



Investigating attachment narratives in couple therapy for depression

Submitted by Helen Davies, to the University of Exeter
as a thesis for the degree of Doctor of Clinical Psychology, May 2015

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**SCHOOL OF PSYCHOLOGY
DOCTORATE IN CLINICAL PSYCHOLOGY**

LITERATURE REVIEW

The utilisation of attachment theory in couple therapy:

a systematic review

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Abstract

Background: Attachment theory has been under-utilised and under-researched in couple therapy, with the exception of emotion focused therapy (EFT) for couples.

Objective: To systematically review empirical studies of couple therapy utilising attachment theory as a key concept in their model of change.

Method: A systematic review of all literature to date using Medline, PsycINFO and Web of Knowledge databases. In addition, searches of the contents of the Journal of Family Therapy and Family Process were undertaken.

Results: Twelve articles were retrieved, eleven of which used the EFT model for couples. Four of the EFT studies had a clinical population (PTSD from childhood sexual abuse or depression) the remainder were non-clinical groups. The non-EFT study included an enactment based intervention focused on enhancing attachment processes in a mixed clinical group. There were eight quantitative studies, three mixed methods studies and one process study.

Conclusions: This review highlights that in couple therapy, EFT is the prevalent model utilising attachment theory within its model of change. There is evidence that EFT can improve marital satisfaction, with effects stable over time, and some evidence of reducing depressive symptoms. The review highlights the limitations of these studies and makes recommendations for future research.

Keywords: attachment, emotion, couple therapy, marital therapy

Introduction

Attachment theory is a comprehensive, well-researched theory of personality development and relationship functioning (Seedall & Wampler, 2013). The theory emphasises the influence of early relationships with caregivers on the mental representations infants develop of themselves and their caregivers. Also, how they process and regulate distressing emotions in adulthood (Bowlby, 1988). In this manner, attachment refers to the models of self and other formed within close relationships, and the conscious and unconscious strategies individuals develop to cope with distress and ultimately, to have their needs met within close relationships (Seedall & Wampler, 2013).

Attachments are not just developed in childhood; it is proposed that romantic love is an attachment process (Hazan & Shaver, 1987). The couple relationship can be an enormous and rich resource for each partner, promoting economic security and providing an emotional safe haven and secure base within a confiding relationship (Byng-Hall, 1995). In this respect, there are findings suggesting that the concepts of attachment categories can alter through the individual's development and across the life cycle (Mikulincer and Shaver, 2003). For example, one member of a couple moving the other from insecure to secure attachment (Hazan & Shaver, 1987).

Given that attachment can be conceptualised as fluid and open to change, the potential for therapies to focus in an explicit way on attachment processes as an area of change seems prudent (Seedall & Wampler, 2013). Couple therapy has the

benefit of not only reviewing past individual attachments but can actively work with difficulties in current relationships. It has been suggested, however, that attachment theory has been under-utilised and under-researched in couple therapy (Seedall & Wampler, 2013), with the exception of emotion focused therapy (EFT) for couples (Johnson & Whiffen, 2003).

EFT conceptualises attachment theory as a theory of emotion regulation (Johnson & Whiffen, 2003) (Appendix A shows the full profile for EFT). It aims to help couples overcome past relationship traumas and re-establish secure emotional bonds by helping them to be emotionally more accessible, engaged and responsive to one another (Johnson & Whiffen, 2003). A meta-analysis of EFT outcome research was carried out over fifteen years ago (Johnson, Hunsley, Greenberg, & Schindler, 1999). The meta-analysis revealed an improvement in marital satisfaction following EFT, with a mean effect size (d) of 1.3 compared with no treatment at one year follow up. Furthermore, a systematic review of process studies in EFT has also been undertaken (Greenman & Johnson, 2013). Process research examines the process of therapy itself, as opposed to either the input variables of therapy or the outcomes of therapy (Oka & Whiting, 2013). Generally, these studies have shown that more intense emotional experiencing in clients appears to be related to more frequent self-disclosure, understanding and intimate sharing (affiliative responses) in session. There is also evidence that blamer-softening¹ events are crucial components of successful EFT (Greenman & Johnson, 2013).

¹ A blamer-softening event is where a previously hostile partner asks, from a position of vulnerability and within a high level of emotional experience, for reassurance, comfort, or for an attachment need to be met. As the blaming partner becomes less angry and the withdrawn partner becomes more engaged, the blaming spouse is then able to congruently share his or her needs and desires. Then, both partners are capable of responsive and engaged connection (Greenman & Johnson, 2013).

Aims of the Review

Attachment theory provides a prudent area of change in couple therapy and yet claims have been made that it has been under-utilised and under-researched (Seedall & Wampler, 2013). Although Johnson et al. (1999) and Greenman and Johnson (2013) have conducted reviews of outcome and process studies in EFT, a literature search suggested that, to date, no systematic review of couple therapies that rely on attachment theory in their model has been conducted. Therefore, we do not know which couple therapy models utilise attachment theory in their model of change.

The aim of this review was to systematically review empirical studies of couple therapy utilising attachment theory as a key concept in its model of change.

As a review of EFT outcome studies was completed in 1999 (Johnson et al., 1999), articles concerning outcome studies in EFT were reviewed beyond this point.

Further, as process studies of EFT were reviewed in 2013 (Greenman & Johnson, 2013) articles concerning process studies in EFT were reviewed beyond 2013.

Couple therapies that were non-EFT but utilising attachment theory as a key concept in their model, were included from 1960 to February 2015.

Method

The structure of the literature search follows the guidelines in the PRISMA statement (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) (Moher, Liberati, Tetzlaff & Altman, 2009), which was developed to improve the standard of reporting of systematic reviews.

Eligibility Criteria

For inclusion in this review, studies were required to fulfil the following criteria:

(1) adults with no age restriction in receipt of a couple therapy (2) quantitative studies, e.g. randomised control trial (RCT) and case controlled study or, qualitative and process study designs (3) the study should be reported in English and appear in a peer reviewed journal. Exclusion criteria: case studies were not included.

Search Criteria

Studies were identified by searching the electronic databases, scanning reference lists of articles and consulting with experts in the field (e.g. Dr Susan Johnson, co-founder of EFT and Professor Janet Reibstein, co-founder of the Exeter Model of Couple Therapy for Depression). The electronic search was applied to Web of Science, PsycINFO and Medline (1960-February 2015). In addition searches of the contents of the Journal of Family Therapy and Family Process were undertaken.

The following search terms were applied using the electronic databases - attachment/emotion/relationships/"couple therapy"/"marital therapy"/"marriage counselling".

All titles and abstracts in the electronic databases were screened. The abstracts of potentially eligible articles were saved in Endnote. Bibliographic references from these articles were systematically searched. Eligible records then had a full text screening by three reviewers, the candidate and the candidate's two supervisors, one of whom is a post-doctoral qualitative researcher and the other an experienced and accredited family therapist. Articles were promoted to the next stage of the process by categorising as 'yes', 'no' or 'maybe'. The next stage was to have a consensus meeting as to whether 'maybe' records should be included in the review.

Quality Appraisal

The Critical Appraisal Skills Programme (CASP) (2006) quality appraisal tool was used to assess the quality of the studies (Appendix B). Areas considered when appraising study quality using the CASP included: research design, sampling method, confounding factors, data collection, value of the research, reflexivity (if a qualitative/process study was employed), analysis and overall assessment of the study. A quality rating score was obtained for each area on the rating tool ranging from 1-3, with 3 being weak and 1 being strong. The overall median score was then used as an indication of the quality of the study. These scores are shown in Table 1.

Evaluation Criteria

To evaluate the data, articles were organised using a framework provided by the Economic Social and Research Council (Popay, Roberts, Sowden & Petticrew, 2006). I reviewed the articles in terms of:-

- 1) Aims
- 2) Design / Method
- 3) Sample
- 4) Measures
- 5) Findings
- 6) Bias / Limitations

A synthesis of the data examined relationships across the studies in terms of aims, method, measures and participants. Findings were explored across studies and then an appraisal examining the quality of the studies and their limitations was applied.

Results

Main Study Findings

In total 12 studies were included in the review. Figure 1 shows the flow diagram detailing the number of studies identified, screened, assessed for eligibility and eventually included in the review (adapted from Moher et al., 2009). The primary reason that only 12 articles out of 1308 articles met the inclusion criteria for the

review was that using 'attachment' and 'emotion' as search terms yielded many studies that were irrelevant to the inclusion criteria of this review.

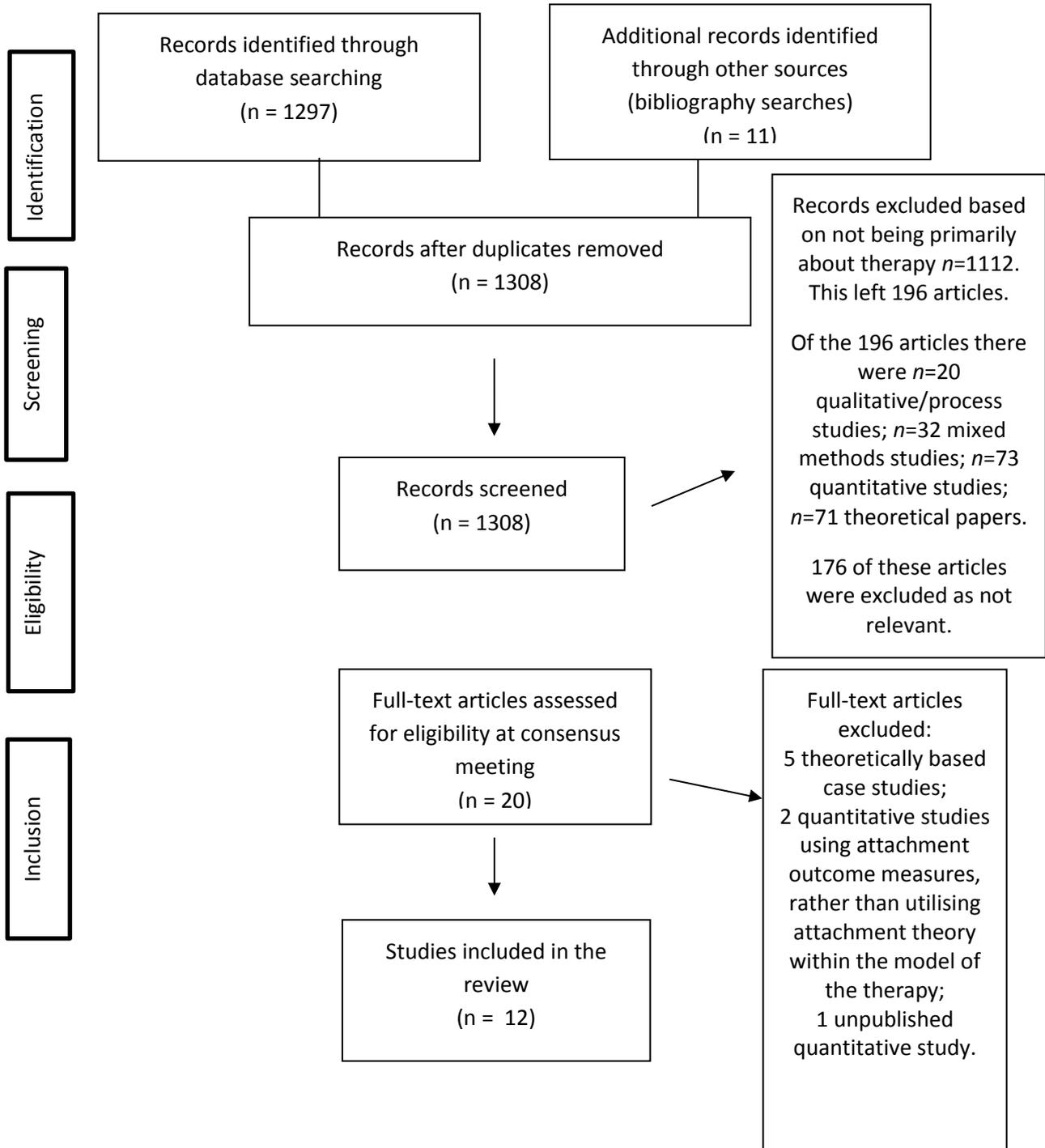


Figure 1 - Flow Diagram adapted from the Prisma statement (Moher et al., 2009).

Table 1 – Summary of the study findings from the systematic review

Authors & Year	Study Aim	Methodology / Design	Sample	Measures	Summary of results and key findings	Risk of Bias / Relevant limitations	CASP Score (1 = strong 2 = moderate 3 = weak)
MacIntosh & Johnson (2008)	1) To explore the use of EFT with survivors of childhood sexual abuse (CSA) and their partners.	Mixed methods. 1) Repeated measures. Client self-report scores at pre- and post-treatment. 2) Qualitative study – thematic analysis Average 19 sessions of EFT.	Community sample. Ten couples. Mean age 43 years. Mean relationship 14.9 years.	1) Dyadic Adjustment Scale (DAS) (Spanier, 1976) ¹ 2) Trauma Symptom Inventory (TSI) (Briere, Elliott, Harris & Cotman, 1995) ²	<u>Pre- and post-outcome measures.</u> 1) DAS: pre-treatment mean score 78. Post-treatment 94. * Improvement in marital satisfaction. 2) TSI: pre-treatment 66. Post-treatment 58 *Reduction in clinical symptoms. <u>Results of thematic analysis.</u> Six main themes were identified. 1) Emotional flooding: feelings are dangerous and overwhelming. 2) Emotional numbing: I can't let	Repeated measures and no control group in quantitative part of the study. Small sample for quantitative study. Confounding factors – three couples concurrently receiving other treatments. Treatment fidelity poor. No information about treatment adherence.	2/3 (moderate/weak)

					<p>myself feel; I will lose control.</p> <p>3) Dissociation: I just can't stay here.</p> <p>4) Constricted range of affect.</p> <p>5) Hypervigilance to attachment figures: I just can't feel safe.</p> <p>6) Sexuality: sex is shameful and I need control.</p>		
Dalton, Greenman, Classen & Johnson (2013)	In couples where the female partner experiences trauma as a result of childhood sexual abuse, to determine whether EFT would be effective at reducing 1) relationship distress 2) trauma symptoms.	<p>RCT. Waiting list controlled. Self-report pre- and post-treatment outcomes.</p> <p>Twenty sessions of EFT.</p>	<p>Tertiary treatment clinic sample. Twenty-two couples randomly assigned to EFT or waiting list. Mean age 43 years. Mean relationship 14.9 years.</p>	<p>1) DAS (Spanier, 1976)</p> <p>2) TSI (Briere et al., 1995)</p>	<p>1) DAS: significant effect of treatment group on relationship distress. EFT group: effect size (ES) 0.61 Control group: ES 0.03.</p> <p>*Greater improvement in marital satisfaction in EFT group.</p> <p>2) TSI: non-significant (ns).</p> <p>*No change in clinical symptoms</p>	<p>Waitlist controls.</p> <p>Non-representative sample from clinic and limited demographic.</p> <p>Sampling bias. Pre selection screening.</p> <p>No description of randomisation process.</p>	2 (moderate)

Dessaulles, Johnson & Denton (2003)	To explore the use of EFT in couples where one member presents with depression.	RCT. Sixteen sessions of EFT.	Community and clinic sample. Eighteen couples randomly assigned to EFT or pharmacotherapy. Mean age 37 years. Mean relationship 11 years.	1) DAS (Spanier, 1976). 2) Inventory to Diagnose Depression (IDD) (Zimmerman, Coryell, Corenthal & Wilson, 1986).	1) DAS: no results published. 2) IDD: pre- post-treatment: EFT group $p < 0.05$. Pharmacotherapy group $p < 0.05$. Six month follow up. EFT group $p < 0.05$. Pharmacotherapy group $p > 0.05$. *EFT and medication improve symptoms post-treatment. EFT group showed continued improvement at 6 month follow up.	Small sample for quantitative study. Third of the sample dropped out by follow up. No information why people dropped out. DAS results not published. Sampling bias. Pre-selection screening. Numerous trainee therapists and no treatment adherence reported. No description of randomisation process.	3 (weak)
Denton, Wittenborn & Golden (2012)	To evaluate whether antidepressant medication management augmented with EFT	RCT. Couples were randomised to six months of antidepressant alone or antidepressant augmented with	Community sample. Twenty-four couples. Mean age 34 years. Mean length	1) Quality of Marriage Index (QMI) (Norton, 1983) ³ 2) IDD (Zimmerman et	1) QMI: EFT+medication showed significant improvement vs medication only post treatment (EFT+medication	High attrition rates. Post-treatment 13 couples remained (out of 24 couples). Twelve month follow-up	2 (moderate)

	(medication+EFT) would reduce depressive symptoms significantly more than medication alone for women with major depression.	EFT. Pre- and post-treatment, six and 12 month post-treatment outcome measures. Fifteen sessions of EFT.	of relationship 14.5 years. Women only presented with depression.	al., 1986).	ES 3.3; medication only ES -0.6). Twelve month post treatment (EFT+ medication ES -0.9; medication only -0.3). 2) IDD: EFT+ medication vs medication = ns. * EFT+medication better at improving marital satisfaction than medication alone. No difference between EFT+medication and medication alone in treating depressive symptoms.	11 couples remained (only 4 in EFT +medication group). Pre-selection screening.	
Greenberg, Warwar & Malcolm (2010)	The goal of this study was to evaluate the effectiveness of EFT for resolving attachment injuries.	Cohort study. The sample were their own waitlist controls. 10-12 sessions of EFT.	Community sample. Twenty couples. Mean age 45.1. Mean length of relationship 6.3 years.	DAS (Spanier, 1976) Enright Forgiveness Inventory (Enright, Rique & Coyle, 2000)	Both injurer and injured person were found to differ significantly over treatment compared to no significant change over the waitlist period on the outcome	Waitlist control only. Poor reporting of statistics and outcomes making interpretation and replication difficult.	2 (moderate)

				Unfinished Business, Empathy and Acceptance Scale (Singh, 1994).	measures.	Self-selected sample. Pre-selection screening.	
Halchuck, Makinen & Johnson (2010)	The aim was to see if couples who had experienced an attachment injury showed decreases in marital distress at three year follow up from receiving EFT.	Repeated measures design – three year follow up study using data from previous study of resolved and unresolved couples following EFT. ⁴	Community sample. Twelve couples. Mean age 36.5 years. Mean length of relationship 10 years.	1) DAS (Spanier, 1976). 2) Relationship Trust Scale (RTS) (Holmes, Boon & Adams, 1990). 3) Experiences in Close Relationships (ECR) (Brennan, Clark & Shaver, 1998).	1) DAS: significant difference between groups ($p < 0.05$) showing stability of effect. 2) RTS: significant difference between groups ($p < 0.05$). 3) ECR: NS between groups. *Improvement in marital satisfaction and trust in the relationship is maintained at 3 years post intervention.	Small sample for quantitative study. High attrition rate. Half of the sample was lost at follow-up. No information as to why they dropped out. No information of other treatments received before follow up assessment. No comparison group.	3 (weak)
Soltani, Molazadeh, Mahmoodi & Hosseini (2013)	To evaluate the effect of EFT on marital discord in couples.	RCT. EFT vs waitlist control. 8-10 sessions of EFT.	Recruited from counselling centre. Fourteen couples. Seven couples in	Intimacy Needs Questionnaire (Oliya, Fatehizadeh & Bahrami, 2006)	Significantly higher levels of intimacy in the EFT group ($p < 0.01$) than wait list group.	Waitlist control only. Small sample size. No information on participants. No information on randomisation.	3 (weak)

			each group.				
Rostami Taheri, Abdi & Kermani (2014)	To evaluate the effect of EFT on marital discord in couples.	RCT. EFT vs waitlist control. Eight sessions of EFT.	Clinic sample. Twenty couples. Mean length of relationship six years.	Marital Satisfaction Questionnaire (Fowers & Olson, 1989).	Significant difference between groups. Difference between pre-test and post-test EFT ES 0.97; wait list ES 0.03.	Waitlist control only. Small sample size. Different outcome measures to other studies.	3 (weak)
Butler, Harper & Mitchell (2011)	Examined enactments as a therapy process and change mechanism to promote secure attachment in couple therapy	Repeated measures design. Enactment led or therapist led intervention. Outcomes pre- and post-therapy.	Clinical group. Sixteen couples. Mixed diagnosis including depression and anxiety. Mean age 30 years. Mean length of relationship nine years.	Security of Attachment measure (SAM) adapted from ECR (Brennan et al., 1998). Only the questions from the secure attachment subscale of the ECR were utilised in this study.	Enactment led ES 1.66; Therapist led ES 0.26. *Enactment led intervention shows better improvement on the SAM.	Pilot study. Small sample for quantitative analysis and no control group. Inexperienced therapists. Use of un-validated measure (SAM). Only secure attachment was measured.	3 (weak)
Zuccarini, Johnson, Dalgleish & Makinen, (2014).	To empirically validate steps in the attachment injury reparation model (AIRM), a forgiveness and reconciliation model from EFT.	Process study. Task analysis of AIRM events using pre-defined coding scales. Thirteen sessions of EFT.	Community sample. Eighteen couples. Nine resolved and nine non-resolved. Mean age 33 years.	Process measures - Experiencing scale (Klein, Mathieu-Coughlan, Kiesler, 1986). Structural Analysis of	Resolved couples processed primary emotions (e.g. sadness) related to an injury in a highly emotional, differentiating, integrating, and affiliative manner. Non-resolved	Selection criteria not clear – data sample taken from previous outcome study. Sampling bias.	2 (moderate)

			Length of relationship not reported.	Social Behaviour (SASB) (Benjamin, 1981).	partners' manner of engagement was mostly emotionally detached and reactive, the incident was processed in an automatic and habitual mode, and interpersonal responses were non-affiliative.		
Meneses & Greenberg (2014)	<p>To explore the process of forgiveness in EFT in the case of women betrayed by their partners.</p> <p>How the presence of three particular components of forgiveness (expression of shame, acceptance of shame, forgiveness) predicted level of forgiveness for the injured partner.</p>	<p>Mixed methods. Process-outcome study.</p> <p>Task analysis of therapy sessions.</p> <p>Twelve sessions of EFT.</p>	<p>Community sample.</p> <p>Thirty-three couples.</p>	<p>Process measure - Degree of Forgiveness in Couples Scale (DFC) (Woldarsky-Meneses, 2006).</p> <p>Outcome measure - Enright Forgiveness Scale (Enright et al., 2000).</p>	<p>Injuring partner's shame and the injured partner's acceptance of the shame were found to be significant predictors of residual change on the attachment injury. Shame accounted for 33% of the outcome variance. The addition of the injured partner's acceptance into the model explained an additional 9%, while in-session forgiveness explained another 8%. This final regression model</p>	<p>Sampling bias: self-selected community sample; limited demographic.</p> <p>Data is part of a bigger study – case selection not discussed.</p>	2 (moderate)

					accounted for 50% of the variance in forgiveness.		
Dalgleish, Johnson, Burgess-Moser, Lafontaine, Wiebe & Tasca (2014)	To explore the process of the blamer-softening event in EFT, and how this event is related to partners' attachment security at intake and changes made in marital satisfaction from pre- to post-therapy.	Mixed methods. Process-outcome study. Twelve sessions of EFT.	Community sample. Thirty-two couples. Relationship length 15.9 years.	Process measures - Experiencing Scale (Klein et al., 1986); SASB (Benjamin, 1981). Outcome measures - ECR (Brennan et al., 1998); DAS (Spanier, 1976).	The blamer-softening event significantly predicted change in marital satisfaction scores from pre- to post-therapy. Couples who had a blamer-softening event had greater positive changes in marital satisfaction. Pre-therapy attachment anxiety and attachment avoidance did not predict a blamer-softening event.	Sampling bias. Self-selected community sample; limited demographic.	1/2 (moderate)

¹ DAS - A score of <97 is the cut-off score for the presence of marital distress. Scores <87 on the DAS are considered to signify significant relationship problems and scores of <70 are typical of divorcing couples (Spanier, 1976). ² Scores greater than 65 warrant further investigation (Briere et al., 1995). ³QMI – lower scores equal greater dyadic discord (range 6-45). ⁴ Study included in previous systematic review (Greenman & Johnson, 2013).

Data Synthesis

Table 1 provides a summary of the studies, including their main characteristics, findings, limitations and quality rating. Of the 12 articles included in the review, 11 are EFT studies. Therefore, this systematic review of empirical studies has shown that there is a paucity of couple therapy models utilising attachment theory within their model of change, with EFT currently being the dominant model.

Study Aims

The study 'aims' highlighted that EFT is used with couples to improve the relationship between partners but also to target symptoms related to mental health problems ($n=4$). Two of these studies evaluated the effectiveness of EFT to reduce trauma in the female member of the couple who had experienced CSA (MacIntosh & Johnson, 2008; Dalton et al., 2013). MacIntosh & Johnson (2008) also applied a thematic analysis to their data exploring the themes arising in sessions. Of the four studies, the remaining two explored the effects of EFT versus medication, where one member of the couple was suffering from depression (Dessaulles et al., 2003; Denton et al., 2012). A non-EFT study ($n=1$) explored the difference between client led enactments versus therapist led enactments on the impact of attachment security in a population of people with depression and/or anxiety (Butler et al., 2011).

Of the remaining EFT studies ($n=7$), four studies evaluated the effects of EFT to reduce marital discord (Soltani et al., 2013; Rostami et al., 2014; Halchuck et al., 2010; Greenberg et al., 2010). Two studies explored the processes involved in EFT in couples where an attachment injury had occurred (Zuccarini et al., 2014; Meneses & Greenberg, 2014) and one study explored the processes in EFT in couples where

marital discord was present, but without any particular emotional injury occurring (Dalglish et al., 2014).

Methods

Various methodologies were employed ranging from quantitative outcome studies, mixed method designs and the exploration of in-depth processes emerging within the therapy sessions. Eight of the 12 studies employed a quantitative methodology. Three of these (Halchuck et al., 2010; Greenberg et al., 2010; Butler et al., 2011) were based on a single cohort design. The remaining five of the eight quantitative studies were designed as RCTs. Three of these RCT designs employed a waitlist control group as a comparison to a group receiving EFT and the remaining two employed an active control group, in the form of medication.

Three of the 12 studies employed a mixed methods design (MacIntosh & Johnson, 2008; Dalglish et al., 2014; Meneses & Greenberg, 2014). MacIntosh and Johnson (2008) employed a cohort design, using repeated measures following EFT. They also employed a thematic analysis to examine themes emerging within EFT for couples where the female partner suffered from complex trauma resulting from CSA. Dalglish et al. (2014) and Meneses & Greenberg (2014) were process-outcome studies examining specific therapist and client tasks related to particular psychotherapy outcomes. Finally, Zuccarini et al. (2014) used a process design employing a task analysis.

Sample and Outcome Measures

Seven of the studies used participants who self-referred in response to adverts in the community, four studies used a clinical sample and one study used a mix of both groups.

The number of couples in the studies ranged from 10 in a cohort study to 33 in one of the process-outcome studies. The median number of couples across studies was 18, which would mean that in the RCT studies there was an average of nine couples in each group. This is a small number of participants for an RCT study (Moher, Dulberg, & Wells, 1994).

There was some consistency in the outcome measures across studies. Eight of the studies employed a measure to evaluate marital satisfaction, with six of the studies using the DAS (Spanier, 1976). In both of the studies examining trauma symptoms, the TSI (Briere et al., 1995) was employed to measure symptom change. In the studies looking at the effects of EFT on depression, the IDD (Zimmerman et al., 1986) was employed as a measure of symptom change. The process-outcome studies used different measures relating to the process being studied. Across all of the studies, only three employed a measure to understand the effects of therapy on attachment styles. Two of these studies employed the ECR (Brennan et al., 1998), which is a well-validated measure of attachment anxiety and avoidance. Butler et al. (2011) used the SAM, which measures attachment security. However, this is an un-validated measure.

Findings

Two studies evaluated the effectiveness of EFT on trauma symptoms resulting from CSA. MacIntosh and Johnson (2008) reported a reduction in trauma symptoms following 19 sessions of EFT, whereas Dalton et al. (2013) did not report any significant change in trauma symptoms following 22 sessions of EFT. This finding may be explained by the severity of symptomatology in Dalton et al's clinical sample. The findings from MacIntosh and Johnson's (2008) thematic analysis may lend support to this hypothesis. The main themes emerging from this analysis for the female partner who was suffering with complex trauma following CSA, involved difficulty with managing distressing emotions, feeling flooded by emotions, emotional numbing and dissociation. Therefore, people with lots of complex trauma may find EFT too overwhelming. However, both studies (MacIntosh & Johnson, 2008; Dalton et al., 2013) reported an improvement in marital satisfaction in couples following EFT.

There were mixed results in the two studies exploring the effects of EFT where one member of the couple presented with depression. Dessaulles et al. (2003) reported no difference in depression symptoms between EFT and medication groups post-treatment. However, there was a reduction in depression symptoms at six month follow up in the EFT group compared to an increase in symptoms in the medication group. The authors note that this could be due to medication termination at 16 weeks, the same time period the EFT intervention completed. Denton et al. (2012) reported no significant difference in depression symptoms between couples who had received medication alone and couples receiving medication augmented with EFT.

However, they did report an improvement in marital satisfaction in the group receiving EFT compared to no EFT.

Greenberg et al. (2010) reported improvements post-EFT in marital satisfaction, forgiveness and empathy, in couples where an emotional injury had occurred. Halchuck et al. (2010) examined the effects of EFT in couples where an emotional injury had occurred at three years post EFT and reported improvements in marital satisfaction and trust. The authors also included a measure of attachment anxiety and avoidance, the ECR (Brennan et al., 1998), but, no change was reported in the incidence of less attachment anxiety or avoidance. Butler and colleagues (2011) employed attachment theory within a non-specific couple model, focusing on enactments as an attachment forming event. They found that starting the therapy process with client-led enactments improved female partners' attachment security, while beginning with therapist-centred sessions negatively impacted male partners' attachment security; although overall attachment differences were not found between the two conditions when measured over all six sessions. Two studies explored the process of the forgiveness cycle in couples using EFT (Zuccarini et al., 2014; Meneses & Greenberg, 2014). This cycle had not previously been studied in EFT. Zuccarini et al. (2014) examined couples who had resolved their emotional injury and compared them to couples who had not resolved the injury. The authors looked at the process of forgiveness in relation to this injury. They found that resolved couples managed to process primary emotions in a differentiating manner, whereas non-resolved couples were emotionally detached and defensive and did not manage to get past secondary emotions in their communication. Meneses & Greenberg (2014) included an outcome measure in their study, which related the process of forgiveness to an outcome of forgiveness. They found that there are

three components to forgiveness - expression of shame, acceptance of shame, and forgiveness - which predicted the level of forgiveness for the injured partner. The expression of shame in the injurer predicts the highest amount of forgiveness in the injured partner.

Finally, Dagleish and colleagues (2014) examined how the blamer-softening event predicted improvement in marital satisfaction and attachment anxiety and avoidance. This study built on previous process research examining the blamer-softening event (Greenman & Johnson, 2013) since it looked at how this event is related to partners' attachment security at intake in addition to changes in marital satisfaction from pre- to post-therapy. It was reported that couples who had a blamer-softening event experienced greater marital satisfaction. However, no changes were seen on the ECR (Brennan et al., 1998) in terms of a reduction of attachment anxiety or avoidance.

Limitations

Studies were rated as 'weak' to 'moderate' on the quality appraisal criteria (CASP, 2006). The main limitations were small sample size; lack of, or poor, control groups; sample bias; lack of clarity in the description of methodology and high attrition rates. With regard to sample size, the median number of couples across studies was 18, which for quantitative studies is low, particularly when multiple outcome measures are being used. It was notable, therefore, that only one study (Halchuck et al., 2010) reported using Bonferroni corrections to adjust for multiple comparisons.

Furthermore, these sample sizes are small compared to other couple therapy research, for example, a multisite study of 134 couples examining integrative

behavioural couple therapy (IBCT) (Christensen, Atkins, Berns, Wheeler, Baucom & Simpson, 2004).

Many of the studies did not have a control group (MacIntosh & Johnson, 2008; Halchuck et al., 2010; Butler et al., 2011), or had poor control groups e.g. using waitlist controls (Dalton et al., 2013; Greenberg et al., 2010; Soltani et al., 2013; Rostami et al., 2014). Waitlist control or no control group shows that the treatment is effectively better than doing nothing. More information on the differential effects of EFT for couples and other evidence-based couple therapies is necessary.

Most of the studies showed bias in terms of the participants being self-selecting or subject to an over-rigorous screening process. Many of the studies included a biased sample in terms of demographic, education and racial bias. Only the non-EFT study (Butler et al., 2011) reported recruiting from a low income community clinic. All of these study biases limit the ability to generalise the findings.

Although five studies were described as RCTs, only one of these (Denton et al., 2012) referred to how randomisation occurred, blinding of researchers to participant treatment and how this was done. Description of treatment fidelity was poor or absent in many studies and numerous studies reported using trainee therapists.

Researcher reflexivity was not completed on the CASP (2006) quality rating tool for the four studies that included a process or qualitative exploration (Zuccarini et al., 2014; Meneses & Greenberg, 2014; Dalgleish et al., 2014; MacIntosh & Johnson, 2008). Therefore, it is not known whether researcher bias was examined.

In three of the quantitative studies attrition rates were high (Dessaulles et al., 2003; Denton et al., 2012; Halchuck et al., 2010), including both of the studies looking at the effectiveness of EFT versus medication for depression. Dessaulles et al. (2003) reported that a third of the sample dropped out by follow-up, with no explanation provided. Further, nearly half of the sample dropped out by follow-up in the study by Denton et al. (2012) with reasons ranging from stress to marriage break-up. High attrition rates in depressed samples may not be unusual, as it has been reported that patients with major depression have the highest chance of treatment dropout (Wang, 2007). Halchuck et al. (2010) provided the only long term follow-up study in the review. However, only half of the original sample, on which the repeated outcome data was based, was available for analysis. Reasons were not provided as to why participants did not wish to take part. A limitation of high attrition is that the resulting low power can inhibit the ability to detect statistically significant differences between groups.

Discussion

This literature review highlighted that EFT is the dominant couple therapy model utilising attachment theory within its model of change. Since the review of EFT outcome studies nearly fifteen years ago (Johnson et al., 1999), this systematic review has highlighted several additions EFT has made to the empirical data in couple therapy. First, EFT may be a more effective approach for reducing depression symptoms compared to medication (Dessaulles et al., 2003). The National Institute for Clinical Excellence (2009) currently recommends behavioural couple therapy as one of the evidence based approaches for treating depression. However, it has been shown that improvements following treatment fade after a year

(Jacobson and Christensen, 1996). Second, it is shown that EFT is effective at reducing marital discord at three year post-treatment. This is a substantial finding for EFT as research on long-term follow-up with behavioural marital therapy indicates that for the majority of couples, marital satisfaction regresses to pre-treatment levels two to three years after treatment (Snyder, Wills, & Grady-Fletcher, 1991).

The review also adds to the systematic review of process studies of EFT undertaken by Greenberg & Johnson (2013). The current review includes studies exploring and understanding the forgiveness cycle (Meneses & Greenberg, 2014), highlighting the important role of the expression of shame in the process of forgiveness between couples. Further, using a thematic analysis design, MacIntosh & Johnson (2008) provided new information about the kinds of themes occurring when working with couples where PTSD is present resulting from CSA. This information could help to refine the EFT model when working with this group of people. Currently, guidelines for trauma survivors advise individual therapy as a first line treatment (NICE, 2005). However, MacIntosh & Johnson (2008) argue that by engaging in individual therapy, the opportunity is missed to engage partners as allies in the healing process and to strengthen these important relationships.

EFT shows promise as an effective therapy for improving difficulties in relationships for couples, however, in terms of whether therapy actually changes generalised attachment strategies, much less is certain. Only two studies, Halchuck et al. (2010) and Dalgleish et al. (2014), fully utilised an attachment change measure, the ECR. Both studies found no change on the attachment dimensions of the ECR in terms of therapeutic outcome. The fact that there was no change on the ECR following EFT

is an interesting finding. It has been shown that with a non-attachment focused couple therapy such as IBCT, security of attachment can improve (Benson, Sevier, & Christensen, 2013). This is based on the hypothesis that changes in satisfaction may lead to changes in attachment rather than the reverse. Benson and colleagues argue that IBCT may have secondary effects on attachment processes without any requirement that attachment is explicitly targeted.

In response to this, Johnson and Greenman (2013) argued that, whilst other couple therapies may initiate change, it is limited change. They suggest that the most effective strategy to create stable loving relationships (rather than just a rise in satisfaction), is to address attachment needs and fears. Therefore, “rewards” that cannot be negotiated, such as trust, emotional responsiveness, and security, can develop (Johnson & Greenman, 2013). It is of interest, therefore, that few of the EFT studies employ a measure that captures these elements over and above marital satisfaction. Future EFT research would benefit from including such a measure.

Further, it would be useful to conduct an RCT comparing EFT with IBCT, and measure attachment outcomes and marital distress to see the extent of change between the therapies in these outcomes.

Limitations of the Review

The exclusion of case studies meant that some therapy models were not included. Omitted case studies from this review e.g. Vetere and Dallos (2008) and Reibstein and Sherbersky (2012), were theoretically driven articles. Currently, it is only possible to compare these two models (Vetere & Dallos, 2008; Reibstein &

Sherbersky, 2012) theoretically to EFT. Whereas in EFT attachment theory is used to conceptualise emotion regulation (Johnson & Whiffen, 2003), attachment narrative work (Vetere & Dallos, 2008; Reibstein & Sherbersky, 2012) has an explicit focus on understanding how past relationships have an impact on empathy, trust and security in the couple relationship.

This review has included both quantitative, process and qualitative methods drawing from multiple methodological traditions. This has made comparison of studies more complex but provided a more comprehensive overview of the evidence to date.

Research and Clinical Implications

It will be helpful for researchers to extend the current case study research, e.g. Reibstein and Sherbersky (2012) and Vetere and Dallos (2008), with empirical studies, to understand how attachment theory is utilised in these models. This will enable clinicians to develop evidence based practice, and help to validate and refine the processes involved in these models.

Further, EFT research would benefit from increasing sample sizes, improving sample retention rates, applying stricter rules for randomisation and utilising a more heterogeneous sample from the community. Future research might also include outcome measures that capture change in attachment security.

Conclusion

It has been proposed that attachment theory has been under-utilised and under-researched in couple therapy (Seedall & Wampler, 2013). This review corroborated this, confirming that EFT is still the main empirically based couple therapy using attachment theory to guide its model of change. Other couple therapies (e.g. Vetere & Dallos, 2008; Reibstein & Sherbersky, 2012) are theoretically described but require empirical support.

This review extends the findings of previous reviews (Johnson et al., 1999; Greenman & Johnson, 2013) and shows EFT to be effective in (a) improving marital satisfaction, with effects stable over time, and (b) some evidence for improving clinical symptoms. However, further studies are required to improve the robustness of this data. Finally, there is a need to examine whether attachment informed therapies, such as EFT, are necessary to bring greater levels of marital satisfaction as well as improving relational trust and security.

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Appendix for Systematic Review

Appendix A – Full profile of EFT

Emotion-focused couple therapy. EFT-C is an affective systemic approach that aims to modify distressed couples' constricted interaction patterns and emotional responses to promote the development of a secure and validating emotional bond (Greenberg & Goldman, 2007; Greenberg & Johnson, 1986a; Johnson, 2004; Johnson & Greenberg, 1988). In this approach, negative cycles are changed by accessing the underlying emotions experienced by each partner in attempts to create new corrective emotional experiences that change interaction (Greenberg & Johnson, 1986b; Johnson & Greenberg, 1988). The treatment has been delineated in a nine-step (Johnson & Greenberg, 1988), three-stage (Johnson, 2004) model as follows:

Stage 1: Cycle De-escalation. The first step is key and involves establishing a strong working alliance with the couple at the beginning of therapy. This is followed by the identification and naming of the negative interactional cycle that maintains the distress in the relationship. Step three involves accessing the underlying feelings and needs of each partner's position. Once underlying feelings have been accessed in step four, the couple's problem is reframed in terms of the cycle and these newly accessed emotional experiences.

Stage 2: Restructuring the Interaction. The focus in step five is on promoting identification with the disowned aspects of experience that may arise in the redefined cycle. Step six focuses on the facilitation of each partner's acceptance of the other's newly experienced aspects of self and emotional responses. The expression of specific needs and wants to restructure the interaction occurs in step seven.

Stage 3: Consolidation and Integration. The focus in step eight is on facilitating the emergence of new solutions to old problematic relationship issues that precipitated the couple's entry into therapy. The final step involves consolidating the new positions partners have taken in the relational interactions and integrating new perspectives on each partner's sense of self and the relationship.

Couples Injury Treatment Manual

A specialized EFT-C treatment manual was developed for this project to focus on facilitating the resolution of emotional interpersonal injuries. The treatment protocol was summarized in the following seven steps, which were implemented within the general EFT-C framework.

1. Identify the idiosyncratic impact of the injury and the painful emotions felt by the injured partner.
2. In identifying the negative interactional cycle and each partner's position in the cycle, both the cycle that is the way of handling the current problem of betrayal as well as the cycle that is the source of prior relationship problems was focused on.
3. Promote expression of empathy from the offending partner for the other's pain resulting from the injury.
4. Access unacknowledged vulnerable attachment and identity-related feelings underlying each partner's interactional positions in the most pervasive problematic cycle.
5. Reframe the problem in the relationship in terms of underlying feelings, and attachment and identity needs, and connect this to the injury.
6. Promote expression of a heartfelt, authentic apology and remorse and regret by the offender.
7. Promote steps toward rebuilding trust.

Appendix B – CASP Quality Checklists

CASP Quantitative Checklist (2006)

1. Selection Bias
 - a. Are the participants likely to be representative of the target population?
 - b. What percentage of selected individuals agreed to participate?
2. Study Design
 - a. Is the design appropriate?
 - b. If randomised, is the randomisation described?
3. Confounders
 - a. Were there important differences between groups prior to the intervention?
 - b. If yes, what is the percentage of relevant confounders that were controlled?
4. Blinding - Was the outcome assessor aware of the intervention or exposure status of participants?
5. Data Collection Methods - Were data collection tools shown to be valid and reliable?
6. Withdrawals and Dropouts - Were withdrawals and dropouts reported in terms of numbers and reasons?
7. Intervention Integrity - What percentage of participants received the allocated intervention of interest?
8. Analysis - Is the statistical method appropriate for the study design?

CASP Qualitative Checklist (2006)

1. Was the research design appropriate to address the aims of the research?
2. Was the recruitment strategy appropriate to the aims of the research?
3. Was the data collected in a way that addressed the research issue?
4. Has the relationship between researcher and participants been adequately considered?
5. Have ethical issues been taken into consideration?
6. Was the data analysis sufficiently rigorous?
7. Is there a clear statement of findings?
8. How valuable is the research?



SCHOOL OF PSYCHOLOGY

DOCTORATE IN CLINICAL PSYCHOLOGY

EMPIRICAL PAPER

Investigating attachment narratives in couple therapy for depression

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Abstract

Objective: The Exeter Model is an integrative systemic-behavioural and systemic-empathic couple therapy for treating people with depression. 'Attachment narratives' is a component of the systemic-empathic approach, which seeks to help the couple understand how past relationships impact on the current relationship with the aim of rebuilding trust and security between the couple. This study sought to examine how attachment narratives in this Model are used by therapists.

Method: Narrative Analysis was employed to explore attachment narratives in three couples who had completed therapy in an outpatient clinic where one member of the couple had been referred with depression.

Results: Analysis highlighted four specific ways in which therapists used attachment narratives. These consisted of: therapist enabled stories of past relationships to be foregrounded; attachment theory employed to build hypothesis about attachment styles based on past relationships; therapist helped the couple understand how attachment styles maintain unhelpful cycles of relating and introduced alternative relationship narratives enabling improved trust and security. Analysis also demonstrated the structuring of these attachment narratives across the therapy sessions.

Conclusion: This study shows that through the therapist paying attention to attachment styles, awareness of unhelpful cycles of relating within couples can be highlighted, and adjustments to how the couple can relate to each other suggested. This exploratory study serves to better inform the use of the Exeter Model.

Introduction

Couple Therapy

Recent national policy guidance on improving mental health in the UK has emphasised the need to 'think family' (Cabinet Office, 2008), to create a 'triangle of care' (Worthington and Rooney, 2010) and to develop specialist family interventions (National Institute for Health and Clinical Excellence [NICE], 2009). In 2009, NICE added couple therapy as a recommended treatment for depression based on randomised controlled trials of behavioural couple therapy (BCT). BCT has an emphasis on couple resources, with the therapy promoting skills in problem solving, clear communication and conflict management (Christensen, McGinn & Williams, 2009). It has been noted that there is a lack of stability in improved symptoms following BCT (Jacobson and Christensen, 1996).

More recently, the 'third wave' (Öst, 2008) couple therapies have built on the behavioural interventions through promoting empathy, the therapeutic alliance and collaborative working (Reibstein & Sherbersky, 2012). Couple therapies such as integrative behavioural couple therapy (IBCT) (Jacobson & Christensen, 1996) and insight-oriented therapy (Snyder, Wills & Grady-Fletcher, 1991) have included strategies that focus on achieving mutual tolerance, acceptance and insight with the aim of promoting empathy and compassion. Whilst these models show promise in improving marital satisfaction, they have no empirical base for treating depression (Snyder & Halford, 2012).

Emotion focused therapy (EFT) for couples (Johnson & Whiffen, 2003) extends the importance of the empathic part of therapy, drawing on attachment theory. EFT posits that the most effective strategy to create stable loving relationships is to address attachment needs and fears, so that unnegotiable 'rewards' such as security, emotional responsiveness and trust, can develop (Johnson & Greenman, 2013). Thus, EFT theorists argue that the lack of stability in improved symptoms following BCT, may be because the economic model of 'adult love' does not address the more 'leading' or organising elements in a relationship, for example, emotional security and trust (Johnson & Greenman, 2013). There is evidence that EFT helps maintain long-term positive outcomes in marital satisfaction and trust (Halchuck, Makinen & Johnson, 2010), and may reduce depression symptoms over medication (Dessaulles, Johnson & Denton, 2003).

Critique of Attachment Theory

Attachment theory may provide a framework in which to understand the aetiology of depression with evidence showing links between problematic attachment histories and depressive symptomatology (Whiffen, Kallos-Lilly, MacDonald, 2001; Scharfe, 2007). Collins and Feeney (2000) suggest that the working models of those who are insecurely attached reflect relational histories with inconsistent or unresponsive carers, and argue that such internal working models negatively bias perceptions of the self and partners, impacting on trust and security in relationships. This concurs with Bowlby's (1988) view that people who have suffered abusive and/or neglectful childhoods, will often have difficulty trusting, and feeling secure with others.

However, critics of attachment theory argue that (a) it over emphasises the role

interaction plays in personality development and on emotion regulation, at the expense of an ability to stabilise the self and strivings for autonomy (Schnarch, 1999), (b) it neglects the impact of multiple early attachments (McHale, 2007) and peer relationships (Harris, 1998) on personality development, and (c) temperament is more important than the transient effects of the early environment (Kagan, 1994) - although research has demonstrated that it is the caregivers' behaviours that form the child's attachment style (Benoit & Parker, 1994). However, attachment theory can be argued to be particularly relevant to family systemic theory, which understands the origin of the problem (e.g. depression) and its potential solutions, as located within an attachment system (Bowen, 1966). This is in contrast to locating the problem within the individual as in psychodynamic couple therapy models (Schnarch, 1999).

Attachment Theory

Attachment theory (Bowlby, 1988) posits that one's emotional security and stability develop through an ever-evolving working model of interpersonal relationships, beginning with the primary caregiver, which remains the strongest. This model of self and other informs beliefs regarding (a) the level of safety and comfort found in close relationships when confronted with separation or distress, (b) the availability and responsiveness of attachment figures in attending to distress, and (c) the individual's own worthiness to receive sensitive, loving care (Seedall & Wampler, 2013).

Attachment Styles

Hazan and Shaver (1987) developed a three-category typology for categorizing adult attachment style; secure, preoccupied, and dismissive-avoidant, to which a fourth category, fearful-avoidant, was later added by Bartholomew and Horowitz (1991). Accordingly, securely attached adults are characterized by comfort with both intimacy and independence and have a positive working model of self and of others. Preoccupied individuals are anxious and clingy in relationships, preoccupied with the relationship, and have a negative working model of self and a positive working model of others. Dismissive-avoidant individuals prefer not to depend on others, seek less intimacy from partners and frequently suppress and hide their feelings. They have a positive working model of self and a negative working model of others. Finally, fearful-avoidant individuals want emotionally close relationships, but find it difficult to trust others completely, or to depend on them. They have a negative working model of both self and others.

Systemic Theory and Attachment

Attachment theory's links to systemic theory make it a suitable vehicle for thinking about couples. Its starting point is two separate individuals who are, at the same time, inescapably in relationship to one another (Clulow, 2012). In adulthood, one's partner becomes the object of attachment from which individuals receive support and to whom they provide care (Hazan & Shaver, 1987). Further, each partner's style of attachment can affect how well relationships progress and end (Hazan & Shaver,

1987). Thus, a partner's characteristics can either maintain existing working models of self and other or promote change for better or worse (Feeney, 2003).

The Exeter Model

There are promising new lines of research seeking to enhance couple therapy (Snyder & Halford, 2012). Systematic integration of different couple therapy approaches, drawing upon specific interventions, is one way forward. Snyder & Halford (2012) suggest 'couple therapy often requires thinking outside the parameters of any one theoretical model' (p.231).

The Exeter Model of Couple Therapy for Depression (Reibstein & Sherbersky, 2012) is an integrative model utilising both behavioural and empathic approaches using a systemic lens (see Appendix A). Systemic behavioural techniques aim to improve communication, conflict management and resolution. Empathic components accord with evidence-based models, including IBCT (Jacobson & Christensen, 1996), which promotes acceptance and tolerance and EFT (Johnson & Whiffen, 2003), which helps couples share their emotional vulnerabilities fostering greater feelings of trust and felt security (Reibstein & Sherbersky, 2012). The empathic approach also draws on Attachment Narrative Therapy (ANT) (Vetere and Dallos, 2008), which is a theoretically driven model. ANT helps clients to develop better trust and security in relationships through exploring attachment narratives within a systemic framework and considers alternative narratives. Components used in the systemic-empathic arm of the Exeter Model include empathic bridging manoeuvres, circularities and attachment narratives (Reibstein & Sherbersky, 2012).

'Attachment narratives' can be understood as a systemic use of attachment theory, in which the aim is to increase trust and security through mutual understanding of each other's attachment histories and their legacy on the relationship (Reibstein & Sherbersky, 2012; Vetere & Dallos, 2008). The systemic nature of the therapy enables the couple to shift from narratives that view problems as residing essentially within themselves to narratives that view them as relational problems (Vetere & Dallos, 2008).

The attachment narrative component, in the Exeter Model, is similar to EFT (Johnson & Whiffen, 2003) and ANT (Vetere & Dallos, 2008) as it employs attachment theory to understand relationship distress. However, EFT focuses on changing relationship-specific emotional processes, helping partners become more secure and less distressed in their interactions whilst ANT considers these attachment experiences to be the stem of all disorders and dysfunctions within a couple (Vetere & Dallos, 2008). The Exeter Model (Reibstein & Sherbersky, 2012) differs from EFT (Johnson & Whiffen, 2003) and ANT (Vetere & Dallos, 2008), as it does not use attachment narratives as the only component of change in its model.

EFT is currently the main couple therapy which draws on attachment theory and has an empirical evidence base (Johnson, Hunsley, Greenberg & Schindler, 1999; Greenman & Johnson, 2013). However, none of these studies have explicitly investigated how the therapist makes use of past attachment histories to understand the couple's present relationship functioning. It has been suggested that "whilst EFT works towards enhancing the emotional quality of couple interactions, it stops short

of addressing how past attachment relationships and experiences may be influencing current relationships” (Seedall & Wampler, 2013, p.48). ANT (Vetere & Dallos, 2008) does not have an empirical base.

To date, there are no empirical studies which investigate how attachment histories are used to help couples make links and repair their relationship through reaching understandings of each other’s attachment histories. However, this is clearly an aspect of therapeutic change in couples’ therapy (Seedall & Wampler, 2013).

Aim

The aim of this study is to investigate how therapists work with the ‘attachment narrative’ component in the Exeter Model with their stated hope of helping the couple have more trust for each other and thus feel more secure in the relationship (Reibstein & Sherbersky, 2012).

The research question is: How does the therapist, working with the attachment narrative component in the Exeter Model and attempting to increase trust and security, help the couple acknowledge and understand how past relationships have a legacy on their current relationship?

Method

Research Design

The Exeter Model is a treatment option available within the AccEPT Clinic at the Mood Disorders Centre, Exeter University. The data came from therapy sessions recorded onto DVD with clients' permission for use in research. Ethical approval was obtained through the Oxfordshire Rec NHS ethics committee (reference 14/SC/0254) and school ethics committee (Appendix B). Nineteen participants' data are held on the database. The first three couples from the database were selected. Twenty sessions were read (three cases) several times and transcribed. These sessions were analysed using Narrative Analysis.

Participants

Case 1 - Peter² and Julie received 7 sessions. Peter was diagnosed with depression 8 years prior to treatment. He and Julie have been married for 25 years and both are in their mid-fifties. They have two children Michelle, 21 and David, 19 who have both recently moved out of the family home. Case 2 - Sarah and Emma received 6 sessions. Sarah and Emma are in their late twenties and have been together for eleven years. Sarah has suffered with depression since her teenage years. Sarah wants to 'come out' as a couple, however, Emma has not been able to tell her own family she is gay. Case 3 - Jo and John received 10 sessions (7 sessions were recorded). Jo and John are both in their early thirties. They have been married for 5 years. Jo has been suffering from depression for 15 years. Jo reported a cycle of

² All names have been changed.

going out and bingeing on alcohol alone without John, and then feeling low afterwards. John is untrusting of Jo as she will go off for days.

The two therapists, who individually saw these cases, are trained family therapists and developers of the Exeter Model (Reibstein & Sherbersky, 2012). Therapist 1 saw Peter and Julie and Sarah and Emma; Jo and John were seen by Therapist 2. There are other trainee therapists in the clinic, but only these two therapists are fully trained in the Model and therefore included in this research.

Narrative Analysis

Narrative³ Analysis was chosen over other possible methods, such as thematic or discourse analysis, as it emphasises the importance of respecting the whole narrative, analysed in its totality and employing a case study format (Reissman, 1993). This is in contrast to coding themes or categories across narratives, as would be standard in thematic analysis, or studying discourses across different cases as is often done in discourse analysis (Lepper & Riding, 2006). Narrative Analysis was also chosen over other process methods, such as the Assimilation Model (Stiles et al., 1990), which is arguably not sensitive enough to the psychotherapeutic process (Peräkylä, Antaki, Vehviläinen & Leudar, 2008). This was something that seemed particularly important to this research topic.

³ The terms narrative and story are used interchangeably, as done in other narrative research (McLeod & Balamoutsou, 2001).

From a narrative perspective, therapy represents one of the few times when a person obtains direct assistance in the telling of their life story (Adler & McAdams, 2007). The therapeutic experience may destabilise a person's established story and challenge the person to make new meaning out of difficult life events (Adler & McAdams, 2007). Avdi and Georgaca (2007) suggest that narrative research enables us to examine key assumptions of narrative approaches to therapy, such as the notion that therapy involves a shift towards more comprehensive, coherent, complex and alternative narratives. Various narrative approaches have been employed to understand these processes such as the study of coherence of narratives (McAdams, 2006), typologies of stories (McCormack, 2004), structural analysis of narratives (e.g. Labov, 1972) or the meta-narrative (McLeod & Balamoutsou, 2001). The latter two of these approaches will be described in more detail as they are the chosen approaches for this study.

Narrative Approach

Within narrative social constructionism, which emphasises the social and cultural construction of identity, and the collaborative co-construction of meaning between therapist and client, McLeod and Balamoutsou (2001) refer to the meta-narrative. This is the interpretive framework offered by the different 'schools' of psychotherapy, which is used as an organising narrative, contributing towards helping clients make different, alternative narratives. This view accords with Schaffer's (1981) suggestion that the psychoanalytic schools represent meta-narratives, which can be used to reframe the stories told at the level of the therapist patient discourse (Lepper & Riding, 2006). This is a helpful approach to use in relation to my research question, as

I am interested in how attachment theory (the meta-narrative) is utilised in narratives to help the couple understand how past relationships have a legacy on the current relationship. The meta-narrative has been written about as a theoretical concept (Schaffer, 1981; McLeod and Balamoutsou, 2001), but has also been applied to case studies (McLeod & Lynch, 2000; McLeod, 2014), where the task of meta-narrative repair, or the construction of an alternative meta-narrative, appeared to be central to the work of therapy (Angus & McLeod, 2004).

Micro-analysis of specific events in Narrative Analysis are characterised by the work of Riessman, (1993), Gee (1986) and Labov (1972). Labov (1972) analyses the structure of the text and states that a story generally contains an abstract (what the story is about); orientation (who, when, where); complicating action (then what happened); evaluation (meaning and emotional interest); resolution (what finally happened); and conclusion. This structural approach provides a way into the interpretation of a text (Reissman, 1993) and is particularly helpful where there is an interest in the co-construction of the narrative, i.e. who is saying what and when (Semino, Demjén, Hardie, Koller, & Rayson, 2014). Further, where evaluative and emotional expressions imbue the narrative, such as in psychotherapy transcripts, a structural approach, which explicitly includes an evaluative component (such as Labov's) is useful (Muntigl, Knight & Angus, 2014). Finally, Reissman (1993) argues that Labov's (1972) structural approach is paradigmatic: most investigators utilising a narrative approach cite it, apply it, or use it as a point of departure. I have applied it in my study for the reasons above.

Analytic Process.

The analysis was split into different steps adapted from McLeod and Balamoutsou (2001).

- (1) Meaning and structure were identified in the text as a whole: for example, overall topics were located and their beginning and ending was identified (Appendix C).
- (2) Narratives which concerned either of the couple and/or therapist talking about a past attachment/relationship experience, or how those relationships are experienced in the current relationship, were identified.
- (3) A micro-analysis of the chosen extracts was conducted.

Labov's (1972) model of story structure, described above, was applied to find the narrative structure: where it starts, how it is evaluated and where it ends. The use of the meta-narrative (McLeod & Balamoutsou, 2001) was applied to open up the meaning of the narrative, i.e. attachment theory was applied to understand types of attachment style/s within the relationship, how these may foster or erode concepts such as trust and security, and how the therapist uses her understanding of these to formulate, and, hopefully, bring a new narrative to foster trust and security in the relationship. The analysis was carried out one case at a time to form a picture of the construction of attachment narratives across each case.

Trustworthiness of the Analysis

According to Reissman (1993) qualitative research can be validated according to persuasiveness, correspondence and pragmatic use. Persuasiveness is greatest when “theoretical claims are supported with evidence from informants’ accounts” (Reissman, 1993, p.65). Here, extracts are provided which give transparency and support the interpretations. Correspondence is demonstrated when the “data, interpretations and conclusions are tested with those from whom it was collected” (Lincoln & Guba, 1985, p.314). Each of the extracts, analysis and final report was shared with the two therapists who had worked with the couples. They found the extracts recognisable as adequate representations of ‘attachment narratives’ and the analysis of them understandable and similar to their experiences of the way they had worked with this component of the model. Pragmatic use is the extent others can use the work, for example, making visible what was done and making primary data available to other researchers. Extracts are included for transparency and full transcripts are available upon request.

Results

From the twenty transcribed sessions, eighteen attachment narratives were identified. Seven for couple one, five for couple two and six for couple three. In the following section the extracts referred to were obtained by selecting exemplar excerpts (McLeod & Balamoutsou, 2001) from the eighteen identified. First, the extract is presented, followed by analysis of content and structure. See Appendix D for abbreviations and notation system used in analysing the transcripts.

Case Examples

Case 1 - Peter and Julie.

Extract 1 – session 1.

1. TH. Now, let me ask Peter. Do you see signs that would set off a lot of
2. alarm bells, because you have been there?
3. PETER. (Nods)
4. TH. I'm not agreeing with Julie here, but I'm trying to get some information here.
5. But, is that different from the way you were when you were his age and full of
6. anger that talking to his parents like that? (...) Would that be different?
7. PETER. My parents were chronic alcoholics. My father was (...) abusive, he was
8. violent, he was a bully, he was a thug. I used to wet my trousers. He starved me,
9. he done all this stuff.
10. TH. He was a sadist it sounds like?
11. PETER. He was a crazy, crazy person. I became an angry person. And talking
12. about suppressing, and I drank, it took me away from feelings. When I drank I
13. drank to get drunk. And the alcohol bought more anger. I have seen David come
14. in, and we really haven't addressed it. I really was going insane because I felt
15. isolated (...). When he picked up the alcohol my son is really angry, really angry
16. and I thought, WOW.
17. TH. It's sounds like it's different from when you were a child. He doesn't have
18. enough knowledge yet. He has been able to say to both of you, compared to
19. what you had, I have a problem.
20. PETER. Yeah.

21. TH. That's different from your experience. I can see it rings different bells for both
22. of you, Peter has been there. He can see when it goes unregulated, uncontrolled,
23. unrecognised.

Here the therapist directs the narrative towards Peter, and provides an 'abstract' of the narrative (lines 1-2). The therapist asks Peter if he has a low threshold to threat, because he 'has been there' (lines 1-2) and then provides Peter with a space to reflect on whether this is different to how his son has grown up (lines 4-6). At this point, Peter provides a story about his childhood where he suffered severe abuse and neglect (lines 7-9). Attachment theory posits that people who have suffered abusive childhoods will have difficulty trusting others, as they were unable to trust those that they relied on for safety (Bowlby, 1988). The person finds it difficult to develop and predict a consistent pattern of responding, and learns to distrust both words and feelings (Liotti, 2004). Therefore, trusting others in times of need or to help co-regulate emotions will likely be difficult for Peter (Hazan & Shaver, 1987), and distrust has become a self-protective strategy (Crittenden, 2006). We learn that Peter's coping strategy has been to get drunk which 'took me away from feelings' (line 12), and the need to 'suppress feelings' (line 12).

The narrative also suggests that because of his avoidance of people in times of need, the isolation this brings leads him to feeling like 'I really was going insane because I felt isolated' (line 14). Thus the hypothesis the therapist could make using attachment theory is that Peter has an avoidant attachment style (Bartholomew & Hortowitz, 1991), which means that the ability to seek out and communicate effectively in times of distress with Julie is absent. It is proposed that negative communication cycles (in this case absence of communication) can foster insecurity

in attachments (Mikulincer, Florian, Cowan & Cowan, 2002) and reinforce insecure internal working models of an individual (Hazan & Shaver, 1987).

The therapist ends the narrative saying to Julie ‘that’s different from your experience’ – thus there is a difference between how Julie and Peter respond to threat, indicating different attachment styles.

Peter uses many Labovian (1972) elements to structure his story; these include abstract, complicating action and resolution (Appendix E). The therapist provides the evaluation of the story, and provides an alternative narrative of how things could be different for Peter’s son (lines 17-19).

Extract 2 – session 1.

1. TH. Well what about you Julie? You don’t have that same sort of background do
2. you? So it doesn’t have the same sort of meaning for you when you see
3. somebody being angry?
4. JULIE. I feel that Peter, this is my perception. I feel (...) when he talks, I can
5. feel it. I’m saying, it’s to the extent that I feel that it’s different to you than it is for
6. me?
7. TH. That’s important, because sometimes when you have these arguments, I
8. mean, you heard her say, that is an issue. If you can name it is an issue, that
9. could work?
10. JULIE. Okay can I come in there. This is often a problem, I feel when these
11. arguments take place at home, I am able to say ‘Peter I actually hear what you’re
12. saying’, however, because I don’t see it the way Peter sees it, he’s got to
13. convince me the way he sees it is right.

14. TH. Ok. I understand that.

Here, the abstract again is offered from the therapist, encouraging Julie to reflect on the differences she and Peter have in responding to conflict, based on their different pasts (lines 1-3). Helping couples recognise the differences between their attachment patterns could help them understand the strengths and vulnerabilities in their relationship (Hazan & Shaver, 1987).

However, Julie does not respond to the first part of the therapist's question about her past, but rather proceeds with problem evaluations of how Peter currently relates to her (lines 4-6; 10-13). Systemic therapists aim to help people understand that problems are maintained relationally rather than in one or other individual (Feeney, 2003). Systemic clinical practice therefore uses the concept of 'both/and' rather than 'either/or' (Minuchin, 1974). The 'either/or' split is a common feature of Western thinking, which separates concepts as either being one thing or the other. Here Julie suggests that Peter sees things one way and she another, with only one person right in an argument (lines 11-12).

Extract 3 – session 6.

1. JULIE. I noticed something last night. It's become relevant when I was talking last
2. night and I was with my sisters and my mum. I was consciously going through
3. what we've talked about. A lot of our problems in the past came from me, because
4. of (...) the role I played in my family, I was not only the listener, I was the
5. interpreter.

7. TH. I noticed that too. Which is what I said at the beginning. What if you didn't go
 8. through her. What if you go straight to your kids. I think you would avoid some of
 9. the distortion.
10. PETER. I think I need to deal with it, for the simple fact. I think I need to assert
 11. myself more with my children, rather than leave it to Julie.
12. TH. It's sort of getting into the habit of having conversations with them.
15. JULIE. I noticed as we were talking, it was left to me.
16. TH. So, that's something to watch, on both sides. Are you taking over? I hope you
 17. would think about changing that pattern between you and the kids. And the other
 18. thing is managing that, as things heated, the impulse for you to not go back being
 19. that little girl, I can't be shut out. The meaning is different now. Because the
 20. meaning is, if he's walking away he's trying to preserve himself from being that
 21. young boy who is being threatened and who could be threatening back,
 22. especially. And you also, if she is pursuing, it's Julie, she's not going to hurt you.
 23. But you have to have faith that she's not going to hurt you.

Here narratives by Julie (lines 1-5) and Peter (lines 10-11) move from blaming each other, and the language of 'you and me' seen in extract 2, to an 'and/both' (line 3) perspective of understanding the problem (De Shazer & Berg, 1985). Julie has reflected outside of the sessions (lines 1-5) on her role in her family growing up, as an 'interpreter'. In earlier sessions it was learned that Julie was the only one of her siblings who was not deaf, and that she cared for her siblings, as well as interpreting for them, roles she continues with Peter.

The therapist provides a new narrative which enables Julie and Peter to recognise their differences in attachment styles and how these can change to foster security (lines 16-23). Peter's mental representation of others has been that they are not to

be trusted, and not to be sought out if in distress. However, Julie's past of providing 'compulsive caregiving' (Bowlby, 1988) has perpetuated this cycle, through taking over (line 16) and pursuing Peter, whereby Peter has become more unavailable to Julie, feeling more threatened and unable to respond. Helping Julie understand why Peter has been walking away, because of perceived threat, based on childhood experiences of frightening caregiving, can help change the cycle of pursuit avoidance. The therapist also highlights to Peter that Julie is a secure base, not a threat, and that security can be found in people (lines 22-23).

From a Narrative Analysis perspective, the therapist has been responsible for many of the evaluations in the narratives (extract 1, lines 17-19; 21-23; extract 3, 16-23).

Case 2 – Sarah and Emma.

Extract 4 – session 2.

1. TH. Let me ask Sarah this, can you tell me something about Emma's family.
2. What are they like? Are they a particular family? Is it a particular family
3. member you think will disown her?
4. SARAH. Yes. Her father.
5. TH. So let's talk about that.
6. SARAH. Your Dad is very opinionated. And verbal to everyone else
7. about it.
8. TH. Tell me about your Dad.
9. EMMA. um, yeah, he's very um opinionated, he's very (um.) like, his way
10. or no way. (...) Um

11. TH. Old fashioned.
12. SARAH. Yes, very, rigid.
13. TH. How would that be shown?
14. EMMA. Um, yeah, doesn't really listen to stuff. Generally, ANY
15. SUBJECT, he doesn't listen to any opinion, it's his opinion. He would get
16. very angry when I was growing up. (...) I didn't want to say anything and
17. hoped it would stop. So really I didn't say anything and mum was the same.
18. TH. So you have learned that staying quiet keeps you safe?
19. EMMA. I guess so.

Narratives arising in previous sessions have indicated that Emma's unwillingness to inform her family, particularly her father, about their relationship is undermining Sarah's trust and security in the relationship.

An abstract of what the narrative will contain is provided by the therapist, directed to Sarah (lines 1-3). We learn that Emma's father has significant power in their relationship, from the fact that he could potentially 'disown her'. This potential for abandonment is likely a terrifying prospect, one that Emma has seemingly never challenged (lines 15-17). Thus, Emma has learned the way to deal with conflict or difficult emotions is to shut down and not challenge. Emma's past of not using language to deal with conflict may mean that in her current relationship she is unable to adequately draw on and employ emotional material (Vetere & Dallos, 2008). The therapist evaluates Emma's narrative of her relationship with her father, suggesting that 'staying quiet keeps you safe?' Thus, evaluating the behaviour helps render the story more vivid and enables fuller access to and affiliate with the stories emotional landscape (Stivers, 2008).

Extract 5 – session 4.

1. TH. If Emma were here now, what would you want to say to her in terms of what
2. has happened?
3. SARAH. I'd say maybe I did jump the gun in not giving her time. I will say exactly how
4. I feel, but it's whether I get comeback from her. I usually say to her when I'm angry
5. come on I want a response now.
6. TH. That's a good point. You two are so different. The key is managing your thinking
7. about her embarrassment, embarrassment is about managing things. Just like her
8. mum didn't want to go to the doctors. It's kind of like you're saying to her 'I know
9. you're going to be overwhelmed by feeling, so let me give you time to come back to
10. me. I just need to know what you're thinking'. You know it already.
11. SARAH Not really, I mean I can normally see outside the box. But because I am so,
12. say everything as I feel, as it is, I find it really hard to, um, understand someone
13. who keeps everything in and not say how she feels.
- 14 TH. But you know what you are also very different. You work in a field where you
15. have to watch people, you were good at that first and you've become more expert
16. as you do it, but you can put words to feelings, Emma can't, she has grown up in an
17. environment where emotions are not expressed and this is the same in her work.
18. SARAH. YEAH, yeah.
19. TH. That's one of the reasons that you can you work here. Because that's what I'm
20. doing for her, I'm saying is it this, is it your father, let's figure it out. I'm unknottting.
21. the things she can't put her words to. It's not that she's being selfish or doesn't love
22. you, she doesn't HAVE the words.
23. SARAH. It makes perfect sense.

The narrative starts with the therapist orienting Sarah to the present with Emma (lines 1-2). This gives Sarah the opportunity to highlight what is difficult in their relationship - communication (lines 3-5) - and also provides information about her attachment needs based on the strategies she uses at times of distress or conflict (Vetere & Dallos, 2008). Sarah reports that she has a high level of emotional responding (lines 3-4) increasing demands and insisting on contact (line 5). Information arising in previous sessions highlighted that Sarah was abandoned by her biological father when three years old, and she became the main carer for her siblings when she was aged nine. Sarah may have developed an internal working model of herself and others that she is not worthy of the care from others, and other people are likely to leave her.

Sarah's narrative of how she responds to Emma is consistent with a preoccupied attachment style (Hazan & Shaver, 1987). Such a style can mean developing a hyper-activating strategy involving monitoring the partner, increasing demands and insisting on contact in case people leave (Vetere & Dallos, 2008). However, in response to Sarah's demands, Emma retreats further, as her default is to retreat in the face of threat (extract 7). Sarah reports that Emma does not respond to her requests (lines 12-13), increasing Sarah's belief of being rejected. This can be understood in the attachment literature as a demand-withdraw cycle (Eldridge & Christensen, 2002). This occurs when one partner, seeking security and to relieve anxiety, metaphorically reaches for the other and in response the second partner may feel overwhelmed and relieve anxiety by withdrawing. Once the withdrawn partner distances, the other partner often pursues even more, perhaps with criticism and anger.

One way to break such a cycle and bring more trust and security into the relationship is to have alternative explanations of why others behave in a particular way (Mikulincer et al., 2002).

The therapist uses a range of manoeuvres, which draw on knowledge about Sarah and Emma's attachment histories, which may help Sarah understand Emma's responses and recast her beliefs about Emma's behaviour. For example, the therapist highlights the difference between Sarah and Emma in terms of their past, highlighting the mismatches between them with expressing specific emotions and attitudes towards introspection and exploration of feelings (lines 14-17) (Reibstein & Sherbersky, 2012). The therapist recasts Emma's avoidant style of responding as being unskilled (because of her attachment past) in her emotional communication and ability to express herself (19-22), thus providing Sarah with a different explanation for Emma's behaviour. Sarah concludes the narrative with the response 'it makes perfect sense' (line 23) suggesting a new way of understanding.

Case 3 - Jo and John.

Extract 6 – session 2.

1. TH. Can I ask, what I don't know going back in time, I hear, I'm getting the sense
2. you've known each other a long time, but what about previous relationships?
3. JO. Well I had relationships and he had relationships. I was going out with
4. someone for five years who, who (...) who used to beat me up. He had a bad
5. drink problem. But when he was normal he was fine, fine. That was awful. But
6. when I knew John, we got on, and he was friendly, and he didn't like it and he

7. used to stick up for me and he beat my boyfriend up a couple of times. I didn't ask
8. him to. I think he had a little thing for me too as well.

Here the therapist provides an abstract, which invites John and Jo to reflect on relationships before they met. Jo provides a story of a past abusive relationship (lines 4-5) which she evaluates as 'awful' (line 5) and contrasts this with how she met John which she evaluates as 'he was friendly' (line 6). We hear of somebody who stayed with an abusive partner for five years and who left when John 'rescued' her⁴. It tells of Jo's beliefs about her own worthiness to receive sensitive, loving care and how her fear of abandonment is at the expense of staying in an abusive relationship only to leave when rescued, thus not to be alone.

Extract 7– session 5.

1. TH. So tell me about this story around his alcoholism?
2. JO. Yeah, well, dad had a really good job, he had the high life, he travelled the
3. world.
4. TH. What did he do?
5. JO. He, um, he um was a sales rep he was really high up and he travelled the
6. world. And he was never there when we were younger. He drank a lot, smoked a
7. lot, and partied hard really. And that had a bit of an effect on the marriage. And
8. then, um, yeah, he just, the drink broke them up.
9. TH. So that's why they split up.
10. JO. Yeah.

⁴ Attachment theory offers a hypothesis of why abuse in relationships may happen. A full account is provided in Appendix F.

11. JO. He's always been there with his cheque book dad, but that's it really.

Extract 7 contains a narrative which provides further information about Jo's attachment history, in terms of her relationship with her father. The therapist provides an abstract of the narrative (line 1) about her father's alcoholism, which was brought up earlier in the session. Jo's story is of a father emotionally absent through her childhood, his work was more important than his family and his lifestyle resulted in her parents splitting up (lines 5-8).

We have two stories involving Jo being either neglected, abandoned or abused by men. It could be hypothesised that Jo's mental representation of herself is that she is not worthy of love and affection, even her father was not there for her emotionally (line 11). Her mental representation of others is that they leave her or abuse her, and not to be trusted.

Jo has not yet explicitly evaluated how her father not being around has impacted on her emotionally, and indeed the legacy this has left on how she experiences others in current relationships.

Extract 8 – session 6.

1. TH. What's your experience of people not being there to help you? Tell me about
2. those experiences. Who hasn't got it right in the past?
3. JO. Well. Well. I don't know. I think people can let you down, can't they?
4. TH. When have you been let down?
5. JO. Loads of time, with loads of things, so I'd rather take control and do things,

6. either myself or get someone to help who I trust.
7. TH. So when you were growing up, who did you feel let down by?
- 13 JO. Well, I suppose in a way by my dad, because he was never there. So I
14. haven't really got that strong bond with him. He's always been there with money,
15. but that's his way of being there. My dad can't be bothered by stress or anything.
16. TH. Or emotions, or
17. Jo. Not really, not really (...). So, I suppose my dad a bit. And, I suppose, (...) coz
18. he let my mum down over the years (...), it's sad.
20. TH. So is there a sense coming from your past that men let you down, that men
21. can't really be there for you?
22. JO. Yeah,
23. JOHN. When have I let you down?
24. TH. But this is relevant because this is your background, way before John came
25. along.
26. JO. Yeah, sometimes when I try and think I am with John, sometimes I think it's
27. because I've been let down a lot, now I've got someone really nice and caring I
28. sort of push them away. John never lets me down.
29. TH. Something important happened there, I just want to zoom into it again. But
30. just say again what you just said
31. JO. He doesn't let me down, he never lets me down. John never lets me down.
32. TH. A lot of time it's about nobody can get it right and trusting that other
33. people can't get it right. It's safer not to trust that people can be there
34. for you so it's safer not to trust. There's a question in your mind that can
35. John really, really be there for me? If he sees me in all my messiness, will
36. he be there? Will he stay? Men sometimes bugger off in your experience.
37. Or they can't hack it. What your saying is you don't think John is that
38. person.

Here the therapist builds on the attachment history stories foregrounded in extracts 6 and 7, and provides an abstract directed towards Jo (line 1), inviting her to reflect on 'who hasn't got it right in the past' (line 2).

Jo describes how she has been let down 'loads of time, with loads of things, so I'd rather take control and do things'. This is indicative of a dismissive avoidant attachment style (Hazan & Shaver, 1987). However, from an earlier narrative Jo's need to be in a relationship was apparent, therefore, she needs people close to her, or distances from them. It could be hypothesised therefore that Jo has a fearful-avoidant attachment style (Bartholomew and Horowitz, 1991). Jo's mistrust of John, based on her attachment history that men will leave her (or abuse her) has potentially meant that becoming too close to him has been too risky, for the ultimate risk of abandonment (Hazan & Shaver, 1987). This fits with her pattern of relating to John in terms of needing him and dismissing him which was brought up in previous sessions. John in turn responds to Jo's distancing as increasingly not trusting her and increasing his surveillance, which leads Jo to distance further for fear of getting too close.

Further along in extract 8, the therapist generalises the statement of Jo's Dad 'letting her down', which Jo has now been able to evaluate as 'sad' to a systemic problem 'that men let you down'. Until now in this extract (and indeed in the previous extracts for this case), John has remained mostly silent, however, the result of Jo agreeing that 'men let you down' (line 22), brings John's voice into this narrative, defending his position as a secure base (Byng-Hall, 1995) in the relationship (line 23). This provides the therapist with an opportunity to help Jo distinguish between her past

and present meanings and realities regarding relationships (lines 24-25) (Reibstein & Sherbersky, 2012) and enables Jo to reflect on the reality of her attachment to John and the probable availability and responsiveness of him when she needs him (Seedall & Wampler, 2013) 'he never lets me down' (line 31). The therapist emphasises the importance of this evaluation, by 'zooming in' (line 29) and provides a summary of what has happened in the narrative (32-38), emphasising Jo's overt expression of trust for John providing new understandings of trusting and fostering a better sense of security for the couple.

Discussion

This is an exploratory study investigating how the 'attachment narrative' component of the Exeter Model is being used. In response to the research question, the analysis shows how therapists use several methods to help the couple acknowledge and understand how past relationships have a legacy on their current relationship with the stated hope of improving trust and security in the relationship (Reibstein & Sherbersky, 2012; Vetere & Dallos, 2008).

Foregrounding Stories of Past Relationships

This is consistently done through the therapist providing an abstract (the substance of what the story will be about) in all three cases (extracts 1, 4, and 6), which leads to a story about an early or past relationships being told by one member of the couple.

Attachment Theory used as a “Meta-narrative” to help the Therapist build Hypothesis about Attachment Styles based on Past Relationships

Through eliciting narratives of past attachments, attachment theory can enable the therapist to develop a hypothesis of attachment styles within the couple (Hazan & Shaver, 1987). For example, in case 1, Peter’s story of his early life being bullied, neglected and turning to alcohol as a way of suppressing feelings leads to hypotheses that he has difficulty trusting others for his safety, and distrust has become a self-protective strategy, in accordance with an avoidant attachment style (Hazan & Shaver, 1987). In case 2, Emma’s narrative of her relationship growing up with a powerful, angry father means she retreats further in conflict situations, her default response is to silence herself in the face of threat and avoid the situation. Sarah’s abandonment when a small child and reports of a ‘high level of emotional responding’, are in accordance with a preoccupied attachment style (Hazan & Shaver, 1987). Jo’s narratives of an ‘emotionally absent’ father, abusive partner but her need to be ‘rescued’ can be hypothesised as both untrusting of others and avoidant but also fear of abandonment. The attachment literature would describe this as a fearful attachment style (Bartholomew and Horowitz, 1991).

The Therapist helps the Couple Understand how their Attachment Style Maintains Unhelpful Cycles of Relating

Through gaining an understanding of attachment history and thus attachment styles, the therapist is able to help the couple understand how patterns in past relationships have a legacy on the functioning in the current relationship. For example, through

highlighting how mismatches between partners' emotional responses and meanings, based on their attachment styles, threaten security in the current relationship. In cases 1 and 2, the therapist brought awareness to the demand-withdraw cycle (Eldridge & Christensen, 2002), based on each of the couple's attachment styles, and how this can erode the sense of security for the couple creating an insecure attachment in the relationship. This cycle provides a good example of the systemic nature of attachment theory and how both partners' styles of attachment affects the emotional trajectory of the relationship (Hazan & Shaver, 1987). Awareness of and changing the demand-withdraw response has been linked to successful outcomes in reducing marital discord in EFT (Dalgleish, Johnson, Burgess-Moser, Wiebe & Tasca, 2014).

In case 3, awareness is brought to the fore of how realities of past relationships inform and overshadow those in the present. The therapist draws attention to difficulties around trust Jo has experienced in past relationships, which enables a narrative of the legacy this has had in terms of trusting others in the present.

Once clients begin to see destructive attachment patterns in relationships, they are in a better position to see the pattern as the problem rather than seeing themselves or their spouse as the source of dissatisfaction (Vetere & Dallos, 2008).

Introducing an Alternative Relationship Narrative

Finally, there is a stage where a new or alternative narrative of relating is introduced with the hope of improving trust and security in the relationship (Reibstein &

Sherbersky, 2012; Vetere & Dallos, 2008). Difficulty with these constructs has been related to insecure attachments and depression (Scharfe, 2007; Collins & Feeney, 2000). In case 1, the therapist provides a summary evaluating Julie and Peter's behaviour differently, providing them with a new meaning based on their awareness of the patterns of demand-withdraw "Peter is trying to preserve himself from being threatened" and "Julie is not going to hurt you, it's Julie". In case 2, the therapist 'recasts' Emma's avoidant responding, based on her attachment history as difficulty with processing and expressing emotion. Thus providing Sarah with an alternative explanation of why Emma withdraws, with the aim of increasing trust and hopefully allowing Sarah to have a better sense of security in the relationship (e.g. Reibstein & Sherbersky, 2012), and break the demand-withdraw cycle (Mikulincer et al., 2002). In case 3, foregrounding Jo's internal model about men, allows John to distinguish and challenge the past and bring into the present a different reality, with the aim of increasing trust and security between himself and Jo. A summary by the therapist provides the context for a corrective emotional experience, which hopefully allows each partner to feel more secure with each other (e.g. Reibstein & Sherbersky, 2012).

Structuring of Attachment Narratives in the Therapy Sessions

These narratives are spread over sessions and woven amongst other components of the model. A pattern is shown whereby past histories are elicited first, before awareness and alternative narratives are introduced. Also, consistently clients acknowledge change in the later sessions. For example, in case 3, Jo does not acknowledge the sadness and feelings of being let down by her Dad until session 5

as well as her acknowledgement that John 'never lets me down' (extract 8, line 28). Further, Sarah does not acknowledge her role in pushing Emma away until session 4. An important therapeutic goal for people with insecure attachment styles is to experience a secure relationship with the therapist (Byng-Hall, 1995). In couple therapy, the therapist is also concurrently working to help partners experience the other person as a secure base. Therapists model a secure relationship with each partner so they can signal their needs more clearly and, in turn, are more responsive to their partner (Seedall & Wampler, 2013). This may particularly be the case for revealing vulnerable emotions such as for Peter (Case 1) admitting the need to be assertive in the face of threats, which Julie does not perceive. Since Peter as a result of his insecure avoidant history, is always on the alert for attacks or danger and sees it in places where it may really not exist.

Critique and Relevance of the Analytic Method

In line with previous researchers (e.g. Georgakopoulou, 2007; Semino et al., 2014), it was found that the 'classic' Labov story structure was not always adhered to. Other studies have classified narratives as stretches of text that depart in different ways from the prototypical cases described by Labov (e.g. Semino et al., 2014). However, some aspects of the Labov structure were particularly relevant in highlighting consistencies across the narratives, for example, the concept of the abstract, the evaluation and their function. It was found that often the 'abstract' of the story was provided by the therapist. This was particularly so for telling stories of past attachments.

Evaluation is a particularly relevant component of the story structure in psychotherapy as it imbues narratives with significance allowing engagement and affiliation with the story's 'affectual landscape' (Muntigl et al., 2014). A key aspect of helping couples develop more empathy is the emotional connection between them. It has been suggested that a person with an insecure attachment style has difficulty in being able to reflect on their own and others' experiences (Vetere & Dallos, 2008). It was noted in these examples that the evaluation from the client/s were missing from initial stories, and the re-evaluation provided in the alternative narrative by the therapist provided a systemic understanding or helped make sense of current relationship patterns based on past experiences in relationships (Appendix G).

Limitations

The depth of the analysis meant that the numbers of couples in the sample were small, however, using small sample sizes is usual when conducting this type of analysis (Reissman, 1993; McLeod & Balamoutsou, 2001). This study has focused on understanding how attachment narratives are being used in this model and did not incorporate measures of change in relation to the use of this component.

Measures of attachment such as the Experiences in Close Relationships questionnaire (Brennan, Clark, & Shaver, 1998) could have provided a way of choosing and comparing the couples in terms of their attachment styles and measured outcomes as seen in EFT process studies (Dalgleish et al., 2014). These limitations enable reflection on directions for future research.

Research and Clinical Implications

The couples in this study were chosen randomly, not because of less security in the relationship. However, it was demonstrated that the attachment narrative component was utilised with all three couples. Johnson & Greenman (2013) suggest that attachment is the “core organizing element of [the couple] system” (p. 423).

Building on the findings of this study, future research could explore whether attachment narratives is a core component of the integrative Exeter Model, or is used more with couples where feelings of security are qualitatively lower. As well as exploring with whom attachment narratives are used, future research should formally assess the Beck’s Depression Inventory (BDI) scores for each couple member, collected before during and after clinical work and seek to understand patterning of change according to use of attachment narratives.

The way attachment theory is used in this study, differs from EFT (Johnson & Greeman, 2013) as it explicitly brings narratives of past relationships into the therapy and draws directly on these to help couples think differently about how their styles of relating impacts on the security in their relationship. This work supports a recent statement, which proposed “attachment theory has great potential for enhancing the effectiveness of couple therapy even beyond its function within EFT” (Seedall & Wampler, 2013, p.2) and begins to help address the claim that attachment theory has been “under-utilised and under-researched in couple therapy” (Seedall & Wampler, 2013, p.2).

Conclusion

To date, there has been limited evidence for the use of integrative approaches and a paucity of research in couples' therapy, even though national policy guidelines recommend its use for treating mental health symptoms. This study used a Narrative Analysis approach to investigate how the 'attachment narrative' component is used in the Exeter Model, and adds to the ongoing impetus to build a more robust evidence base for working with couples and depression.

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Appendices

Appendix A - Components of the Exeter Model of Couple Therapy for Depression

Systemic-behavioural/systemic- empathic:

Systemic Empathic

- Reframing
- Genograms
- Interviewing internalised other
- Circular questioning
- Sculptures
- Empathic bridging manoeuvres
- Investigating family scripts:
- Investigating attachment narratives

Systemic Behavioural

- circularities
- Enactments
- Role play
- Communication training
- Problem solving
- Homework tasks
- Behavioural exchange
- Communication skills training

Appendix B – NHS Ethical Approval and School Ethics



Health Research Authority

NRES Committee South Central - Oxford A

Bristol Research Ethics Committee Centre
Whitefriars
Level 3 Block B
Lewins Mead
Bristol
BS1 2NT

Telephone: 01173421331
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18 June 2014

Dr Helen Davies
Trainee in Clinical Psychology
Exeter University
Exeter University
Washington Singer Building
Perry Road
EX4 4XG

Dear Dr Davies

Study title:	Evaluation of attachment narratives in couples therapy for depression
REC reference:	14/SC/0254
Protocol number:	n/a
IRAS project ID:	152674

Thank you for your letter of 17 June 2014, responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The response has been reviewed and approved by the sub-committee.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager Miss Stephanie Macpherson, nrescommittee.southcentral-oxforda@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

School Ethics

To: Helen Davies
From: Tim Kurz
CC: Janet Smithson
Re: Application 2013/548 to Ethics Committee
Date:

The School of Psychology Ethics Committee met and your NHS Local Research Ethics Committee application and approval were reviewed. In line with our procedures, your project is now de facto approved.

The agreement of the Committee is subject to your compliance with the British Psychological Society Code of Conduct and the University of Exeter procedures for data protection (<http://www.ex.ac.uk/admin/academic/datapro/>). In any correspondence with the Ethics Committee about this application, please quote the reference number above.

I wish you every success with your research.

Yours sincerely,

A handwritten signature in black ink, appearing to be 'TK' followed by a long, sweeping horizontal stroke.

Dr Tim Kurz
Chair of School Ethics Committee

Appendix C – List of Topics found across the Therapy Sessions

Couple 1
<p> Anger Abuse Alcoholism Children Depression Early life Menopause Mis-communication Emotions Moods Parents Protection Abandonment Relationships Step children Therapy goals Trust </p>
Couple 2
<p> Alcohol Abortion Abuse Babies Control Depression Early life Emotions Independence Loss Miscommunication Moods Overdose Parents Pregnancy Protection Rebellion Other family members Trust Therapy goals Rebellion Work </p>
Couple 3
<p>Abandonment</p>

Abuse
Depression
Babies
Depression
Homosexuality
Miscommunication
Moods
Parents
Power
Relationships
Siblings
Trust
Work

Appendix D

The following notation system was used in the transcripts:

(...) = Pause of less than 2 seconds,

(3) = Pause longer than 2 seconds, the number indicating the duration of the pause in seconds

CAPS = loud talking

TH = therapist

Appendix E – Example of Labovian Structure

Abstract

TH. Now, let me ask Peter. I know that for you, you see signs that would set off a lot of alarm bells, because you have been there?

PETER. (Nods)

TH. I'm not agreeing with Julie here, but I'm trying to get some information here. But, is that different from the way you were when you were his age and full of anger that talking to his parents like that? (...) Would that be different?

Orientation

Peter: My parents were chronic alcoholics. My father was (...) abusive

Complicating Action

He was violent, he was a bully,

he was a thug

I used to wet my trousers

He starved me.

he done all this stuff

Evaluation

TH. He was a sadist it sounds like?.

PETER. He was a crazy, crazy person

Conclusion:

PETER: I became an angry person.

Abstract

And talking about suppressing,

Complicating Action

And I drank, it took me away from feelings

When I drank I drank to get drunk

And the alcohol bought more anger.

I have seen David come in and we really haven't addressed it.

Resolution

I really was going insane because I felt isolated

When he picked up the alcohol my son is really angry, really angry 16. and I thought, WOW.

Evaluation

TH. It's sounds like it's different from when you were a child. He doesn't have enough knowledge yet.

He has been able to say to both of you, compared to what you had, I have a problem.

PETER. Yeah.

TH. That's different from your experience. I can see it rings different bells for both of you, Peter has been there. He can see when it goes unregulated, uncontrolled, unrecognised.

Appendix F – Attachment Styles and Violence

Taken from - Bond, S. B., & Bond, M. (2004). Attachment styles and violence within couples. *The Journal of nervous and mental disease*, 192(12), 857-863.

Females were largely classified as having an anxious attachment style and males as dismissing and secure. This finding is consistent with Feeney's (2003) explanation that gender roles may affect the way attachment behaviors are experienced: "The clinging style associated with relationship anxiety, corresponds with the stereotype of female relationship behavior, whereas the distant style associated with the dismissing style (discomfort with closeness) parallels the stereotype of male behavior."

Logistic regression has provided evidence for the combination of female-anxious and male-dismissing attachment patterns with poor problem-solving and communication skills within the context of a longer relationship as significant predictors of relationship violence for the whole sample.

Couples with this relationship pattern are approximately nine times more likely to have violence in their relationship than couples who do not report this combination of attachment styles. These results have identified a particular toxic gender-defined couple attachment pattern that can predispose a couple for relationship violence.

Feeney (2003) has postulated that anxious wives perceived their nonanxious husbands as unable to comprehend their emotional concerns. This situation could potentially lead to escalating coercion and hostile communication, as the female pushes for relationship closeness and the male for distance. The dismissing partner's denial of his attachment needs contributes to his inability to provide the needed soothing required to allay the fears and concerns of his anxious wife. The male's denial of his need for relationship connection further contributes to his wife's fear of abandonment.

Anger then becomes integrated into couples' behavioral repertoire, with its central function the preservation of the relational integrity. From this perspective, functional anger can be seen as a progression from the healthy expression of individual need to forceful coercion, designed to preserve the couple homeostasis. Attachment theory has provided for a conceptualization of anger as an expression of caring and an attempt to protect the relationship viability, thus restoring intimacy and security (Bowlby, 1988). The progression to physical violence can be understood as an out-of-control couple system that also suffers from poor problem solving and communication.

Appendix G –Evaluation Examples

Case 1

TH: It sounds like it's different from when you were a child. He doesn't have enough knowledge yet. He has been able to say to both of you, compared to what you had, I have a problem.

TH. That's different from your experience. I can see it rings different bells for both of you, Peter has been there. He can see when it goes unregulated, uncontrolled, unrecognised.

TH: Because the meaning is, if he's walking away he's trying to preserve himself from being that young boy who is being threatened and who could be threatening back, especially. And you also, if she is pursuing, it's Julie, she's not going to hurt you. But you have to have faith that she's not going to hurt you.

Case 2.

TH. So you have learned that staying quiet keeps you safe?

TH: But you know what you are also very different. You work in a field where you have to watch people, you were good at that first and you've become more expert as you do it, but you can put words to feelings, Emma can't, she has grown up in an environment where emotions are not expressed and this is the same in her work.

TH: It's not that she's being selfish or doesn't love you, she doesn't HAVE the words.

Case 3.

TH. A lot of time it's about nobody can get it right and trusting that other

people can't get it right. It's safer not to trust that people can be there for you so it's safer not to trust. There's a question in your mind that can John really really be there for me? If he sees me in all my messiness, will he be there? Will he stay? Men sometimes bugger off in your experience. Or they can't hack it. What your saying is you don't think John is that person.

Appendix H - Self-reflexivity

Research in a social constructionist paradigm calls on the researcher to take responsibility for their own positioning (Guba and Lincoln, 1994), similar to systemic practice. An examination of the interactional processes in the research process can help highlight researcher effects, themes neglected, and areas opened up and closed down.

For example, the examples of the narratives shown here are not the only attachment narratives to occur across the data. Why did I open up these narratives for exploration over others? For example, there was a narrative about Jo's relationship with her mother (Case 3). This also could have been interesting to understand Jo's past and her attachment style. Perhaps this reflects an interest I have with my own father, that I chose to pursue the narrative of Jo's relationship with her father. Also, in Case 2, a narrative about Sarah's relationship with her parents was closed down and rather the focus was on Emma. Pragmatically, I chose this narrative because it highlighted the attachment styles both Emma and Sarah were bringing to the relationship, which worked well with extract 5, which showed how both of their styles were impacting on the security of the relationship.

Appendix I - Dissemination Statement

The results of this study will be disseminated to interested parties through feedback, journal publication and presentation.

Dissemination to participants and NHS services.

The NHS research ethics committee at Exeter and RD&E Research and Development team will be sent a summary of the findings of the study and will be informed that the study is now complete.

Journal publication.

It is expected that the study will be submitted for publication with the Journal of Family Therapy (Impact factor 1.02).

Presentation.

On 8th June 2015, my research findings were presented to an academic audience, for peer review, as part of the Doctorate in Clinical Psychology at the University of Exeter.