EXPLORING THE INFLUENCE OF THE ATTACHMENT ORGANIZATIONS OF NOVICE THERAPISTS ON THEIR DELIVERY OF EMOTIONALLY FOCUSED THERAPY FOR COUPLES

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Clinicians' own internal resources for understanding relationships—that is, their attachment organizations—have been found to influence the process and outcome of treatment. The current study addressed whether the attachment organizations of novice couple and family therapists were associated with couples' experiences of their therapists, therapeutic alliance, session impact, and emotionally focused couple therapy (EFT) fidelity (i.e., especially as related to targeting and working with attachment needs and overt and underlying emotions). Novice couple and family therapists delivered EFT, an attachment-based approach, to couples in a simulated session and an embedded multicase study design guided a cross-case analysis. Findings indicated that secure therapists, when compared to their insecure peers, were more competent at working with attachment needs, as well as the overt and underlying emotions of their clients. Secure therapists perceived themselves as being more skilled in emotion regulation, which may have contributed to their abilities to remain attuned to their clients' attachment needs and emotional expression, even in the face of emotional arousal in session. Couples of insecure therapists also reported greater alliance splits. Future research is needed to further explore the dyadic influences of both therapists' and clients' attachment organizations, as well as the training and supervision practices these findings implicate.

Bowlby (1988) contended that therapists, like caregivers, are tasked with being sensitive and appropriately responsive to clients. For an emotionally focused couple therapist (EFT; Johnson, 2004), this is particularly relevant. Emotionally focused couple therapists must provide a context in which clients can safely engage and move into corrective emotional experiences. In EFT, change occurs in the presence of emotional arousal within session and therapists must be competent in attuning to clients' implicit and explicit emotional experiences and responding appropriately. In essence, therapists are using their knowledge of secure base behavior and effectively regulating their own affect during emotionally intense interactions in session to respond quickly and precisely to guide clients towards secure base behavior in their relationships. It makes sense then that therapists' own understanding of relationships, or attachment organizations in particular, would be reflected in the treatment process.

Consider a case, for example of, a couple in which a female partner had a background of previous trauma in her family-of-origin and who had often received inconsistent and insensitive responses from her parents. These dynamics were also visible in the couple relationship, and she often expressed feeling rejected by her partner. When her bids for validation from her therapist were not responded to in session, she then believed her therapist was also sending the

message that she was not worth her time and she subsequently became highly defensive, blaming, and challenging. In the face of such emotional arousal, a therapist with a secure state of mind with regards to attachment may have the internal capacity to regulate her immediate defensive reactions and recognize how the client's internal experiences have informed her highly aroused, defensive responses. This therapist might respond by validating the client's experience, reassuring the client of a personal concern for her (and the couple's relationship), and begin repairing the therapeutic relationship. However, for a clinician whose understanding of relationships is informed by an insecure state of mind, such a situation may not proceed in a similar manner. The client's defensive responses could lead to the clinician feeling personally attacked, unable to effectively regulate her affect in the moment, and move beyond the surface meaning, instead responding defensively herself, resulting in increased activation of negative emotion on the part of the client, and perhaps therapy drop out.

This simple clinical example demonstrates how therapists' internal organizations of relationship information or attachment organizations can guide the meaning they make of clients' responses. It seems logical to assume that novice therapists, or therapists-in-training, could experience a greater pull to intervene based on their internal organization of relationship information, as has been found in prior research with established case managers (Tyrrell, Dozier, Teague, & Fallot, 1999). Beginning therapists have received limited training and experience pertaining to issues of countertransference or person of the therapist work, especially how to manage their own reactions to the high arousal of their clients; beginning couple and family therapists in particular may have received comparatively less direction in this area than therapists using other schools of therapy (e.g., psychoanalysis). This study was designed to explore the influence of the attachment organizations of novice therapists on their delivery of EFT for couples. This exploratory investigation is the first study in the field of couple and family therapy concerned with understanding whether novice therapists with secure attachment organizations enter clinical training with more of the internal resources necessary to be sensitively responsive to clients' attachment-related needs, in contrast to their insecure peers who may require more intensive supervision in regards to their ability to implement attachment-related treatment.

ATTACHMENT ORGANIZATIONS AND TREATMENT

Therapists' secure attachment organizations may provide valuable internal resources for intervening in a sensitive and appropriately responsive way in the therapy they conduct (Dozier, Cue, & Barnett, 1994). Using these internal resources, or alternative forms of understanding, is an important tool for directing clients out of their current interactional cycles that are guided by clients' own attachment strategies. Several prior studies on attachment and treatment provide some understanding of how clinicians' attachment organizations may influence their clinical interactions. Although other scholars have studied therapist attachment using self-report measurement of attachment (e.g., Dunkle & Friedlander, 1996; Mohr, Gelso, & Hill, 2005; Rubino, Barker, Roth, & Fearon, 2000; Sauer, Lopez, & Gormley, 2003), only studies utilizing expert-rated, interview measures of attachment, such as the adult attachment interview (AAI), will be reviewed here given the differences in their conceptualization of individual differences (Waters, Crowell, Elliott, Corcoran, & Treboux, 2002) and findings (Crowell, Treboux, & Waters, 1999; Waters et al., 2002).[1]

In Dozier et al.'s (1994) revolutionary study on this topic, 18 case managers and 27 of their clients all of whom had serious psychiatric disorders were studied. Dozier et al. (1994) concluded that case managers' attachment organizations influenced their interventions. The authors suggested that secure case managers were more skilled at responding to clients' underlying needs, resisting the pull to respond to their clients in ways that were confirmatory of their internal working models (e.g., being able to help dismissing clients, as opposed to preoccupied clients, increase their capacity for depending on others). In contrast, insecure case managers were unable to challenge their clients' attachment organizations by responding to their underlying needs, subsequently confirming the clients' existing models of relationships.

In a second study, Tyrrell et al. (1999) examined 21 clinical case managers and 54 of their clients with serious psychiatric disorders. They studied the interaction between client and

clinician's states of mind, specifically examining how the attachment organizations of both case managers and clients influenced the therapeutic process and outcomes. Most of the case managers were classified as secure, and the majority of clients were classified as insecure, so the analysis examined attachment dimensions accounting for tendencies towards preoccupied or dismissing patterns in the largely secure group of case managers. The study concluded that clients work best with case managers who utilize attachment strategies that are different from their own. In other words, preoccupied clients had better working alliances and outcomes (e.g., psychological, social, and occupational global functioning) with secure case managers who tended to use dismissing strategies themselves, and dismissing clients had better working alliances and outcomes with secure case managers who had the tendency to use preoccupied strategies. Findings suggest that when secure case managers tend towards secondary attachment strategies opposite of their insecure clients, clinicians are more skilled at disconfirming their clients' usual relational strategies.

One recent study examined therapists' attachment organizations and the development of alliance over time (Dinger, Strack, Sachsse, & Schauenburg, 2009). They studied the alliance ratings of 281 inpatients and the 12 psychotherapists who were providing their treatment. They reported that while therapists' attachment organizations were not associated with alliance development, therapists' preoccupation was associated with a lower level of alliance overall. However, results are tentative as the findings were not statistically robust (associations only reached .10 alpha levels) but instead represent trends among the relatively small number of therapists under study.

In addition to relationships with case managers and their clients, studies of institutional caregivers and counselors and their target adolescents have been conducted in residential treatment facilities. Collectively, these findings have indicated that attachment organizations have an influence on the development of and treatment process in therapeutic relationships (Wolfe & Wittenborn, in press; Zegers, Schuengel, van IJzendoorn, & Janssens, 2006). Specifically, Zegers and colleagues (2006) prospective study found that between 3 and 10 months after admission, adolescents who were assigned secure mentors perceived them as being more psychologically available than those who were assigned insecure mentors. Similarly, Wolfe and Wittenborn's (in press) findings suggest that the counselors' attachment (as measured by Waters & Waters, 2006 prompt-word measure) was related to whether their target incarcerated adolescents reported actively seeking proximity to them during times of stress or whether they perceived them as trustworthy.

Together these studies indicate that more insecure clinicians are more likely than secure clinicians to experience difficulty developing strong therapeutic relationships and providing effective intervention. However, the clinical practices of case managers and institutional caregivers are qualitatively different from those of couple and family therapists; thus, it is unclear whether these findings generalize to couple and family therapy. Additionally, beyond the differences in treatment, working with couples or families as opposed to individuals may add further complexity. What happens, for example, when a couple in which one partner is preoccupied and the other is dismissing of attachment begins working with a preoccupied couple therapist? This is but one of many questions that remain unanswered. Given the relative uncertainty of the influence of couple and family therapists' own expectations of relationships on psychotherapy, the current study was conducted.

THE PRESENT STUDY

Pattern matching techniques were employed in a cross-case analysis of qualitative and quantitative data in this embedded multicase study (Stake, 2006; Yin, 2009). The study design provided a mechanism for exploring the phenomenon in an in-depth, intensive case analysis, using attachment theory as a guide. The current study was primarily concerned with addressing whether patterns of differences in couples' experiences of their therapists, therapeutic alliance, session impact, and EFT fidelity (i.e., especially as related to targeting and working with attachment needs and overt and underlying emotions) were associated with the attachment organizations of couple and family therapists-in-training. Novice therapists in particular were studied because it was assumed that they would have developed fewer strategies for minimizing the

influence of their own attachment organizations in session; thus, if differences were to exist, they would be apparent. Scholars have suggested that affect regulation may help to explain the process by which attachment organizations affect treatment outcome and process (Tyrrell et al., 1999). As such, a secondary interest of this study was to investigate whether patterns of differences were present in regards to clinicians' perceived affect regulation and, if so, whether these patterns were related to the clinicians' attachment organizations and clients' and experts' perceptions of the process of treatment.

METHOD

Participants

Participants were marriage and family therapist trainees and ''healthy'' couples in the community who volunteered to receive couple therapy in simulated sessions. The seven therapist trainees who completed the study were predominately female (83.3%) and Caucasian (100%). Their ages ranged from 23 to 54 with a mean age of 33 years ($SD = 12$ years). At the time of the study, half of the therapist trainees were married and half were single. Most held Bachelor's degrees (83.3%), while one (16.7%) held a Master's degree in something other than marriage and family therapy. Four ''healthy'' heterosexual, married couples also volunteered to participate in the study. The partners reported themselves as Caucasian (87.5%) or Hispanic (12.5%). They had an average age of 50 years ($SD = 6$ years), and their ages ranged from 51 to 69 years. About 63% held a college or graduate degree, while the remaining reported that they had completed high school or trade school.

Procedures

Using criterion sampling (Hesse-Biber, 2010), therapist trainees in their first year of study were recruited and interested participants responded to an email announcement. Intensive attachment interview data were collected from the therapist trainees, as well as a self-report measure of affect regulation. Within 1–3 weeks after completing the measures of attachment and affect regulation, trainees were asked to conduct a 50 minute simulated therapy session with a couple who volunteered to receive treatment for purposes of the study. Couples were recruited from the community using convenience and snowball sampling methods (Hesse-Biber, 2010) and were provided specific training for participation in their session. Couples qualified to participate if they considered their relationship ''healthy,'' if their committed relationship had persisted for at least one year, and if they had not met their assigned therapist prior to the session. The volunteer couples were trained to present with relational difficulties, and one partner also demonstrated some depressive symptoms, because this is a common presenting problem in couple and family therapy (Doherty & Simmons, 1996). Because EFT training often addresses treating such couples, couples were instructed to engage as if one partner was preoccupied and one partner was dismissing (Johnson, 2004). The way in which the depressive symptoms manifested and the relational cycle of interaction that couple volunteers were instructed to portray was based on a published case study (Denton & Burwell, 2006). However, in an effort to make the sessions more realistic, couples were asked to maintain their own identities (e.g., names, occupations, and children) and discuss some of their own common difficulties (e.g., work-family balance conflict), in addition to those from the case study, being careful to integrate these into a pursue-withdraw interactional cycle. This was performed in hopes that some prior personal experience of the problems would enable volunteer couples to engage with one another more naturally and with a level of emotional intensity commonly displayed in couple therapy.

The trainees received a clinical intake form describing the couples' presenting problems prior to the sessions and were instructed to adhere to the Emotionally Focused Therapy model as described in Johnson, 2004—they were not privy to the roles and interactional cycles couples were asked to portray before the sessions began. Therapist trainees had recently read the manual and received approximately equivalent levels of training in EFT prior to treating the volunteer couples. Treatment sessions were videotaped, and the volunteer clients were asked to complete a self-report postsession measure of alliance and session impact, as well as provide qualitative responses about their experiences of their therapist, perceptions of their therapists'

intervention during times of emotional intensity, and the treatment process. The videotaped sessions were later observed and coded for EFT treatment fidelity by an expert coder who was blind to the therapists' attachment classifications, and supervisor comments were documented.

Measures

Adult attachment interview (George, Kaplan, & Main, 1985). The AAI assesses participants' states of mind with regard to attachment through a 60 to 90 minute semi-structured interview. Questions pertain to the participants' early experiences with their parents, their perceptions of the influence these experiences have had, and their current relationships with their parents. Participants also respond to questions about the loss of significant persons, as well as traumatic experiences. The interviewer in this study had received training administering the AAI and had also attended the AAI coding workshop. The interviews were digitally recorded and transcribed verbatim by a professional transcription service. The transcriptions were coded in accordance with Main, Goldwyn, and Hesse's (2002) coding system by a coder who passed the reliability certification requirements with Drs Main and Hesse.

After the transcripts were coded and rating scales were scored, each transcript was placed in the secure/autonomous (F), dismissing (Ds), or preoccupied (E) classification category and their subcategory was also identified. Scores leading to placement in contradictory categories, such as high idealization (Ds) and high angry preoccupation (E), indicate a cannot classify (CC) classification. A transcript classified as secure could describe either negative or positive experiences with attachment figures but must discuss the experiences in a coherent, balanced, realistic manner, acknowledging the impact of the experiences on oneself. A dismissing classification is given to participants who either idealize one or both parents, dismiss attachment figures in a derogatory manner, or reveal limited memories of early experiences. Dismissing participants may also describe negative experiences but report that those experiences had no negative effect. A preoccupied transcript would contain actively angry or vague discourse. A final classification is unresolved/disorganized (U/d). U/d category placement is given when participants' exhibit lapses in discourse or reasoning or if either extreme behavioral reactions to the loss of a loved one or traumatic experiences were described. Subclassifications on the AAI indicate other attachment tendencies. For example, a participant might be classified as secure tending towards preoccupied. Bakermans-Kranenburg and van IJzendoorn (1993) report effective test-retest reliability and discriminant validity; AAI classifications have been found to be independent from IQ, social desirability, and memory not relevant to attachment.

Difficulties in emotion regulation scales (DERS; Gratz & Roemer, 2004). The DERS is a 36-item scale that was used to assess trainees' perceived emotion regulation. The measure assessed the beginning clinicians' awareness of emotions, understanding of emotions or emotional clarity, acceptance of emotions, abilities to tolerate emotional experiences, engagement in goal-directed behaviors instead of acting impulsively, and utilization of emotion regulation strategies perceived as effective. Participants were asked to indicate how often each item applied to them with responses ranging from 1 (almost never, 0–10% of the time) to 5 (almost always, 91–100% of the time). An overall sum score and summed scores for the six subscales were used in the current study and higher scores indicated more difficulty with emotion regulation. Prior findings have reported the DERS to have high internal consistency ($\alpha = .93$) and test-retest reliability ($\rho = .88$, $p < .01$; Gratz & Roemer, 2004). Cronbach's alpha in the current study was .95.

Working alliance inventory (WAI; Hovarth & Greenberg, 1989). Volunteer couples completed the WAI immediately following the simulated sessions. The WAI assessed working alliance and is based on Bordin's (1979) theoretical conceptualization of alliance as having three components—tasks, bonds, and goals. The scale consists of 36 items in which clients provided responses based on a 7-point Likert scale anchored by 1 (never) and 7 (always). Scores were summed to create an overall composite score, as well as subscale scores for the three components of alliance. The WAI composite score can potentially range from 36 to 252, with higher scores indicating a stronger working alliance. The scale has been found to have good internal consistency ($\alpha = .93$; Hovarth & Greenberg, 1989). Cronbach's alpha for women and men in the current study was .93 and .87, respectively.

Session evaluation questionnaire (Stiles & Snow, 1984). Following the sessions, couples completed the SEQ measure of session impact that is designed to capture the immediate subjective effects of treatment. The SEQ includes 24 bipolar adjective scales presented in a 7-point semantic differential format and includes two session evaluation scales (Depth and Smoothness) and two mood scales (Positivity and Arousal). Scores on the four dimensions are averaged and scale scores range from 1 to 7, with higher scores indicating more favorable or influential sessions. The four dimensions have good internal consistency—Cronbach's alphas ranged from .78 to .91 in a prior report (Stiles & Snow, 1984).

EFT-therapist fidelity scale (EFT-TFS; Denton, Johnson, & Burleson, 2009). A therapist who had received advanced training in EFT observed the videotaped couple therapy sessions and coded therapist fidelity using the EFT-TFS. The EFT-TFS was developed to assess for both model adherence and competence; that is, therapy sessions were coded for whether the therapist adhered to the tasks specific to EFT, as well as scored on the level of skill or competence demonstrated. The EFT-TFS rates therapist fidelity on the following tasks: (1) alliance making, alliance maintenance, and creating safety in session, (2) validation of each partner, (3) continually reframing the problem in terms of the cycle, (4) management of couple's interaction, (5) processing emotions, (6) working with primary emotions, (7) placing emerging emotions into the cycle, (8) therapeutic use of enactments, (9) managing defensive responses, (10) maintaining session focus on emotion, the cycle, and attachment issues, (11) Framing cycle, problems, and emotions in terms of attachment needs and fears, (12) Following the steps and stages of EFT, and (13) consolidation of change and the development of new narratives. Ratings range from poor (1) to exemplary (5). Scores were summed to obtain a total score and, for purposes of this study, items 5, 6, 7, 10, and 11 were summed to create a score representative of attention to emotion and attachment needs. The potential range of scores is 13–65, and higher scores indicate higher fidelity. This is the first known study to report findings from the EFT-TFS, and only content validity has been examined (Denton et al., 2009).

Qualitative data. Immediately following the sessions, couple volunteers were asked to provide responses to qualitative questions about their experiences of the sessions, including strengths and weaknesses of their therapists, and their beliefs about how their therapist responded to their emotional experiences in session. Additionally, the EFT therapist who observed and coded the sessions provided qualitative responses about the therapists' intervention.

Data Analysis

The current study used an embedded multicase design (Yin, 2009). Data analysis was guided by an attachment theoretical framework. More specifically, the EFT treatment provided by novice therapists was expected to differ (i.e., EFT fidelity, working alliance, session impact, and volunteer couples' and supervisors qualitative responses) for therapists with different attachment organizations. Therefore, in an effort to compare patterns across groups, data from therapists and their clients were grouped into categories based on the therapists' attachment classifications (Yin, 2009). The majority of clinicians were classified as secure; therefore, AAI subclassifications were used to create the three groups of *Prototypical Secure* or F3 ($N = 3$), *Secure with Elements of Preoccupation* or F5 ($N = 2$), and *Dismissing of Attachment* or Ds1 ($N = 1$). One case received a classification of unresolved cannot classify or U/d CC and, as a result, was not included in the current analysis. It is not uncommon for studies of clinicians to find that most are classified as secure, thereby requiring the use of AAI subclassifications or continuous measures of the deactivating and hyperactivating attachment dimensions in analyses (Tyrrell et al., 1999). AAI subclassifications provide meaningful data beyond the main classification on individual differences with respect to attachment (Main et al., 2002).

Stake's (2006) cross-case analysis guidelines were followed to examine, compare, and contrast patterns between the three groups of embedded data. First, the sorted data were examined, and tentative assertions about existing patterns were made (Stake, 2006; Yin, 2009). Extensive, systematic research notes were recorded in reference to the emerging assertions and note taking continued throughout the analytical process. For purposes of triangulation, recurrent consultations were held with colleagues to discuss the tentative assertions, as well as to compare them to existing literature. Data from multiple sources were also collected (e.g.,

clients' and supervisor's report of alliance). During the analysis process, care was also taken to eliminate potential rival explanations when possible (Yin, 2009). Rival explanations were explored to ensure that treatment differences were a product of the independent variable as opposed to extraneous variables, for example, the beginning clinicians' differing levels of previous clinically relevant work experience (e.g., crisis hotline responder or in-home counselor) were compared with differences in treatment process and fidelity to determine whether potential patterns existed. After data were reviewed several times to determine the validity of the tentative patterns and dispel potential rival hypotheses, subsequent themes were confirmed (Stake, 2006). Findings based on the cross-case analysis will be presented next.

RESULTS

Descriptive statistics for the measures collected from each therapist and their respective couple are shown in Table 1. Several themes emerged from the cross-case analysis. The themes will be discussed, and the data relevant to each finding will be presented as supporting evidence.

Theme 1: The Relationship between EFT Fidelity and Therapists' Attachment

The Prototypical Secure and Secure with Elements of Preoccupation groups received higher ratings on the composite EFT-TFS score in comparison with the Dismissing clinician (See Table 2). After examining the EFT-TFS total score, summed ratings for the specific items concerned with working with attachment needs and related emotions were compared and revealed that the Ds clinician received the lowest possible score of 1 on all related EFT-TFS items. In contrast, Prototypical Secure and Secure with Elements of Preoccupation clinicians received moderate to high scores indicating greater competency in these tasks (See Table 2). Supervisor notes supported these differences, indicating that the Dismissing clinician "dismissed" clients' emotional experiences in session, moved away from poignant emotions, and appeared to remain at a cognitive level of intervention. The two secure groups were described as being emotionally attuned, engaged, and focused on clients' emotional experiences. However, the use of some problem solving techniques was noted for two of the therapists. There were no differences between the three groups in clients' perceptions of their therapist's ability to respond appropriately to their emotional experiences.

Table 1

Descriptive Statistics for Therapist (N = 6) Presession and Couple (N = 6) Postsession Measures

Measure	Therapist M (SD)	Range	Female partner M (SD)	Range	Male partner M (SD)	Range
Difficulties in emotion regulation scales	68.17	45–105	—	—	—	—
EFT-TFS	38.75 (11.25)	18–48.5	—	—	—	—
Working alliance inventory	—	—	212.17 (24.39)	180–241	207.58 (25.53)	163–234
SEQ-S	—	—	5.67 (0.35)	5.20–6.20	5.4 (0.50)	4.60–6.00
SEQ-D	—	—	5.7 (0.62)	4.6–6.2	5.57 (1.24)	3.40–7.00
SEQ-P	—	—	6.27 (1.23)	3.80–7.00	5.50 (1.13)	3.80–7.00
SEQ-A	—	—	3.29 (1.13)	2.25–5.25	4.02 (1.12)	2.88–5.50

Table 2
Emotionally Focused Couple Therapist (EFT)-TFS Raw Scores

Adult attachment interview	Therapist	EFT-TFS	EFT-TFS emotion and attachment items
F3	A	36.5	12.5
	B	38	14
	C	48.5	20
F5	A	47	18
	B	48.5	18.5
Ds	A	18	5

Note. F3 = Prototypical Secure, F5 = Secure with elements of Preoccupation, Ds = Dismissing of Attachment

Theme 2: The Relationship between Therapeutic Alliance and Therapists' Attachment

When examining patterns between the three groups on the partners' reports of alliance on the WAI, no initial differences were apparent. In other words, while alliance ratings appeared to differ across therapists, the differences did not appear to be aligned with group membership. However, further exploration revealed that the Dismissing (mean difference = 48 points) and Secure with Elements of Preoccupation groups (mean difference = 44.25 points) had larger discrepancies between the male and female partner's reports of alliance when compared with the Prototypical Secure group (mean difference = 6.33; See Table 3). The highest scores of alliance belonged to the partner in the couple who was told to enact similar attachment strategies as the therapist, as indicated by the AAI classification or subclassification. That is, in the Secure with Elements of Preoccupation group, the partner with the highest alliance score for both couples in the group was the partner who was told to enact a preoccupied partner. Similarly, for the Dismissing clinician, the partner with the highest alliance score was the partner who was taught to enact a dismissing partner. For each of the couples in the Prototypical Secure group, both partners' ratings of alliance were similar to one another. The EFT-TFS item aimed at rating alliance, supervisor's notes, and participants' responses revealed few differences across groups on alliance development and maintenance in the session.

Table 3
Alliance Raw Scores and Difference Scores

Adult attachment interview	Therapist	Female working alliance inventory (WAI)	Male WAI	WAI Difference Score	Emotionally focused couple therapist (EFT)-TFS Alliance Item
F3	A	229	226	3	5
	B	180	195	15	5
	C	213	214	1	4
F5	A	241	213.5	27.5	4
	B	224	163	61	4
Ds	A	186	234	48	3.5

Note. F3 = Prototypical Secure, F5 = Secure with elements of Preoccupation, Ds = Dismissing of Attachment

Table 4
Emotion Regulation Scale and Subscale Raw Scores with Notable Differences

Adult attachment interview	Therapist	Difficulties in emotion regulation scales (DERS) total score	DERS nonacceptance	DERS goals	DERS awareness
F3	A	61	10	13	7
	B	45	8	8	6
	C	62	10	12	9
F5	A	105	13	24	19
	B	69	18	13	14
Ds	A	67	12	16	11

Note. F3 = Prototypical Secure, F5 = Secure with elements of Preoccupation, Ds = Dismissing of Attachment

Theme 3: The Relationship between Therapists' Affect Regulation and Therapists' Attachment

Differences between the three groups of therapists' self-reported affect regulation abilities appeared less marked; however, some differences were present. On average, Prototypical Secure therapists reported lower scores on the affect regulation measure indicating that they perceived themselves as having less difficulty with emotion regulation in comparison with the Dismissing and Secure with Elements of Preoccupation therapists (See Table 4). Differences also existed on the nonacceptance of emotional responses, difficulties engaging in goal-directed behavior, and lack of emotional awareness subscales, with the Prototypical Secure clinicians reporting less difficulty. The Secure with Elements of Preoccupation therapists reported experiencing more difficulty with emotion regulation than the other two groups. Differences were less apparent or nonexistent on the remaining subscales.

DISCUSSION

This is the first study to examine how the internal resources in terms of the attachment organizations of novice couple and family therapists influence the process of EFT. Clear cross-case patterns in EFT treatment fidelity, especially in relation to attending to attachment needs and related emotions, were present. In comparison with the insecure therapist, secure therapists were more skilled and competent in delivering EFT, especially in terms of addressing attachment needs and attachment-related emotions. Conversely, the treatment provided by the dismissing therapist was not aligned with the underlying philosophical assumptions of EFT. Namely, the experiential stance of the therapist was not apparent and while the therapist appeared to be moving towards some of the tasks of the approach, treatment relied heavily on cognitive interventions. Johnson (2004) describes the importance of empathic attunement in EFT, moving alongside the client to understand her or his experiences. Such an approach requires specific internal resources on the part of the therapist. Wallin (2007) suggests that therapists may avoid experiences that are difficult for themselves and their clients, consequently supporting the current problematic relational or attachment strategies of their clients. Interestingly, the dismissing therapist's actions, behaviors, and relational patterns manifested in session appeared in keeping with a dismissing of attachment state of mind. When the partners expressed emotion relevant to their interactional positions and attachment needs, the therapist often dismissed it by moving off topic, perhaps to a topic that felt safer.

Tyrrell et al. (1999) proposed affect regulation as a mediating variable that explains the process by which attachment affects treatment effectiveness. While this study did not specifically

test for this, the findings suggest trends in this direction. In keeping with attachment theory (Bowlby, 1988), this study found that, on average, secure therapists perceived themselves as more effective at regulating their affect in comparison with their insecure peer. These affect regulation skills may have contributed to their abilities to remain attuned to their clients' attachment needs and emotional expression, even in the face of emotional arousal in session—an important skill in EFT.

Working alliance did not appear to be related to clinicians' attachment organization upon first review. However, when examining differences in partners' ratings of alliance within each couple across groups, a theme of split alliances emerged. Specifically, the partners in the dismissing and secure with elements of preoccupation groups rated the alliance much differently than their respective partners, in comparison with couples in the Prototypical Secure group. EFT focuses on the interpersonal and intrapersonal, meaning that some focus on the individual is necessary, and EFT therapists must take care to maintain balance in their focus on each partner's experience (Johnson, 2004). Scholars of alliance in couple and family therapy reinforce this idea stating that discrepancies in partners' alliances with their therapist must be attended to or can lead to poor outcomes, including therapy dropout (Friedlander, Escudero, & Heatherington, 2006). Findings revealed that the partner who reported higher ratings of alliance in each of the couples in the dismissing and secure with elements of preoccupation groups was the partner who was asked to portray a pattern of attachment that was similar to their respective clinician's AAI classification. While we caution that these findings are tentative for a number of reasons (e.g., the study was of a small sample, the session was simulated, and couples were acting out the positions), it is possible that beginning couple therapists are more likely to develop a stronger working alliance with a partner who shares a similar internal organization of relationships. While prior research on psychiatric clients and the case managers they had been clients of for at least 7 months reported higher alliance ratings from clients paired with clinicians dissimilar to themselves (Tyrrell et al., 1999), they suggested this relationship might not exist in the early phases of treatment. They indicated that clients with clinicians similar to themselves in regards to interpersonal strategies or expectations of relationships may rate their alliance as higher at the start of treatment because such a match would likely create less discomfort and defensiveness. Following this reasoning, it makes sense then that during this "first session," the clients who utilized similar attachment strategies as their therapists would rate their alliance as higher in comparison with their partners who had dissimilar attachment organizations, as was found in the dismissing and secure with elements of preoccupation groups. In contrast, perhaps the Prototypical Secure group had more internal resources allowing for more relational flexibility.

Training and Clinical Implications

Dozier and Tyrrell (1997) argue that insecure clinicians experience more difficulty effectively intervening in treatment in comparison with their secure peers. Our findings support their work, showing that insecure novice therapists have greater difficulty with the tasks of EFT than those who are secure. Couple and family therapists with no prior experience of a secure base may require additional training and supervision to support their clients towards more security in their relationships. Holmes (2009, p. 294) states that "for therapists to be securely attached is desirable, but not essential." He makes the point that therapists must be mindful of their own attachment tendencies when providing treatment. Clients enter treatment with expectations for relationships based on prior relationships meaning that, at times, clients' responses to therapists' will have less to do with their therapists' actual availability or sensitivity and more to do with clients' previous experiences with important others (Dozier & Bates, 2004). Additional supervision on countertransference or person of the therapist issues might encourage an enhanced awareness of novice therapists' own responses, as well as an increased ability to act on this new found awareness in session.

Further, novice therapists may benefit from education and supervision aimed at increasing their abilities to become aware of clients' underlying tendencies, learning to move beyond the level of clients' overt expressions to their underlying emotions and needs. Attachment scholars indicate that clients may present themselves differently to clinicians based on their attachment

organizations, with dismissing clients appearing more independent and less vulnerable (with an underlying need for emotional support) and preoccupied clients presenting themselves as more dependent and vulnerable (with an underlying need for support towards more autonomy; Dozier, 1990; Slade, 1999). Perhaps live and video supervision targeting this skill could increase novice therapists' abilities to move beyond surface complaints to underlying concerns and needs, a task essential to EFT.

Limitations and Future Directions

The embedded multicase design, utilizing qualitative and quantitative, including observational, intensive interview, and self-report data, provided an opportunity for a rich exploratory analysis. Given the substantial time and cost of the intensive measurement tools and the exploratory nature of the study, the current sample size was deemed reasonable (Hesse-Biber, 2010; Yin, 2009). Attachment-related investigations in particular can be time intensive and expensive to conduct. Given the clear differences between self-report and interview measures of attachment and the benefits of expert-rated over self-report instruments (Crowell et al., 1999; Waters et al., 2002), the AAI is often regarded as the "gold standard" of attachment measurement and was used in this study. However, given the limited number of participants, the findings presented should be considered tentative and future studies are needed to determine the validity of the results.

Future research could improve on and further explore the topic under study in several ways. First, this study could not rule out other potential rival explanations. Future studies would benefit from examining, for example, whether differences in novice therapists' time in supervision, IQ, or scholastic achievement explain differences in treatment delivery above those explained by attachment organization.

Second, attachment is a dyadic, relational process. Both clients and therapists should be studied for how their respective attachment organizations simultaneously influence the treatment process. In couple and family therapy, systemic processes are of particular interest. Marvin (2003) has discussed the systemic nature of attachment relationships, and others (Dozier & Bates, 2004) further argue that what the therapist brings to the treatment relationship in terms of attachment is equally important to the client's contribution. Thus, this study could be expanded by exploring the dyadic influences of both therapists' and clients' attachment organizations in the therapeutic setting. In addition, a longitudinal study would advance our knowledge of the influence of therapists' and clients' attachment organizations on the development and continuation of the therapeutic relationship over time, including treatment outcomes.

Third, most of the novice therapists in this study had secure attachment organizations. It was not surprising that most of the couple and family therapists-in-training were secure because (1) prior research has found similar results (Tyrrell et al., 1999), and (2) graduate programs serve as gatekeepers to the field and are often selective of applications based on their interpersonal comfort and competence, especially in regards to relational issues. However, research is needed to study the practices of secure and insecure therapists with a more balanced sample.

Fourth, results cannot be generalized to couple and family therapists with more experience and such studies could provide valuable information. For example, common factors research has found differences in therapists' efficacy regardless of factors such as therapists' level of experience, therapists' age, and the treatment approach utilized (Beutler et al., 2004; Blatt, Sanislow, Zuroff, & Pilkonis, 1996). Research exploring whether therapists' attachment organizations predict such differences, particularly for EFT therapists, could be beneficial. The value of such findings lies in the training and supervision practices they implicate, which has potential further the effectiveness of psychotherapy training and effectiveness.

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NOTE

[1]While both are framed in terms of Bowlby's attachment theory, developmental and social/personality psychology researchers are described as coming from "two cultures" regarding descriptions of individuals differences (e.g., preoccupied vs. anxious and dismissing vs. avoidant) and measurement (e.g., expert-rated vs. self-report) of attachment (Waters et al., 2002). This brief distinction between terms for individual differences in attachment is intended to assist readers who are less familiar with the developmental tradition used in this study—see Waters et al., 2002 for further information.