A Comparison of Attachment Outcomes in Enactment-Based Versus Therapist-Centered Therapy Process Modalities in Couple Therapy

MARK H. BUTLER, PH.D.*
JAMES M. HARPER, PH.D.*
CARI B. MITCHELL, M.S.†

All abstracts are available in Spanish and Mandarin Chinese on Wiley Online Library (http://wileyonlinelibrary.com/journal/famp). Please pass this information on to your international colleagues and students.

Attachment issues are viewed by many therapists as lying at the heart of couple distress. It is critical to empirically validate therapy processes that facilitate couples in responding to each other’s attachment needs. This study examined enactments as a therapy process and change mechanism to promote secure attachment in couple therapy. Sixteen couples were randomly assigned to 1 of 2 experimental groups—1 group received 3 therapist-centered sessions followed by 3 enactment-based sessions, and a second group received 3 enactment-based sessions followed by 3 therapist-centered sessions. To measure between-session and within-session change, each spouse completed presession and postsession measures of attachment security each week. Results showed that couples who received enactment-based sessions first reported greater increases in attachment security than those receiving therapist-centered sessions first. These same couples continued to show improvement after switching to the therapist-centered sessions. Conversely, couples who received therapist-centered sessions first did not increase attachment after switching to enactment-based sessions. For wives, enactment-based sessions produced the greatest improvement in attachment, yet both therapy process modalities led to some improvement. Conversely, for husbands, attachment improved only when they received enactment-based sessions first. Enactment-based sessions may therefore be more important for husbands than wives. Overall, with some qualification it appears that enactment-based therapy process may improve attachment more than a therapist-centered process. These observed trends and findings are generally consistent with previous research supporting use of enactments in couple therapy.

Keywords: Enactments; Attachment; Clinical Process-Outcome Research

Fam Proc 50:203–220, 2011

Correspondence concerning this article should be addressed to Mark Butler, Brigham Young University, Marriage and Family Therapy, 262 TLRB, Provo, UT 84602. E-mail: Mark.Butler@BYU.edu

All authors are equal authors.

*Marriage and Family Therapy, Brigham Young University, Provo, UT
†LDS Family Services, Provo, UT

INTRODUCTION

A secure couple attachment bond is an “active, affectionate, reciprocal relationship in which partners mutually derive and provide closeness, comfort, and security” (Johnson, Makinen, & Millikin, 2001, p. 145). Enactments represent a therapy process that facilitates couples in identifying, acknowledging, and responding to their own and their partner’s attachment needs and accompanying emotions. Enactments may thus be utilized as a primary process in any attachment-oriented therapy. The purpose of this study was to examine how enactment-based versus therapist-centered therapy process affects a couple’s attachment experience.

Secure attachment behaviors are related to more positive outcomes in couple therapy (Andersson, Butler, & Seedall, 2006; Johnson, 2004; Johnson & Greenberg, 1988). For example, softening (Andersson et al., 2006; Johnson & Talitman, 1996), open emotional expression (Feeney, 1995, 1999; Johnson, 2004; Johnson & Greenberg, 1988), high levels of self-disclosure, and the ability to elicit self-disclosure from one’s partner (Keelan, Dion, & Dion, 1998), commitment, trust, and relationship satisfaction (Schachner, Shaver, & Mikulincer, 2003; Zitzman & Butler, 2005) are all dimensions of secure attachment that are empirically linked to positive outcomes.

Conversely, insecure attachment is related to numerous harmful effects in relationships. The isolation, separation, or disconnection from a partner that accompanies feelings of insecure attachment is often accompanied by feelings of depression and anxiety (Johnson et al., 2001). Partners who are denied soothing and supportive responses and who feel their relationship is not a safe place for emotional engagement thereby experience significant personal and relationship distress. By helping couples improve how they “deal with their emotions, process and organize information about the self and others, and communicate with loved ones” (Johnson, 2004, p. 36), therapists can help couples create secure attachment through safe emotional connection and mutual responsiveness.

Emotionally focused therapy (EFT), an evidence-based therapy model (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Johnson, Hunsley, Greenberg, & Schindler, 1999), represents one approach to helping couples learn to identify, express, and properly fulfill each other’s attachment needs and longings. Secure adult pair-bond attachment (Hazan & Zeifman, 1999) lies at the heart of emotionally focused couple therapy (EFCT; Johnson, 2004), and focusing on attachment issues has enabled EFT to provide significant short- and long-term positive outcomes in couple therapy (Johnson et al., 1999).

The success of EFCT has also awakened the attention and interest of therapists using other models and led them to investigate attachment theory as a means for understanding and aiding couple change (Davila, 2003; Johnson & Whiffen, 2003). The growing acknowledgement of the significance of attachment to individual and relationship well-being recommends more general research on therapy processes that may help couples strengthen attachment. Enactments represent a couple interaction-based approach to facilitating attachment work, one that is independent of any particular therapy model, and as such, enactments may represent a common process element for attachment work in therapy (Gardner & Butler, 2009).

ENACTMENT-BASED AND THERAPIST-CENTERED INTERACTION PROCESS IN THERAPY

Enactments are one change mechanism therapists use to help couples attune to (“get in touch with”) and fulfill each others’ attachment needs. Butler and colleagues
Butler, Andersson, & Seedall, 2006; Butler & Bird, 2000; Butler, Davis, & Seedall, 2008; Butler & Gardner, 2003; Butler & Wampler, 1999; Davis & Butler, 2004; Gardner & Butler, 2009; Seedall & Butler, 2006, 2008) have extensively investigated enactments, and along with other scholars (e.g., Allen-Eckert, Fong, Nichols, Watson, & Liddle, 2001; Nichols & Fellenberg, 2000) have suggested that enactments are an effective means for change in couple therapy—indeed, independent of theory, model, or problem (Butler & Bird, 2000; Butler & Seedall, 2006; Gardner & Butler, 2009).

Enactments consist of face-to-face couple interaction that is carefully guided by the therapist. Enactments are distinct from role-plays, in which couple interaction is narrowly focused on the development of a specific skill set, or where, as an experiential intervention, couples are invited to assume role positions other than their own. In enactments therapists invite couples into direct interaction with each other, where they are helped to successfully enact their relationship in its real-life totality. The therapist provides coaching—in terms of interaction process and emotionally focused probing and invitations, for example—to assist the couple in achieving meaningful, secure interaction around attachment and other core issues and strivings. Though commonly used in a variety of relationship therapies (e.g., EFT, structural therapy, narrative therapy, behavioral marital therapy), there are comparatively few empirical investigations of the effectiveness of enactments and/or their utility in promoting couples’ secure attachment (cf. Andersson et al., 2006; Butler & Wampler, 1999; Seedall & Butler, 2006).

Conversely, therapist-centered approaches, characterized by interaction channeled through the therapist, use interpretation and direct instruction, and may be linked to less successful clinical outcomes (cf. Butler & Bird, 2000; Butler & Wampler, 1999). Therapist behaviors that primarily channel in-session interaction through the therapist are associated with increased therapist-client struggle (Butler & Bird, 2000; Butler & Wampler, 1999; Patterson & Forgatch, 1985). Various behaviors likely to be associated with therapist-centered clinical process are associated with negative treatment outcomes: For example, therapist interpretation along with general verbal activity level and confrontation are linked to treatment dropout (Miller, Benefield, & Tonigan, 1993; Postner et al., 1971). Direct instruction, which includes therapist teaching, directives, and advice giving, may also be associated with negative clinical outcomes (Beutler, Machado, & Neufeldt, 1994; Patterson & Forgatch, 1985). A therapist-centered process may temporarily contain and structure interaction for volatile couples, yet it may ultimately be counterproductive and disempower couples in their progress toward successful, self-reliant interaction (Butler & Gardner, 2003; Gottman & Gottman, 1999, p. 310).

EFT (Johnson et al., 1999) utilizes enactments to urge couple expression of and responsiveness to primary emotions and attachment needs with the intent that more positive, attachment-promoting interaction patterns will develop (Johnson, 2004). Behavioral marital therapy, another evidence-based treatment, uses role-plays to improve communication and conflict resolution skills such as listening or speaking nondefensively (Jacobson, 2001). In marital enrichment programs such as relationship enhancement, relationship practice is used for training new relationship skills (Scuka, 2005). Along with EFT, narrative couple therapy comes closest to incorporating enactment-like processes as they encourage couples to restory their relationships and problems together (Brimhall, Gardner, & Henline, 2003). Structural couple therapists use relationship enactments for clinical assessment purposes and to redirect the structure of family interactions (Keim & Lappin, 2002).
EMPIRICAL SUPPORT FOR ENACTMENTS’ EFFECTIVENESS

A recent study investigating therapy processes that aid couples recovering from a husband’s use of pornography found that enactments are effective for promoting couple self-reliance, healing, and softening (Zitzman & Butler, 2005). A study investigating proxy-voice intervention within the context of enactments (Seedall & Butler, 2006) found further evidence supporting use of enactments for helping and healing the couple relationship. Proxy-voice intervention occurs when the therapist briefly interrupts couple interaction to offer his/her “proxy” voice on behalf of the latent emotion and attachment experiences that the couple are struggling to recognize and articulate. The therapist listens and tracks couple dialogue at an attachment and emotional level, “below” the superficial content of what a partner is saying, and focuses on identifying underlying primary emotions and attachment needs. The therapist then articulates and sometimes reframes what she or he hears the client saying in terms of primary emotions and attachment striving and longing. The study’s results showed that utilizing proxy-voice intervention during enactments was inversely related to couple withdrawal and negativity and positively associated with couple softening. Andersson et al. (2006) also found that appropriately conducted enactments are an effective tool for fostering client softening—even among more volatile couples.

Butler and Wampler (1999) found that enactments not only relate to couples’ greater sense of responsibility for their own therapeutic progress, but also predict superior outcomes compared with those achieved by a therapist-centered approach. Twenty-five couples were exposed to couple-responsible versus therapist-responsible episodes during one therapy session. Couple-responsible episodes were defined by (1) use of enactments to enable couple interaction and emotional connection, (2) accommodation to the couple’s worldview and interaction style, and (3) inductive processes for promoting self-reliant problem-solving. Therapist-responsible episodes were defined by (1) interaction primarily channeled through the therapist, (2) therapist interpretation, and (3) direct instruction. Immediately following the session, couples reviewed their videotapes and completed measures of responsibility, struggle, and cooperation. Results showed that couples significantly perceived their personal responsibility as higher and their therapy resistance as lower during the enactment-based, couple-responsible episodes.

Building on these previous studies, the purpose of the present pilot investigation was to examine enactments specifically as a potential change mechanism in couple therapy promoting secure attachment. We hypothesized that enactment interventions would be associated with higher scores of attachment and have greater impact on couples’ attachment within session and between sessions than would therapist-centered interventions.

METHOD

Participants

Participants consisted of 16 married couples who presented for marital therapy at a community clinic in the Western United States known for serving lower income couples and families. Presenting problems included such issues as behavioral addictions, communication problems, anxiety, and depression. The mean age for husbands and wives was 32.63 and 30.88, respectively. Participants’ length of marriage averaged
9 years and ranged from 3.5 to 27 years. Each couple had on average 2.44 children. Participants were Caucasian (92%) and Hispanic (8%). Participants reported annual household income as follows: under US$14,999 (8%), between US$15,000 and US$29,999 (42%), between US$30,000 and US$44,999 (25%), and > US$50,000 (25%).

**Procedure and Design**

Couples were offered the opportunity to participate in the study at intake at a community clinic. Participant couples were offered either free therapy or a US$45 gift certificate. Volunteering couples were randomly assigned to one of four MFT interns trained in the two therapy process modalities and in the study protocols. Couples were randomly assigned to participating therapists. The therapists were four interns (two males, two females, average age = 26 years) in a COAMFTE-accredited marriage and family therapy graduate program.

The study used a pretest-posttest, repeated measures design with a treatment and alternate treatment comparison. Each participating couple experienced six experimental therapy sessions—three sessions each of therapist-centered and enactment-based therapy. The sequencing of therapy process modalities was alternated across participant couples.

During enactment sessions, couples were exposed to enactment-based clinical process (see Figure 1) wherein the therapist coached the couple through sustained interaction with each other following Butler and Gardner’s model (2003) and Davis and Butler’s single-episode conceptualization (2004) of enactments. During therapist-centered sessions, couples were exposed to therapist-centered clinical process (see Figure 2) wherein the therapist directed the couple to speak to each other rather than to the therapist at least once during the session and sustained and coached their ensuing interaction.

To ensure that therapists executed the designated therapy condition over each of the six sessions, each session was video-recorded and later viewed by a trained coder who assessed whether the appropriate treatment type was conducted using the proficiency tests already noted (see Figures 1 and 2). The coder verified a session as therapist-centered if the therapist channeled all interaction through herself or himself and prevented or interrupted direct couple interaction. The coder verified a session as enactment-based if the therapist directed the couple to speak to each other rather than to the therapist at least once during the session and sustained and coached their ensuing interaction.
Therapist training and proficiency

Therapists received 12 hours of specific training from an AAMFT-approved supervisor proficient in both enactment-based and therapist-centered therapy process modalities. Training for both therapy approaches included readings and didactic instruction describing each therapy condition, viewing of videotaped examples, experiential practice through role-play, proficiency tests, and, as needed, reviews of their results. Therapists also received specific training in the descriptive criteria for both therapy conditions used in the study.

Following training, therapist proficiency in each therapy process modality was tested by video recording each therapist executing each therapy condition (separately).
In an experiential role-play, these proficiency tests were then coded by one of the study’s principal investigators according to the criteria for enactment-based and therapist-centered process. In a role study, proficiency in therapist-centered process was attained if therapists exhibited four of the key indicators. Proficiency in therapist-centered process is a measure of the degree to which therapists are able to maintain a coherent and organized approach to the therapy process. This includes the ability to listen to the client, to reflect back the feelings and thoughts of the client, to use open-ended questions, and to offer suggestions for how to improve the client’s understanding of the situation.

FIGURE 1. Continued.

BUTLER, HARPER, & MITCHELL / 209
Fam. Proc., Vol. 50, June, 2011
in enactment-based process was attained if therapists executed at least eight of nine key ("Mid"-level) enactment indicators. During the study, therapists were instructed to review the criteria for the appropriate therapy condition that they were to execute before each experimental session.

www.FamilyProcess.org
Measures

To assess the relationship between therapy process modality and couples’ secure attachment, each partner completed a secure attachment measure (SAM) before and after each therapy session over the course of the six experimental sessions. Within-session change for each session was determined by subtracting the pre-session SAM score from the post-session score. Between-session change was calculated by subtracting the post-session SAM score from the pre-session score of the next session.

SAM

The SAM was adapted from the experiences in close relationships measure (ECR; Brennan, Clark, & Shaver, 1998). The ECR is a 36-item self-report attachment measure where respondents use a 7-point Likert scale to indicate how much they disagree or agree with items such as “I worry about being abandoned by my partner” and “I tell my partner just about everything.” Fraley, Waller, and Brennan (2000) examined the validity of several self-report attachment measures and determined that the ECR is empirically the best quantitative self-report adult attachment measure. Fraley et al. (2000) reported the original Cronbach’s $\alpha$ reliability coefficient for the attachment subscale as .91. Factor validity studies of the ECR have shown that items load on the appropriate subscales with loadings ranging from .68 to .93. Concurrent validity has been demonstrated by showing that the ECR scale was moderately correlated with scoring of attachment interview scripts (Dykas, Woodhouse, Cassidy, & Waters, 2006).

All of the 19 questions from the secure attachment subscale of the ECR were utilized in this study. The other subscales were not used. The items were slightly reworded to reflect within- and between-session sensitivity and partner-specificity. Participants responded to a 7-point Likert scale, with 1 and 7 reflecting less and more secure attachment, respectively. Possible scores ranged from 19 to 133. The SAM was administered immediately preceding each therapy session with participants rating how they felt toward their partner over the past week (e.g., “Over the past week, I felt comfortable sharing my private thoughts and feelings with my partner”). The SAM was also administered immediately after each session with participants rating how they felt toward their partner during and after the session, compared with how they felt at the beginning of the session. Cronbach’s $\alpha$ for the pre-session SAM was .96 and .95 for the post-session SAM, and factor analysis showed that all the items were related to one scale with factor loadings ranging from .60 to .87. The correlations between SAM scores and revised dyadic adjustment scale (RDAS) scores were .74 for wives and .71 for husbands.

RDAS

The RDAS (Busby, Christensen, Crane, & Larson, 1995) consists of 14 Likert-scale items that measure a person’s perception of their relationship adjustment and was completed by each partner at the beginning of the first session and at the end of the sixth session. Factor analysis (Busby et al., 1995) showed all items loading above .50. Concurrent validity was demonstrated with correlations between the DAS and RDAS of .97 and between the RDAS and the Marital Adjustment Inventory of .68. The original interitem reliability coefficient was .90 and the split half reliability coefficient was .95. The RDAS has demonstrated good discriminant validity in identifying distressed and nondistressed couples.
RESULTS

Results from a 2 × 2 ANOVA revealed that beginning mean attachment scores for husbands and wives in each treatment were not significantly different (F = 0.927, df = 1, 3, p = .44). The means for husbands and wives in the enactment first group were 83.71 (SD = 21.98) and 77.21 (SD = 21.18) and for husbands and wives in the therapist-centered first group were 91.35 (SD = 26.03) and 88.70 (SD = 27.25). The RDAS mean scores were also very similar across groups: 42.73 (SD = 11.52) and 42.18 (SD = 7.49) for husbands and wives in the enactment first condition, and 42.27 (SD = 8.27) and 41.27 (SD = 10.49) in the therapist-centered first condition. Mean RDAS scores for both husbands and wives showed that on average couples in both sequence conditions were distressed when they started treatment (below the cutoff of 48; Busby et al., 1995). Specifically, 62.5% of husbands (range 38–55) and 75% of wives (range 39–53) in the therapist-centered first condition, and 62.5% of husbands (range 16–56) and 87.5% of wives (range 26–59) in the enactment first condition fell below the cut off (48) for distress at intake. While no similar cut off scores have been established for attachment, the highest mean of 91.35 for husbands in the therapist-centered first treatment would indicate an average response of slightly <5 on a 7-point scale, which is only 1 point higher than the middle. So the couples as an entire group appear to report minimal attachment, certainly not moderate or high attachment.

At the end of the six sessions evaluated in this study, SAM mean scores for both men and women were higher for both groups than at the start of treatment. The 2 × 2 ANOVA results with gender as one level and treatment condition as the other level showed that while the overall results were not statistically significant (F = 1.53, df = 1, 3, p = .22), the main effect for treatment condition was with those in the enactment first condition showing better outcomes (F = 4.23, df = 1, 3, p < .05). SAM scores for men in the enactment first group started at 83.71 (SD = 1.98) and ended at 108.56 (SD = 21.04), and mean scores for women started at 77.21 (SD = 21.18) and ended at 103.91 (SD = 21.01). Mean scores for men in the therapist-centered first group started at 90.31 (SD = 26.78) and ended at 97.56 (SD = 27.49), and mean scores for the women in the therapist-centered first group started at 87.85 (SD = 28.12) and ended at 102.40 (SD = 27.49).

RDAS mean scores at the end of the study were 48.89 (SD = 11.62) for men and 44.89 (SD = 11.17) for women in the enactment first group and 47.67 (SD = 9.73) for men and 41.27 (SD = 0.53) for women in the therapist-centered first condition.

We hypothesized that enactment-based sessions would result in higher secure attachment (SAM) scores than therapist-centered sessions. We first tested this hypothesis by an omnibus comparison of attachment anchored versus therapist-centered SAM scores. Separately summing the differences of all within- and between-session attachment scores for husbands and wives combined, enactment-based versus therapist-centered sessions revealed only nonsignificant trends toward enactment sessions producing greater increase in secure attachment within or between sessions [383.86 (SD = 59.81) vs. 348.60 (SD = 38.89) for within-session change and 360.43 (SD = 49.40) vs. 352.20 (SD = 71.41) for between-session change].

We next tested this hypothesis by examining participants’ secure attachment scores before and after each enactment-based session with those from before and after each therapist-centered session. As shown in Figure 3, the graph of scores showed a consistent rise in within-session secure attachment scores for wives over the course of both the enactment-based and therapist-centered sessions.
Wives who started with the enactment interventions in the first three sessions continued to become more securely attached even through the therapist-centered sessions, and this increase in attachment change from 14 points in the first session to 51 cumulative points at the end session is assumed to be clinically significant because it is a 1.74 SD increase. While no clinical cut off scores have been determined for SAM, it is likely that this increase is also clinically significant. Husbands in the enactment first condition reported some change in attachment from first to sixth session, but the overall increase is only 7 points on a scale that runs from 19 to 133 points. The graph of results also showed that wives in the enactments first condition continued to increase in self reported attachment with each successive session. Wives who started in therapist-centered interventions also reported a slight increase in within-session attachment over the first three sessions, but their reported within-session attachment grew even more when they entered the enactment intervention condition. Husbands who received therapist-centered interventions first showed a consistent decline in within-session change in attachment, and they continued to decline even in the enactment sessions. These findings were contrary to our hypothesis that both husbands and wives would show increases in within-session attachment in the enactment conditions regardless of whether the enactment phase was first or second. What appears to be the case is that only those in the enactment first condition reported increase in within-session attachment, and they did so, or that effect carried through, even in the subsequent therapist-centered condition.

Figure 4 shows the between-session changes in attachment for both husbands and wives in the enactment first condition and in the therapist-centered first condition.
Both husbands and wives who were in the enactment interventions first condition showed a consistent increase in attachment between sessions until the fifth session and then they both reported a decline in attachment between the fifth and sixth sessions when they were receiving the last of the therapist-centered interventions. Between-session changes in attachment continued to deteriorate for wives who received therapist-centered interventions first even through the last phase when they were receiving enactment interventions. While husbands in the therapist-centered treatment first condition showed some improvement between sessions 5 and 6, it was not enough to get back to their attachment level at the beginning of treatment.

The small number of couples in each treatment condition makes an attempt at statistical analysis difficult because one cannot conclude that nonsignificant findings are accurate when they may simply be a function of a small $n$. The findings from these statistical analyses should thus be considered exploratory at best.

Initially, we conducted simple paired $t$-tests for within subject change (e.g., changes in SAM scores from pretreatment to the end of session 3 for each treatment group. Four separate $t$ tests were run examining difference scores separately for husbands and wives for the first three sessions of the enactment first condition, then separately for husband and wives for the first three sessions of the therapist-centered first condition. Results showed that for the enactments first condition, the differences between pre- and end of third session scores approached significance for husbands ($t = -2.11, p < .056$) and were significant for wives ($t = -3.10, p < .05$). For the therapist-centered first condition, there were no significant differences between pre- and end of third session scores for either husbands or wives.

**FIGURE 4.** Cumulative Changes in Between-Session Attachment for Husbands and Wives Receiving Enactment-Based or Therapist-Centered Interventions First.

*Note:* The values on the $y$-axis represent cumulative change. In other words, postsession attachment scores of the previous session were subtracted from the presession attachment scores of the next session to create a between-session change score.
Next we conducted a 2 × 2 repeated measures ANOVA with gender as one variable with two levels and treatment condition in first phase (first three sessions) as the other variable with enactment-based and therapist-centered as the two levels, controlling for pretreatment SAM scores by using them as a covariate. The within-session changes and the between-session changes in SAM were summed across the first three sessions to create the first level in the analysis and then the SAM scores across the last three sessions were summed to create the second level since our interest was in the differences between the two treatment conditions rather than in variation from session to session. This analysis was also repeated using attachment change in the last three sessions as the dependent variable. These analyses were also performed using between-session change as the dependent variable. As with analyses for the first three sessions, the within-session sum for the last three sessions was the pre-post scores for sessions 4, 5, and 6, summed. The between-session sum was the difference between the pre of the next session and the post of the previous session, summed.

Results from the first analysis showed that there was a significant difference in the first three sessions between individuals in the enactment condition and those in the therapist-centered condition. Participants in the enactment condition showed larger within-session changes in attachment (X = 10.98 vs. 9.65; F = 10.14, df = 1, 3, p < .05).

There were no statistically significant differences between the two experimental conditions (enactment-based vs. therapist-centered) in within-session or between-session changes in the last three sessions of treatment. Neither group’s attachment scores improved more than the other.

Although the ANOVA results did not reveal a statistically significant gender difference, the fact that the small n does not allow adequate power to adequately test the hypothesis is most likely the explanation especially when the graphical representations in Figures 1 and 2 seemed to indicate that men and women did respond differently. Further investigation will have to wait until statistical analyses can be conducted with a larger participant sample.

At the couple level, SAM within-session changes for husbands and wives were summed across the first three sessions, and then enactment first couple scores were compared with therapist-centered first couple scores. There was a significant difference, with enactment condition couples reporting greater increases in attachment than did therapist-centered couples (X = 131.04 vs. 117.25, t = 2.71, p < .05). This same analysis of SAM between-session changes resulted in no significant differences between the two groups. The same procedure was completed for the last three sessions and showed that enactment first couples’ within-session scores were significantly higher than therapist-centered couples’ scores (X = 108.08 vs. 100.11, t = 2.15, p < .05). This means that couples in the enactment first condition continued to enjoy greater gains in attachment—on through their therapist-centered sessions—than the therapist-centered first couples, even after these latter couples shifted to enactment sessions.

**DISCUSSION**

This study served as the pilot study for a planned larger-sample investigation examining enactments as a potential change mechanism to strengthen secure attachment in marital therapy. The results provide preliminary evidence offering moderate support for using enactments, especially early in therapy, as a tool for increasing couple attachment within and between sessions. The trends suggest that couples who
receive enactments early in therapy may improve in attachment between therapy sessions, thus helping couples learn to strengthen their secure attachment on their own. This trend continued even when the types of interventions therapists were using changed from enactments to client centered. This is significant given that a fundamental theoretical and clinical assertion of enactment proponents (see literature review) is that they facilitate self-reliant, positive couple interaction. However, it is important to note that, given the small sample size, the results of this study represent only descriptive trends and trajectories.

We hypothesized that enactment-based sessions would reveal evidence of increased secure attachment scores. Our omnibus test, separately summing all within- and between-session attachment scores for husbands and wives combined, revealed a nonsignificant trend for enactment-based versus therapist-centered sessions to produce a greater increase in secure attachment scores. However, other findings were somewhat contrary to our hypothesis in that couples who received therapist-centered interventions in the first three sessions did not generally fare better after they entered the last three enactment-based sessions, and couples who received enactment-based interventions continued to show improvement even when they entered the last three therapist-centered sessions. Still, the direction of observed trends and these findings seem generally consistent with previous research and theory, suggesting enactments are an effective change mechanism in couple therapy (Allen-Eckert et al., 2001; Andersson et al., 2006; Butler & Bird, 2000; Butler & Gardner, 2003; Butler & Wampler, 1999; Davis & Butler, 2004; Nichols & Fellenberg, 2000; Seedall & Butler, 2006, 2008), particularly in strengthening couples’ secure attachment. It may also be true that timing of enactment interventions is an important variable given that couples in this study who received enactment interventions in the first three sessions continued to increase in attachment even when the interventions changed.

Enactments appear to allow couples to develop new interaction patterns that promote emotional sharing, partner softening and responsiveness, and the expression of attachment needs (Andersson et al., 2006; Butler & Seedall, 2006; Gardner & Butler, 2009; Seedall & Butler, 2006). Couples may thus be enabled to acknowledge and process emotion and make relationship-enhancing changes in their attitudes, attributions, emotions, and attachment (Butler & Gardner, 2003). We hypothesized that enactment-based sessions would produce greater shifts toward couples’ secure attachment than therapist-centered sessions. Our data showed preliminary support for this hypothesis in that those receiving enactments in the first three sessions reported greater increase in attachment than did those receiving therapist-centered interventions first, and this difference was statistically significant, even in the face of a small sample. These results relate to previous research findings that show active client participation and engagement is essential for successful therapeutic outcomes (Brimhall et al., 2003; Butler & Bird, 2000; Butler & Wampler, 1999; Holtzworth-Munroe, Jacobson, DeKlyen & Wisman, 1989; Johnson, 2004).

Distinguished from a therapist-centered approach, enactments actively engage and involve couples in their own therapeutic process. It is hypothesized that as therapists carefully coach couples to experience healthier interaction patterns, couples create their own relationship-strengthening and relationship-healing journey, rather than relying on the therapist to do so for them. Consequently, couples are more likely to become self-reliant and able to work through their own conflicts, safely express their needs and emotions, and respond to each other in a relationship-enhancing, attach-
Familial-secure way—with or without the therapist (Butler & Gardner, 2003; Butler & Wampler, 1999). Though the results showed trends in this direction, future research needs to test these preliminary trends with a larger sample of couples.

While gender differences in within-session and between-session changes in attachment did not attain statistical significance, the trend shows that both types of therapy show potential to benefit females’ sense of secure attachment, while males’ scores revealed a growth trend only when they received the enactment interventions first. Even so, the changes in attachment for males in the enactment first condition were relatively small. Perhaps males experienced some overall discomfort from the candid openness, intense processing, and demanding interaction during therapy sessions. It may be that when interventions are primarily therapist-centered, husbands can hear what their wives say, but the intervention may not be sufficiently experiential for them to shift their perceived attachment. A paradoxical dynamic might exist where, for males at least, enactments may be the “distasteful medicine” (namely, engagement in challenging emotional interaction) that nonetheless produces recognizable and essential healing, particularly for their wives.

Another possible explanation for this gender difference could be that among couples who present for marital therapy, women typically initiate therapy and report more marital dissatisfaction than males. Thus, the women might have experienced any therapeutic effort to strengthen the marital relationship as beneficial, whether the therapy process was enactment-based or therapist-centered. Perhaps the fact that their husband was willing to come to therapy and work on the relationship was enough to increase females’ secure attachment scores, regardless of the therapy process. Still, though both therapy types appeared to increase females’ secure attachment scores, enactment sessions were associated with greater increases than were therapist-centered sessions. Thus, while both therapy types appeared to benefit females’ sense of secure attachment, enactment sessions may have the greater potential to do so. Given that marital success is predicted by wives’ more than by husbands’ ratings, interventions that positively impact wives’ experience of the marriage deserve particular attention.

The overall decrease in male scores across therapist-centered sessions could be related to the fact that therapist-centered sessions are typically more directive and require less client participation than enactment sessions. Men may be more reactive than women to directive therapy and instruction (cf. Butler & Bird, 2000). Perhaps they perceive their position in this type of therapy as less autonomous and feel less in control. Our conjecture is that such feelings might influence males to feel less capable of strengthening their own marriage and could precipitate an increased sense of inadequacy. Decreased secure attachment might result if such worrisome feelings of inadequacy lead husbands to withdraw instead of draw close to their wife. Conversely, while initially difficult and challenging, we surmise that the active client participation and interaction encouraged by enactments may inspire males’ confidence that they can personally help their marriage to progress, rather than relying on a therapist to do so. We speculate that conclusive realization of this prospect and confidence through positive out-of-session interaction may account for between-session gains in males’ attachment security. Perhaps males are more likely to experience an increased sense of secure attachment (as well as positive self-concept) when they are the ones actively and successfully engaging and interacting with their spouse, rather than the therapist. Men may also tend to value seeing themselves as competent emotional providers for their families—not needing to be substituted for by a therapist.
Directive, therapist-centered sessions might highlight therapist skills and engagement in contrast with an implicit communication of deficit on the part of the husband in therapy, leading to a diminished sense of connection/attachment with his spouse.

**LIMITATIONS AND FUTURE RESEARCH**

As this was a small-sample pilot study, our findings cannot be considered conclusive. Nevertheless, given the intensive time, labor, and financial costs associated with process-outcome research, a pilot-study approach is clearly warranted as a way to refine and warrant subsequent full-scale investigations. We now need to see whether the same findings will be replicated in a larger sample with adequate statistical power.

This study also debuted new measures to assess secure attachment scores which have not been statistically tested for validity. A larger-scale study is also needed to examine the SAM items individually to discover which, if any, are actually sensitive to change at between-session and within-session intervals. Process-outcome research related to attachment, as well as numerous other variables, is desperately in need of instruments sensitive to fine-grained change over brief intervals.

The therapists used to execute the different experimental types were unlicensed, first-year graduate students in MFT training. While potentially resulting in unknown confounds due to inexperience, utilizing student MFT interns has the advantage of accessing therapists willing to learn and practice contrasting treatment modalities according to strict research criteria. Still, the generalizability of our findings to licensed therapists could be debated.

Another limitation is that our study only analyzed participants’ secure attachment based on aggregate scores across the entire couple sample, masking potential variability and heterogeneity between couples. Research examining patterns of attachment couple-by-couple could reveal a nuanced picture, with different couples responding quite differently—as couples—to enactment-based versus therapist-centered clinical process.

Additionally, possible gender differences hinted at by our findings suggest that a larger-scale study is needed to confirm whether enactment-based versus therapist-centered therapy process modalities are consistently experienced differently by males and females. Couple therapy could be significantly complicated by a finding that men and women respond significantly differently to distinct therapy process modalities. Finally, our study examined the influence of enactments on secure attachment among a demographically nondiverse couple sample. Obviously, the base of diversity in our pilot study will need to be systematically expanded in order to achieve broadly generalizable results.

The findings of this study invite more extensive investigation of the comparative utility of enactment-based versus therapist-centered therapy process modalities. Our pilot findings leave open the possibility that enactments may prove to be more than just a particular, stylized approach to EFT and other relationship therapies, but an essential process modality in couple and/or family therapy, one most conducive to deep, couple/family attachment experiences in therapy and positive relationship outcomes. Through their direct enactment of relationship experience, emotion, interaction, and change, couples may be helped to strengthen their attachment security.

The findings suggest that it may become important for couple and family therapists to familiarize themselves with effective enactment execution (Butler & Gardner, 2003; Davis & Butler, 2004; Nichols & Fellenberg, 2000) and utilize enactments to enable couples and families to strengthen secure attachment.
REFERENCES


