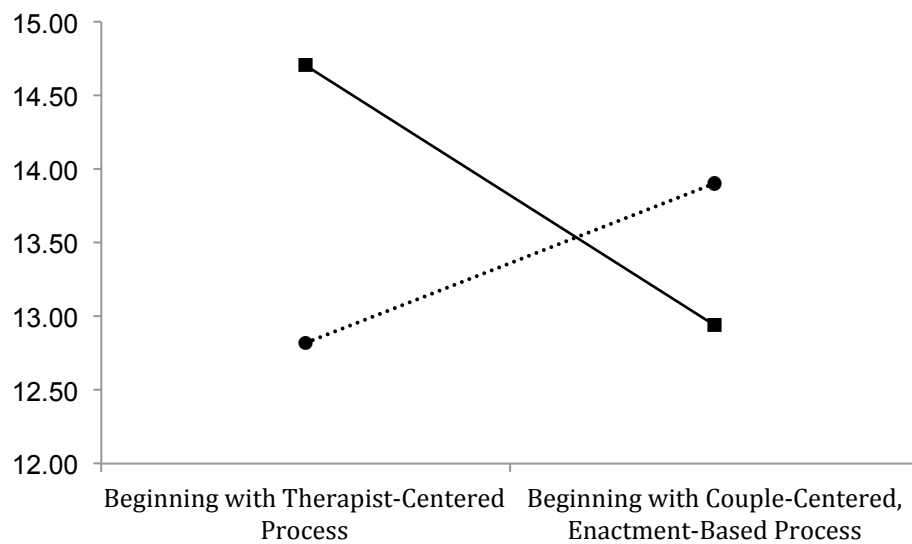
Part A	Part B	Part C	Part D
Treatment Group A (Therapist-Centered; Couple-Centered, Enactment Based)	Therapist-Centered	Session 1	Males
		Session 2	
		Session 3	Females
	Couple-Centered	Session 4	Males
		Session 5	
		Session 6	Females
Treatment Group B (Couple-Centered, Enactment-Based; Therapist-Centered)	Couple-Centered	Session 1	Males
		Session 2	
		Session 3	Females
	Therapist-Centered	Session 4	Males
		Session 5	
		Session 6	Females

Figure 5. Post-Session Secure Attachment Interaction Effect for First Received Therapy Process and Partner Gender



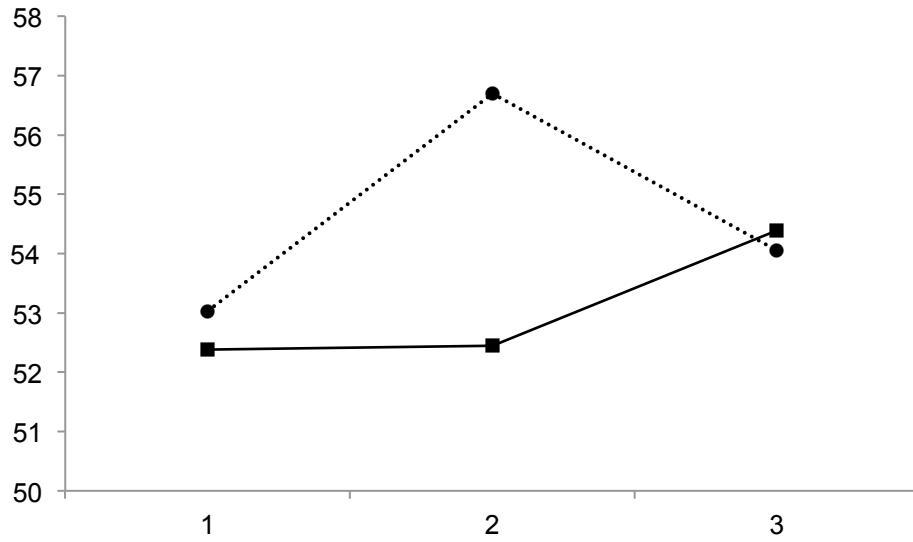
Note: Solid line with solid squared: Males; Dashed line with solid circles: Females

Figure 6. Post-Session Attachment Avoidance Interaction Effect for First Received Therapy Process and Partner Gender



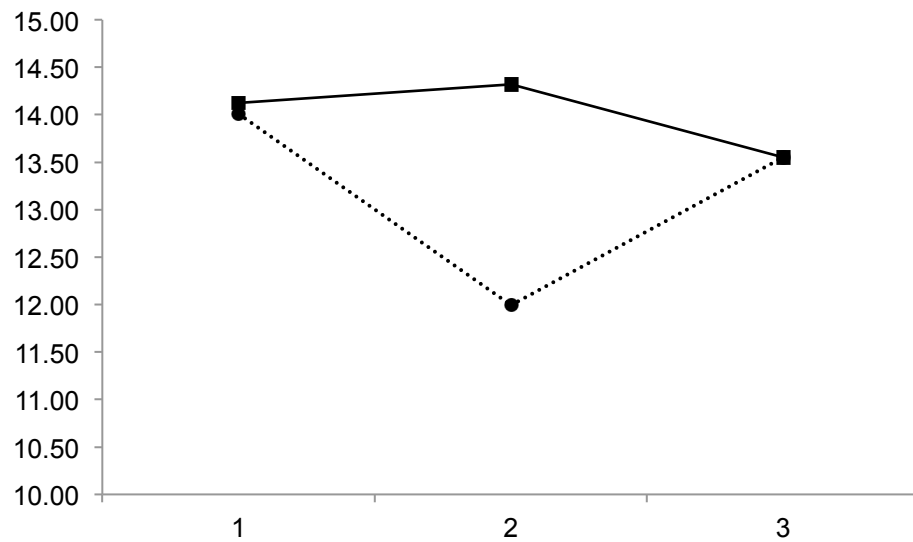
Note: Solid line with solid squared: Males; Dashed line with solid circles: Females

Figure 7. Post-Session Secure Attachment Interaction Effect of Therapy Process and Therapy Process Over Time



Note: Solid line with solid squared: Therapist-Centered; Dashed line with solid circles: Couple-Centered, Enactment-Based

Figure 8. Post-Session Attachment Avoidance Interaction Effect of Therapy Process and Therapy Process Over Time



Note: Solid line with solid squared: Therapist-Centered; Dashed line with solid circles: Couple-Centered, Enactment-Based

Table 1. Post-Session Secure Attachment

	<i>Numerator df</i>	<i>Denominator df</i>	<i>F</i>	<i>Sig</i>
Treatment Group	1	39.982	0.06	0.807
Therapy Process Modality	1	436.263	3.706	0.055
Partner	1	436.253	0.36	0.549
Therapy Process Over Time	2	436.297	2.101	0.124
Treatment Group × Therapy Process	1	436.265	1.513	0.219
Treatment Group × Partner	1	436.253	6.231	0.013
Treatment Group × Therapy Process Over Time	2	436.291	0.064	0.938
Therapy Process × Partner	1	436.184	0.554	0.457
Therapy Process × Therapy Process Over Time	2	436.357	3.074	0.047

Table 2. Post-Session Attachment Anxiety

	<i>Numerator df</i>	<i>Denominator df</i>	<i>F</i>	<i>Sig</i>
Treatment Group	1	39.926	0.048	0.828
Therapy Process Modality	1	438.107	3.363	0.067
Partner	1	438.209	0.008	0.928
Therapy Process Over Time	2	438.155	2.348	0.097
Treatment Group × Therapy Process	1	438.107	3.029	0.083
Treatment Group × Partner	1	438.205	1.434	0.232
Treatment Group × Therapy Process Over Time	2	438.152	0.101	0.904
Therapy Process × Partner	1	438.146	1.319	0.251
Therapy Process × Therapy Process Over Time	2	438.218	2.111	0.122

Table 3. Post-Session Attachment Avoidance

	<i>Numerator df</i>	<i>Denominator df</i>	<i>F</i>	<i>Sig</i>
Treatment Group	1	39.931	523.246	0.00
Therapy Process Modality	1	39.931	0.082	0.776
Partner	1	443.03	3.303	0.070
Therapy Process Over Time	1	443.135	1.082	0.299
Treatment Group × Therapy Process	2	443.053	1.397	0.248
Treatment Group × Partner	1	443.032	0.412	0.521
Treatment Group × Therapy Process Over Time	1	443.141	10.111	0.002
Therapy Process × Partner	2	443.055	0.053	0.948
Therapy Process × Therapy Process Over Time	1	443.035	0.126	0.723

Table 4. Within Session Secure Attachment

	<i>Numerator df</i>	<i>Denominator df</i>	<i>F</i>	<i>Sig</i>
Treatment Group	1	39.072	0.116	0.735
Therapy Process Modality	1	428.879	2.433	0.120
Partner	1	429.162	10.043	0.002
Therapy Process Over Time	2	429.053	1.49	0.226
Treatment Group × Therapy Process	1	428.88	0.244	0.622
Treatment Group × Partner	1	429.14	0.027	0.869
Treatment Group × Therapy Process Over Time	2	429.038	1.084	0.339
Therapy Process × Partner	1	428.743	1.534	0.216
Therapy Process × Therapy Process Over Time	2	428.773	0.733	0.481

Table 5. Within Session Attachment Anxiety

	<i>Numerator df</i>	<i>Denominator df</i>	<i>F</i>	<i>Sig</i>
Treatment Group	1	39.73	0.131	0.719
Therapy Process Modality	1	435.058	0.403	0.526
Partner	1	435.56	7.616	0.006
Therapy Process Over Time	2	435.095	1.187	0.306
Treatment Group × Therapy Process	1	435.063	0.193	0.660
Treatment Group × Partner	1	435.534	0.001	0.979
Treatment Group × Therapy Process Over Time	2	435.091	0.694	0.500
Therapy Process × Partner	1	435.135	1.732	0.189
Therapy Process × Therapy Process Over Time	2	435.376	1.486	0.227

Table 6. Within Session Attachment Avoidance

	<i>Numerator df</i>	<i>Denominator df</i>	<i>F</i>	<i>Sig</i>
Treatment Group	1	39.039	0.107	0.746
Therapy Process Modality	1	438.495	5.221	0.023
Partner	1	438.46	4.555	0.033
Therapy Process Over Time	2	438.863	1.392	0.250
Treatment Group × Therapy Process	1	438.494	0.066	0.798
Treatment Group × Partner	1	438.459	0.046	0.830
Treatment Group × Therapy Process Over Time	2	438.858	0.791	0.454
Therapy Process × Partner	1	438.781	1.727	0.19
Therapy Process × Therapy Process Over Time	2	438.472	1.615	0.20