Addiction and Emotionally Focused Couple Therapy, A Replication Case Study

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Abstract

Substance addictions represent a serious social problem in North America, negatively impacting family relationships and couple functioning. Research is increasingly considering the potential for couple therapy as a model within this context. Using a replicated case study design, this study explored a proposed theoretical extension of Emotionally Focused Couple Therapy (EFT) in the context of substance addictions. Results are presented in a three-article manuscript. The first article explicates the overall results of the study. Comparisons between the normative EFT model and the theoretical extension are made, and recommendations are provided for further adaptations to the model. The second article discusses the impact of substance relapses in couple therapy and recommendations are made for addressing these occurrences in the context of EFT. Finally, the third article assesses outcome interpretation in therapy for couples in the context of addiction. Study outcomes are analyzed and compared with client interpretations of outcome. Results from this study indicate the important place of couple therapy in addiction treatment and provide important rationale for future research in this context.

Résumé

La toxicomanie représente un problème social sérieux en Amérique du Nord qui a une influence négative sur les relations familiales et le fonctionnement du couple. De plus en plus de recherches considèrent le potentiel de la thérapie de couple comme une approche dans ce contexte. À l'aide d'un modèle d'étude de cas répliqué, cette étude a exploré une proposition de prolongation théorique de la thérapie de couple axée sur les émotions dans le contexte de toxicomanie. Les résultats sont présentés ici dans un manuscrit de trois articles. Le premier article explique les résultats généraux de l'étude. Des comparaisons entre le modèle normatif de la thérapie de couple axée sur les émotions et la prolongation théorique sont faites. Des recommandations sont également formulées pour de future adaptation du modèle. Le deuxième article examine l'impact des rechutes sur la thérapie de couple. Des recommandations sont faites pour aborder ces incidents dans le contexte d'une thérapie de couple axée sur les émotions. Finalement, le troisième article s'appuie sur les résultats de l'étude de cas pour analyser comment le succès est défini dans le traitement des dépendances et dans la thérapie de couple. La diversité dans les définitions des résultats positifs du traitement était présente dans l'étude. Certains couples se sont concentrés sur l'abstinence comme mesure du succès, tandis que d'autres ont utilisé d'autres paramètres pour évaluer le succès. Les résultats de cette étude révèlent l'importance de la thérapie de couple dans le traitement de la toxicomanie et fournissent une base importante pour la recherche future dans ce contexte.

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Preface and Contribution of Authors

This dissertation is original, independent work by the first author, Kara Fletcher and second author, Heather MacIntosh. All three manuscripts have been submitted for publication however they are currently unpublished. The research in this thesis is original scholarship and aims to provide distinct contributions to knowledge on treating couples in the context of addiction using a theoretical extension of Emotionally Focused Therapy.

Introduction

Substance addictions represent a serious social problem in North America, negatively impacting family relationships and couple functioning. Research is increasingly considering the potential for couple therapy as a model within this context. Issues presented by an addiction can be exacerbated by other issues present in a couple relationship. Using a multiple case replication study design (Yin, 2009), this dissertation evaluated a proposed theoretical extension of Emotionally Focused Couple Therapy (EFT) in the context of substance addictions. Comparisons between the normative EFT model and the theoretical extension are made, overarching themes are discussed, and recommendations are provided for further adaptation to the model. Results from this study support continuing to evaluate EFT as a treatment model in the context of addiction.

Substance addictions in the social context

In Quebec, 39.6% of the population reported they have suffered the negative consequences of excessive drug or alcohol use by someone close to them (Kairouz & Nadeau, 2010). Substance addictions are seen to co-occur with and exacerbate numerous social problems such as poverty, crime, and conjugal violence (Cunradi, Mair, Todd, & Remer, 2012). Studies have found that drug and alcohol use are both independent predictors of intimate partner violence (Moore & Stuart, 2004; Stuart, Moore, Kahler, & Ramsey, 2003). Substance abuse has also been attributable to more than 80 disease conditions, reflecting a significant impact on the health care system (Rehm et al., 2006).

Substance addictions in the individual context

In 2012, about 21.6% of Canadians (approximately 6 million people) met criteria for having had a substance use disorder in their lifetime (Pearson, Janz, & Ali, 2013). A wide variety

of factors contribute to why an individual develops an addiction. An individual does not simply use a substance and become addicted. In fact, addiction to a substance only occurs in a small percentage of individuals who try addictive substances (McLellan, Lewis, O'Brien, & Kleber, 2000; Vanyukov et al., 2012; Zeinali, Sharifi, & Enayati, 2011). Initiating substance use, while a necessary precondition, is not sufficient for developing a substance addiction.

Addiction is a "complex and multidimensional phenomenon" (Larkin, Wood, & Griffiths, 2006, p.210). Individuals with substance addictions seek out and use drugs with impaired control, at the expense of other aspects of their lives, and negative consequences arise from this behaviour (Durrant, Adamson, Todd, & Sellman, 2009; Saha, Harford, Goldstein, Kerridge, & Hasin, 2012). While many individuals (40-60%) recover from substance addictions, many factors, which have influenced the onset of the addiction, can persist and interfere with sustained recovery. Some of these factors include genetic traits, psychiatric conditions, peer culture, social milieu, gender, education, employment, and parental care (Menicucci & Wermuth, 1989; Zeinali et al., 2011).

In 2011, the fifth edition of the Diagnostic and Statistical Manual (DSM-5) was released, and combined the diagnostic categories for "substance abuse" and "substance dependence". These diagnoses have been replaced with the term, "substance use disorders" (O'Brien, 2011). The "substance abuse" category has been removed as the committee argued there was not enough evidence of a distinct intermediate state between substance use and substance dependence (O'Brien, 2011; Saunders, 2007). The DSM-5 definition of substance use disorder is "a cluster of cognitive, behavioural, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems" (American

Psychiatric Association, 2013, p.483). Initiating drug use, while a necessary precondition, is not sufficient for developing a substance use disorder.

Addictions in the couple context

Discussion about the impact of substance addiction on romantic partners has shifted from early literature that focused on the romantic partner's pathology, positing that wives of men with alcohol use disorders were inevitably disturbed and "mad" (Hurcom, Copello, & Orford, 2000). In the 1980's two models emerged: the codependency model and the stress and coping model. Similar to earlier literature on wives of individuals with substance addictions, the codependency model emphasized that there was something pathological about a spouse who formed a relationship with a person who had a substance addiction (Hurcom et al., 2000). From this perspective, close involvement with an addicted partner risked enabling behaviour and codependency. Codependency literature warns the romantic partner about being codependent and facilitating their partner's use of substances (Rotunda, West, & O'Farrell, 2004). A common argument in the codependency model is the non-addicted partner should emotionally detach from their loved one (Casey, 2008). These perspectives have been criticized for pathologizing the existence of interdependency within a couple.

The stress and coping model focuses on the problem solving that spouses do to manage their experience of the addicted partner's substance use (Hurcom et al., 2000). This perspective is more strength focused and highlights that couples affected by substance addiction may require support to problem solve in their relationships. Addictions inevitably impact couple relationships, however, many couples may want to continue a relationship, despite a substance addiction.

A substance addiction can become the focus of interactions and relations within a family (Saatcioglu, Erim, & Cakmak, 2006). Studies demonstrate that family members benefit from involvement in treatment (Benishek, Kirby, & Dugosh, 2011; Fischer & Wiersma, 2012; Saatcioglu et al., 2006). For example, as early as the 1970's, the National Institute on Alcohol Abuse and Alcoholism identified couple and family therapy as a promising new treatment approach in the psychotherapy of alcoholism (Ruff, McComb, Coker, & Sprenkle, 2010).

Despite the impact of substance addictions on the family system and the couple relationship more specifically, treatment often occurs separately (Stanton, 2005). That said, research is increasingly considering the couple relationship in treatment and the potential for couple therapy as a modality within this context (Bischoff, 2008). More and more in the past twenty years, couple therapy has been studied as a treatment for individuals with substance addictions and their partners.

At a meeting in January 2012, the Association des Centres de Réadaptation en Dépendance du Québec (ACRDQ), made specific recommendations for rehabilitation centres in Québec to improve and promote practice with couples and families, and the importance of training front line workers to use couple and family therapy in their practice (Mongrain, 2011). This research study explored the application of a proposed adaptation of Emotionally Focused Couple Therapy (EFT) for couples dealing with a substance addiction in one partner.

Couple functioning and substance addictions

Substance addictions are predictive of couple distress. Regardless of gender, substance addictions are correlated with relationship instability and an increased risk for intimate partner violence (Boden, Fergusson, & Horwood, 2013). Partners living with individuals with substance addictions can struggle with psychosocial difficulties (Dethier, Counerotte, & Blairy, 2011). The

partner who does not have a substance addiction may feel burdened with maintaining the couple relationship and may feel their own needs are not met within the relationship (Cropley, 2006). Even when an individual within a couple has started treatment, couple conflict and relationship distress can continue to be reported as after-effects of the addiction and can precipitate a relapse (Navarra, 2007; Stanton, 2005).

There are persuasive reasons for providing couple therapy in the context of addiction. Research has found that including the partner in therapy is predictive of successful treatment (Heinz, Wu, Witkiewitz, Epstein, & Preston, 2009; Nelson & Sullivan, 2007). Addiction programs that use couple therapy as part of their treatment are demonstrating positive outcomes (lower rates of relapse and higher couple satisfaction) (O'Farrell & Fals-Stewart, 2000). Specifically, couples *may need support* developing a new interaction cycle (Bradley & Furrow, 2004). Navarra (2003) conceptualized addiction in a couple as a trauma. He emphasized the importance of "couple recovery" where couples are given a safe structure and space to discuss their relationship issues (Navarra, 2002). Mutual support and care allow needs to be met (Landau-North, Johnson, & Dalgeish, 2011). Talking together, for any couple, can begin to facilitate closeness and intimacy within the relationship (Dandeneau & Johnson, 1994). Relationships can be damaged by a substance addiction; however, where there is a desire to improve the quality of the couple relationship, couple therapy could help repair those bonds in each partner simultaneously.

The quality of romantic relationships is associated with both psychological and physiological well-being in both partners (Butler & Randall, 2013; Holt-Lunstad, Birmingham, & Jones, 2008). Psychological symptoms such as depression and increased stress are seen to be higher in romantic partners of individuals with a substance addiction (Copello, Templeton, &

Velleman, 2006). These couples are also seen to have poor problem solving skills and lower functioning in comparison to couples where there is no substance abuse issue (O'Farrell & Fals-Stewart, 2002). Research suggests that healthy relationships are correlated with positive health and well-being for both partners and children, including living longer, and experiencing fewer physical and mental health problems (Halford & Snyder, 2012; Overall, Fletcher, & Simpson, 2006). Addiction is a systemic issue that impacts all involved.

Theories of the development of substance addictions

It is important to consider some of the many theories that have contributed to current understanding and treatment of substance addictions prior to further exploring the couple context. Addiction was conceptualized as a disease starting in the late eighteenth century (White, Boyle, & Loveland, 2003). The related "disease model of addiction" posits that the addicted individual has a genetic predisposition to developing an addictive disorder. From this perspective, addiction is a disease characterized by dysregulation in decision-making, reward systems, memory, learning and motivation (Angres & Bettinardi-Angres, 2008). Like other diseases, addiction has heritable, genetic, psychosocial, and environmental components that influence its development (Meyer, 1996). From the disease model perspective, the addicted individual is unable to control their substance use and is caught in a vicious cycle of withdrawal and pursuit of reward (Angres & Bettinardi-Angres, 2008). One variant of the disease model, the disease concept of addiction, became a focus of treatment during the 1980's and 1990's. For example, twelve-step programs such as Alcoholics Anonymous (A.A.) use the disease concept to highlight an individual's "powerlessness" over their addictive disorder, and to encourage individuals to recognize the "delusions" the disease has caused them (Angres & Bettinardi-Angres, 2008; Erikson, 2007).

With more research, conceptualizations of addiction began to shift from viewing addiction through a "disease concept" lens, to understanding addiction as a bonafide medical disorder, largely driven by genetic vulnerability (Erikson, 2007; Kaplan, 1997). McLellan, Lewis, O'Brien and Kleber (2000) in the *Journal of the American Medical Association (JAMA)* posited that substance dependence is a chronic disorder. Understanding addiction as a chronic relapsing disorder supports the notion that addictive behaviour can persist for decades and may require multiple episodes of care over many years (Dennis, Scott, Funk, & Foss, 2005; McKay & Hiller-Sturmhoefel, 2011). However, unlike other chronic medical disorders, the addicted individual is often faulted and hence stigmatized for initiating behaviours that led to dependence.

Many contemporary conceptualizations of addiction continue to define addiction as a chronic relapsing brain disease. The American National Institute on Drug Abuse (NIDA) funds research on addiction globally, and views addiction as a brain disease which results from potentially long-term changes in the brain structure and how it works (NIDA, 2014). While the debate on whether addiction is disordered choice, a myth, or a social construction continues (see Heyman, 2009; Vrecko, 2010), many treatment models and research alike continue to define addictive disorders as a brain disease (Glantz, 2010; McKay & Hiller-Sturmhoefel, 2011; Volkow, Wang, Fowler, Tomasi, & Telang, 2011). Some of the developmental etiological theories are reviewed here.

Neurobiological Theories

Research continues to demonstrate the strong link between neurobiology and the etiology of addictive disorders. A comprehensive review of the neurobiology of addiction will not be provided here, however, a brief overview is outlined. From a neurobiological perspective, addiction is a chronic, relapsing brain disease that impacts an individual's life medically,

socially, and interpersonally (Arria & McLellan, 2012; Levran, Yuferov, & Kreek, 2012; McLellan, 2002). Researchers now better understand the neuroadaptative changes that occur in the brain between initiating drug use and developing an addiction (Hall, Carter, & Morley, 2004; Koob & Simon, 2009). Drug consumption has the capacity to affect the brain and emotional states. Addictive disease occurs in the prefrontal cortex (Volkow et al., 2011). The mesolimbic dopamine system, also known as the "reward pathway" in the brain is one of many dopamine pathways that contribute to drug reward and addiction (Erikson, 2007; Volkow et al., 2011). Drugs impact certain neurotransmitters or receptors depending on the action of the drug (Erikson, 2007). Drugs act on the evolved reward system within the brain, and, over time neural processes enhance the reward value of the substance, until automatic addictive behaviours occur without conscious thought (Gifford & Humphreys, 2007).

Substance addiction is progressive. An individual's neurobiological relationship with substance use moves from impulsivity to compulsivity, into a cycle of being preoccupied with the anticipation of substance use, using to the point of intoxication, and then experiencing withdrawal symptoms and negative affect, until the cycle begins all over again (Koob et al., 2004). Brain systems alter during the development of an addiction (Koob & Simon, 2009). Theories abound as to why this happens, but neuroscientists believe that a combination of drug exposure leading to neuroadaptation, genetic heritability and environment causes the dysregulation in neurotransmitting systems that contribute to addiction (Erikson, 2007). Over time, alcohol and other drugs may cause more permanent changes in the inner workings of the nervous system, changing the way cells communicate with one another (Erikson, 2007). Continued drug use can cause long-lasting or even permanent changes in brain chemistry and function (Durrant et al., 2009; McLellan et al., 2000; Sloboda, Glantz, & Tarter, 2012).

Evolutionary Perspective

From the evolutionary perspective, addiction develops as a result of an individual's innate motivational-emotional reward system (Durrant et al., 2009). From this view, individuals who begin abusing substances are typically living in suboptimal environments, and employing short-term strategies for living (Lende & Smith, 2002). They have finite resources, and over time must decide in what to invest effort (Durrant et al., 2009). They take risks (substance use) in an effort to gain an evolutionary advantage (the ability to cope with their environment). Evolutionary theory focuses on competition: arguably substance use initially provides adaptive benefits (e.g. staying awake, improved mood) (Lende, 2011), however, like any other potentially rewarding activity, substance use can become compulsive. Individuals begin substance use in an effort to get ahead, however this strategy is short-lived and ineffective. Evolutionary theorists further argue that until treatments address the short-term adaptive strategies that individuals use which leads to addiction, substance abuse will continue to occur as a maladaptive evolutionary strategy (Lende & Smith, 2002).

Addiction as a Psychological Symptom

Another explanation for the development of substance addiction is addiction as a psychological symptom or a psychological compulsion. From this perspective addiction is a form of psychopathology, and stems from a narcissistic conflict (Dodes, 2009; Kohut & Wolf, 1978; Wurmser, 1974). Narcissism in this case refers to one's self view about their competence in relation to others (Ames & Kammrath, 2004). This narcissistic conflict occurs as a result of intolerable helplessness (Dodes, 2009). Intolerable helplessness can result from any type of emotional crisis such as the loss of a job, etc. The emotional crisis or "narcissistic injury" initiates an addictive search for a solution. The solution becomes alcohol or drugs. Alcohol and

drugs offer control over one's emotional state and provide tools for self-stimulation (Kohut & Wolf, 1978). Substance use is the active behaviour that is a necessary response to perceived helplessness in an effort to control and regulate one's own affective state (Dodes, 2009; Ruiz, Strain, & Langrod, 2007). From this view, addiction is a displaced attempt at self-mastery. In this theory, narcissism provides for oneself, what is not provided by others (Flores, 2004).

A psychological view of addiction situates addiction as character-driven and resulting from emotional conflict. Peele and Brodsky (1975) also identified addiction as a psychological symptom in their early discussion of addictive behaviours in adolescence. They saw addiction as a symptom to hide behind, in an effort to evade the upcoming challenges of adulthood. There are several arguments that do not view addiction as a psychological symptom, but instead posit that addiction *causes* psychopathology (e.g. Vaillant & Milofsky, 1982). While characterizing addiction as a psychological symptom helps frame addiction as something that can be overcome, this perspective can neglect the complexity of addictive disorders.

Family Systems Perspective

Earlier research on addiction conceptualized addictions from a family systems perspective. The family systems perspective views addiction as an organizational symptom within the family. Menicucci and Wermuth (1989) describe addiction developing as a "paradoxical resolution" to the relationship strains within the family. The addiction becomes a focus for the family and begins to determine their systemic organization. The family organize their behaviour and responses around the addicted person. If an individual begins to seek treatment, or stop using substances, the family needs to reorganize and this is not always desirable for a family. In these instances another individual in the family may develop symptoms and become the identified patient, or, alternatively the family may enable the individual with the

substance dependence to continue their addiction. The family systems framework has been critiqued for neglecting the broader social and development contexts in which addiction occurs (Menicucci & Wermuth, 1989). It may be too simplistic to argue that addiction exists exclusively as a symptom for family organization.

Child Maltreatment and Trauma

Contemporary research on addiction in the family is focused on developmental and genetic risk factors for children. A major developmental risk for addiction is the maltreatment of a child by their parent or caregiver (Enoch, 2011; Medrano, Hatch, Zule, & Desmond, 2002; Rowe, 2012). Maltreatment encompasses poor quality of parent-child interactions, conflict, low levels of parental warmth, and inconsistent discipline (Arria, Mericle, Meyers, & Winters, 2012). Other adverse childhood experiences include growing up neglected or abused, witnessing parents in conflict, domestic violence, substance abuse in parents, mental illness in parents or criminal behaviour (Morgan, 2009). In particular, a family history of substance use problems can be a significant risk factor for exposure to traumatic events (Najavits, Weiss, & Shaw, 1997). In the Adverse Childhood Experiences (ACE) study, Felitti et al., (1998) found that growing up with four or more adverse experiences increased a child's chance of becoming an alcoholic by 740 percent and of using illegal drugs by 470 percent. Research continues to find potentially traumatic childhood experiences of maltreatment risk factors in the etiology of addiction and other mental health issues (Anda et al., 2002; Arria et al., 2012; Enoch, 2011; Medrano et al., 2002). While substance abuse is not typically initiated in childhood, individuals who grew up maltreated or traumatized are more likely to develop addictive behaviours in adolescence than other children (DeBellis, 2001). Early traumatic childhood experiences appear to impact developmental mechanisms within the individual, placing them at risk for substance abuse.

While substance use problems in one's family history can be a risk factor for exposure to traumatic events, exposure to traumatic events in one's environment unrelated to their family of origin can also be a risk factor for substance addictions (Enoch, 2011). Traumatic events in a social or environmental context can equally impact an individuals' propensity to develop a substance use problem that began in an effort to cope with distress (Sloboda et al., 2012). Environmental disaster, war, sexual abuse, times of economic distress, such as job loss, and various other environmental and sociological traumas could trigger the onset of addiction.

Multigenerational Transmission Perspective

Family environments with an addicted parent can be traumatic, chaotic, and unpredictable (Arria et al., 2012). The multigenerational transmission of addiction has been well established in the literature. The higher functioning the parents, the less likely it is that their children will develop an addiction (Gifford & Humphreys, 2007). For example, adult children of alcoholics are 3-4 times more likely to develop alcoholism in adulthood than adults with non-alcoholic parents (Anda et al., 2002). There are strong social, genetic and environmental risks if one's parent has an addictive disorder, and the hereditary components of addiction remain present throughout the life span (McCrady et al., 2006; Sloboda et al., 2012). Individuals who grow up in an environment of unresolved family conflict are also at risk for substance dependency. These individuals may have experienced a continuous cycle of crisis in their family and may replicate this pattern through substance dependency in adolescence and into adulthood (Menicucci & Wermuth, 1989). A family conceptualization of the development of addiction neatly captures some of the environmental and developmental influences of substance addiction.

Peer Influence

One clear sociological factor that can influence the development of addiction is one's peer group in middle childhood and adolescence. Individuals initiate substance use around the same time they begin differentiating from their family of origin and start seeking closer relationships with their peers; this typically occurs between age 13 and 16 (Sloboda et al., 2012). Peer groups may normalize drug or alcohol initiation, and provide an attractive context for continued use (Dube et al., 2003; Lende & Smith, 2002). During this time, the adolescent's brain is still developing, and their learning is largely experience dependent (Sloboda et al., 2012). If peer influence is negative, the risk for developing a substance addiction is increased (Tanner-Smith, 2012). Adolescents will have lower risk of negative peer influence if they maintain positive relationships with their primary caregivers and if they are participating and doing well in other pro-social activities, such as school.

Neighbourhood

Socioeconomically disadvantaged neighbourhoods can place individuals at risk for a substance addiction. These environments may involve stressful living conditions, social disorganization, few social opportunities for youth, and instability (Buu et al., 2012; Karriker-Jaffe et al., 2012). Residents may move in and out of these neighbourhoods, creating very little social cohesion amongst neighbours (Buu et al., 2012). These environmental conditions create more isolation among individuals, which could lead to substance abuse in an effort to quell boredom. While neighbourhood may impact the onset of substance dependence for a variety of reasons, there are other contributing factors to consider.

Critical addiction theory

Contemporary addiction theory is moving away from a medical model towards a more sociological and multi-factorial approach. Critical addiction theory posits that social, political,

and cultural factors shape our ideas about addiction (Boyd, Carter, & MacPherson, 2016). Theorists recognize there may be benefits to drug use for individuals, even illegal drug use. Critical addiction theory considers the experiences of individuals who live with addiction and how society responds to them (Boyd et al., 2016). There are six principles in critical addiction studies: 1) historical and cultural specificity, 2) context as integral, 3) addiction as sociologically contingent and indeterminate, 4) social inequality and differential consequences, 5) multi-disciplinary and multi-vocal investigative strategy, and, 6) consequentialist conceptualization of policy (Boyd et al., 2016). These conceptualizations value a harm reduction model over an abstinence approach (Reinarman, 2016). Critical addiction theory is moving considerations of addiction away from a medical model towards a more critical, intersectional, and sociological perspective.

Attachment theory

Attachment theory offers a compelling developmental perspective on the etiology of addictive disorders. An explanation of the theory will be provided here, along with specifics as to how it pertains to addictive disorder. Attachment theory offers a hypothesis about how the self develops in relation to others. Based on the collaborative work of John Bowlby and Mary Ainsworth, attachment theory has been influenced by the existing paradigms of psychoanalytic theory, cybernetics, information processing, security theory, and ethology (Bretherton, 1992). According to attachment theory, from infancy, physical and emotional proximity to a loved one feels good, and being far away or emotionally distant causes loneliness, anxiety and sadness (Bowlby, 1988). Attachment behaviour is present throughout the life cycle, and the attachment between a primary caregiver and their child is seen to have determining effects for later relationships and functioning (Bowlby, 1988; Peter Fonagy, Gergely, Jurist, & Target, 2002;

Stevenson-Hinde, 1990). Ainsworth and Bowlby viewed attachment as related to the non-verbal realm and the relation of self to experience (Bowlby, 1988). Ainsworth's student Mary Main expanded on these ideas and shifted understanding of attachment away from just comprising non-verbal behaviour, to also including mental representations (Wallin, 2007).

Within the attachment framework, John Bowlby developed the concept of internal working models (IWMs). An IWM is developed at an early age and is a "relational template" that shapes the way a child interprets themselves and understands the world around them (Anda et al., 2002; Padykula & Horwitz, 2012; Thompson, 2008). Functionally, an IWM encompasses a child's capacity to maintain close relationships, regulate emotions, and manage early negative experiences (McCarthy & Maughan, 2010; McNally, Palfai, Levine, & Moore, 2003). A child's IWM will likely mirror the IWM and attachment security of their primary caregiver (Main, 1995; Wallin, 2007).

Internal working models are shaped by an individual's attachment style. An attachment style is a pattern of relational behaviours, emotions, and expectations (Brenning, Soenens, Braet, & Bosmans, 2012). Attachment styles are defined broadly as secure, or insecure. Ainsworth's "Strange Situation" laboratory procedure provided a classification system to define different attachment behaviours. The Strange Situation is designed to assess attachment quality based on how children try to restore a sense of security with their attachment figure when reunited after a brief separation (Grossman, 1995). In the Strange Situation, securely attached children played energetically in the presence of their mothers and wanted physical contact when their mother's returned (Bretherton, 1992). They felt secure enough to explore, while returning frequently to seek and receive comfort and nurture from their attachment figure (Byng-Hall, 2008). As they develop, the secure individual is able to maintain a calm state of mind while being challenged,

and is able to devote cognitive and emotional resources to challenges and important tasks (Schindler, Thomasius, Petersen, & Sack, 2009; Zeinali et al., 2011).

Insecure attachment styles are varied, and are linked to either normative abuse (subtle neglect, inconsistent responsiveness etc.) or overt abuse in an infant's early years (Walant, 1995). Ainsworth classified insecure attachment styles as ambivalent or avoidant. In the Strange Situation, insecure children would either not react to their mother's absence or return (avoidant), or they had an exaggerated, prolonged behavioural reaction to the experiment (ambivalent) (Bretherton, 1992). Mary Main added a fourth classification "disorganized/disoriented" attachment which refers to infants who are unable to coherently organize attachment behaviour (Liotti, 2004; Slade, 2008). Children with disorganized attachments experience contradictory urges to pursue and detach from attachment figures (Wallin, 2007).

Attachment and romantic relationships

Cindy Hazan and Phillip Shaver (1987) were the first to apply Bowlby's theory and Mary Ainsworth's three-category classification system of attachment (secure, anxious/ambivalent, and avoidant) to romantic dyadic relationships. They predicted, that like children and their parents, adult individuals would experience their romantic partners differently, depending on their attachment style (Hazan & Shaver, 1987). Their initial study confirmed this hypothesis (Hazan & Shaver, 1987). Following their work, a significant body of research has developed on how attachment both impacts and is impacted by the couple relationship (McCarthy & Maughan, 2010; Sbarra & Hazan, 2008; Simpson, 1990).

While Hazan and Shaver (1987) proposed that Ainsworth's classification system could be applied to romantic relationships, Bartholomew (1990) developed another classification system of adult attachment drawing from Bowlby's concept of *internal working models*. Bartholomew

(1990) argued there are two independent dimensions in adult attachment: image of the self, and image of the other. These two dimensions of attachment can be positive or negative (T. Li & Chan, 2012; Wood, Werner-Wilson, Parker, & Perry, 2012). Using these dimensions, Bartholomew proposed a four-group model of attachment styles: secure (positive view of self and others), dismissing (positive view of self, negative view of others), preoccupied (negative view of self, positive view of others), and fearful (negative view of self and negative view of others). While Bartholomew (1990), and Hazan and Shaver's (1987) systems have differences between how their attachment categories are divided and defined, both continue to be applied to couple attachment (Li & Chan, 2012).

The attachment process of romantic love is unlike parent-child attachments, as romantic attachment is reciprocal (Bowlby, 1988; Wittenborn, Faber, & Keiley, 2012; Zeifman & Hazan, 2008). In adult attachment, the nature of one's attachment needs shift, and are more related to closeness and intimacy (Mikulincer, Florian, Cowan, & Cowan, 2002). Partners are involved in both care taking and care seeking and the couple's relationship offers an opportunity for a revision of earlier attachment patterns.

Hazan and Shaver (1987) found that how an individual experienced their love relationship was predictive of attachment style. Attachment security is consistent with stable and affiliative couple relationships (Pistole, Roberts, & Chapman, 2010). Partners in secure couples are available, sensitive to attachment needs such as support, and work to maintain closeness in the relationship (Johnson & Zuccarini, 2010; Mikulincer et al., 2002; Mikulincer, Shaver, & Pereg, 2003; Pistole et al., 2010). Securely attached individuals are comfortable being interdependent, and communication between secure partners tends to be constructive and supportive (Domingue & Mollen, 2009; Hazan & Shaver, 1987). They are able to view their

partners as trustworthy and can, in turn, provide a "safe haven" for their partner. Relationships where even one partner is secure are seen to be more harmonious and less conflictual than relationships where both partners are insecure (Johnson & Zuccarini, 2010).

Unlike those who are securely attached, avoidant attached individuals in Hazan and Shaver's (1987) model and dismissing or fearfully attached individual's in Bartholomew's (1990) model struggle with managing feelings, self-disclosure, commitment, and emotional dependency (Brennan & Shaver, 1995). They unconsciously fear separation and abandonment. They minimize the importance of attachment-related experiences and are unlikely to accept their partners' faults (Hazan & Shaver, 1987; Main, 1995). They do not seek support from their partners, but instead rely on themselves in an effort to feel secure (Feeney, 2008; Schachner, Shaver, & Mikulincer, 2003). In times of distress these individuals are more likely to externally seek attachment, and may develop maladaptive coping skills. Fearful-avoidant attachment has been associated with conjugal violence, child maltreatment, and substance addictions (Schindler, Thomasius, Sack, Gemeinhardt, & Küstner, 2007; Simpson & Rholes, 2002).

Attachment theory and substance addictions

While a secure attachment style serves as a protective factor against developing substance addictions, insecure attachments are potential risk factors (Kassel, Wardle, & Roberts, 2007). Research has struggled to settle on linking substance addictions to a specific classification of insecure attachment, however recent studies have found fearful-avoidant attachment to be linked to substance addictions (Peter Fonagy et al., 1996; Piehler, Veronneau, & Dishion, 2012; Schindler et al., 2007). Schindler et al., (2009) argue that empirically, fearful avoidant attachment has the best established link with substance addictions. As children, fearful-avoidant individuals learned that caregiver comfort and regulation was unsafe or inconsistent. As a result,

they were not provided with coping strategies to manage emotional distress. As adults, interpersonal relationships are frightening and unpredictable, and as a result they may favour the immediate gratification of substance addictions (Brennan, Shaver, & Tobey, 1991; Lende & Smith, 2002). Substances become a form of self-medication in an attempt to cope with insecurity and emotional distress (Schindler et al., 2005). This coping strategy can also be used to help them manage their avoidance of interpersonal relationships.

Addiction has been referred to as an attachment disorder within the literature (Flores, 2004, 2006). Individuals, who struggle with developing intimacy and closeness with others, may seek out a method in which to self-soothe in times of distress. Particularly during the life-transition stage of adolescence, an individual may chose a substance as an attachment alternative to relationships, especially if they have had attachment ruptures in childhood (Höfler & Kooyman, 1996). The likelihood that an adolescent will develop an addiction increases with how insecure their attachment trajectory has been (Schindler et al., 2005). By adolescence (between the ages of 8 and 14), peers can become preferred for proximity seeking over parents (Zeifman & Hazan, 2008). Confiding and support in peer relationships can offer the same safe haven that children experienced with their parents (Zeifman & Hazan, 2008). Unfortunately, peer relationships can be risky for youth who are disengaged and not bonded with their families. These individuals are vulnerable to peers and often have early contact with illicit substances (Höfler & Kooyman, 1996; Schindler et al., 2005). As a result, they may develop a substance addiction.

Substance use can arguably become an attachment, which acts as both an obstacle and a substitute for interpersonal relationships (Flores, 2006). A drug can create the feeling of having a secure base and, within this framework; addictive behaviours can be understood as misguided

attempts at self-repair (Flores, 2004; Schindler et al., 2005). Through these efforts the addicted individual uses the substance as opposed to another person to regulate their distress. These individuals avoid engaging with others and instead maintain a direct focus on their substance of choice. Substance addiction then becomes both the solution and the consequence of an individual's impaired ability to develop and maintain healthy attachment to their partner.

Deficits in self-regulation

Self-regulation is a meta-cognitive strategy that enables individuals to make plans, choose between alternatives, control impulses, regulate social behaviour across multiple domains such as affect, emotion and cognition and can also be used to understand addiction (Heatherton & Wagner, 2011; Vaughn, Bost, & Van Ijzendoorn, 2008; Zeinali et al., 2011). It also refers to the manner in which an individual alters or maintains their behaviour, in the absence of immediate external support (Kanfer & Kaholy, 1972).

Infants are not born with a self-regulatory system (Fitton, 2012). Self-regulatory functioning develops through an individual's attachment to their caregiver (Dales & Jerry, 2008). Parents or primary caregivers who respond sensitively to their child's distress help foster secure relationships that continue to benefit children as they mature and become more capable of their own self-regulation (Bowlby, 1979; Thompson, 2008). From birth, a baby responds to contingent mirroring from their parents. Contingent mirroring is when the affect of the parent corresponds to the affect of the child in order to give, "back to the baby the baby's own self" (Winnicott, 1971, p.188). A responsive attachment figure will regulate and reassure the baby, whereas absent or inconsistent responsiveness is an insecure attachment for a child (Wallin, 2007).

Once a child is confident that their caregiver will help them regulate, they develop confidence in their own capacities for regulation (Sroufe, 2011). A child, who is secure in their

attachment to their caregiver, is likely to learn effective self-regulation skills. If an individual has positive self-regulation skills, they are able to be goal directed and delay short-term gratification in order to meet longer-term goals (Zeinali et al., 2011). They are also more likely to seek external support when they need to discuss problems (Belsky, 2002). An insecure attachment style is linked with low self-regulatory skills. For example, children with disorganized or avoidant attachments are unable to regulate their own arousal nor are they able to get their caregiver's assistance in regulating, and as a result, may mentally isolate or dissociate (Deklyen & Greenberg, 2008).

Self-regulation and addictions

Insecure attachment is associated with low self-regulatory skills. Building on the idea of attachment and addictions, self-regulation directly impacts risk of substance addiction. Individuals with greater levels of self-regulation are better able to resist abusing substances (Piehler et al., 2012; Quinn & Fromme, 2010). Unlike those with poor self-regulation, they have the cognitive resources to be resilient in times of stress. Individuals with poor self-regulation however, are less able to control their substance use, and attempt to regulate mood states (in particular, negative moods) through the use of substances (Hull & Slone, 2004; Quinn & Fromme, 2010; Thorberg & Lyvers, 2006). Individuals who continuously employ substance use as a negative mood regulating method are more likely to develop drug and alcohol related problems than those who seek out more adaptive, external support. While self-regulation may be the intended goal of continued substance use, substance addiction can develop.

Substance addictions are common in insecurely attached individuals because the substance is used as a method of self-regulation (McNally et al., 2003). For example, McNally et al., (2003) found that a negative self-view was predictive of a greater likelihood of drinking to

cope. From their study, the more an individual was unable to regulate negative affect in their interpersonal relationships, the more likely they were to turn to substances to cope (McNally et al., 2003). Insecurities can enact defenses and feelings of being threatened, which can then propel ineffective responses to stress. Substance abuse becomes a deactivating coping tool that allows individuals to manage insecurity and regulate their interpersonal relationships.

Drawing on ideas of self-regulation and attachment, in the 1970's Edward Khantzian and David Duncan co-founded the theory of addiction as a self-medicating process, naming it the "Self-Medication Hypothesis". According to this conceptualization, addictive vulnerability is a result of exposure to drugs, in combination with the inability to tolerate or understand one's own feelings (Khantzian, 1997). Within this hypothesis, addiction is not about pleasure seeking, but instead, seeking comfort and contact. Addiction is a self-regulation disorder and individuals self-medicate in an effort to manage their self-regulation issues. Substances relieve psychological suffering and compensate for an alienated sense of self (Khantzian, 2011). Because these individuals have an inability to recognize and regulate their own feelings and sense of self, they act as though they do not need close interpersonal relationships (Khantzian, 2012). This disengagement and alienation from self and others produces immense distress and creates a further reliance on addictive drugs (Khantzian, 2011).

Self-regulatory capacities are directly impacted by an individual's attachment security. Overt or covert traumas in early attachment relationships can influence how an individual is able to form social relationships and interact with romantic partners later in life. If an individual is insecure, it is unlikely that they will use close relationships to self-regulate in times of distress. Instead, many individuals will use substance as a means of self-regulation, which can create a problematic attachment relationship to a particular drug (Flores, 2004). Using a substance as a

means of self-regulation will also impair an individual's ability to perspective take in their interpersonal relationships.

Current research on couple therapy and addiction

Behavioural Couples Therapy

Behavioural interventions share the approach that psychological disorders or distress are linked to and maintained by cognitive factors (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012). Pioneered by Beck (1970) and Ellis (1962) behavioural therapies aim to change behaviours and maladaptive cognitions that contribute to problems. Timothy O'Farrell, William Fals-Stewart and colleagues have conducted over three decades of research on Behavioural Couples Therapy in the context of drug and alcohol addiction. BCT theorists posit that family members' interactions with the person abusing substances can reinforce their substance using behaviour (Lam, Fals-Stewart, & Kelley, 2009). BCT developed out of the Harvard Counselling for Alcoholic Marriages Project (Project CALM). CALM was developed in the 1980's as one of the first manualized behavioural treatment models for couples treatment and alcohol (Ruff et al., 2010). Within the CALM project, the couple completes a daily "trust discussion," also known as a "sobriety contract" or "recovery contract" where the individual with the substance abuse issue contracts to stay abstinent that day (O'Farrell & Fals-Stewart, 2008). The CALM BCT protocol was created initially for use in conjunction with individual treatment; however O'Farrell and Schein (2011) have since argued that BCT can be used as a stand-alone model.

BCT has two overarching components: assessing and improving behavioural interactions between the substance dependent person and their partner, and improving communication skills within the couple (Copello et al., 2006). This approach posits if couples are happier and improve their communication, there will be a lower chance of relapse (O'Farrell & Clements, 2012).

From this perspective, relationship functioning and substance dependence are reciprocal (Powers, Vedel, & Emmelkamp, 2008). The manualized model typically involves 12-20 weekly couple sessions in conjunction with individual treatment (Ruff et al., 2010). Throughout the 12 weeks, the focus of BCT shifts from recovery and abstinence to the couple relationship (O'Farrell & Fals-Stewart, 2008). The couple is encouraged to avoid discussion of past substance abuse and fears about future substance use outside of therapy sessions (O'Farrell & Schein, 2011).

Alcohol Behavioural Couple Therapy (ABCT) Program

Elizabeth Epstein, Barbara McCrady and their research team developed a variation of BCT, the Alcohol Behavioural Couple Therapy (ABCT) program. Integrating social learning theory with systemic models, this model assumes problematic drinking occurs within an interactional context (McCrady, 2012). The structured program uses "alcohol-focused spouse involvement" where the non-addicted spouse is taught skills to deal with alcohol-related situations (Epstein & McCrady, 1998). The spouse becomes a secondary therapist or coach for the addicted partner, helping them through the process of behavioural change (Walitzer & Dermen, 2004). Like the BCT model, ABCT uses cognitive-behavioural elements to help clients stop drinking and maintain abstinence (McCrady, Epstein, & Hirsch, 1999). ABCT also uses behavioural contracts between intimate partners to support abstinence and in some cases, the use of medication (e.g. Antabuse) (Velleman, 2006). ABCT has since been expanded to include treatment for couples where one partner has a drug addiction.

Empirical Studies

Behavioural Couples Therapy comprises the vast majority of empirical studies on couple therapy in the context of addiction. BCT is arguably the relational approach to treating substance

dependence most based on evidence (O'Farrell & Clements, 2012; Ruff et al., 2010; Shadish & Baldwin, 2005; Stanton & Shadish, 1997). This theoretical model has positive results with both heterosexual couples and same-sex couples. The action of BCT appears to be the ability to enhance satisfaction within the couple relationship, which, in turn, leads to a reduction in substance use (Fals-Stewart, Klostermann, & Yates, 2006; Powers et al., 2008). Treatment effects of BCT are promising, however there is evidence they dissipate over time (Fletcher, 2013).

BCT targets behaviours in couple relationships and does not address interpersonal factors that could contribute to the etiology of addictive disorders (eg. attachment, trauma, etc.). This focus may explain why the positive effects of BCT are not always longstanding. In a meta-analysis of BCT studies, Powers et al., (2008) also noted that the patterns of results varied as a function of time. A meta-analysis of thirty randomized control BCT studies indicated that an average couple receiving BCT has better outcomes than those couples who receive no treatment (Shadish & Baldwin, 2005). Thus, couples treated together are seen to do better at least when measured at short-term follow-up) than couples treated separately. However, it is not yet known if another model could produce positive effects (improved couple relationship, lowered substance use) that are sustained long-term.

Emotionally Focused Therapy

Landau-North, Johnson and Dalgleish (2011) provided a theoretical extension of Emotionally Focused Therapy for couples with addiction, which, they argue, warrants testing. Separate from this extension, EFT in the context of addiction was also piloted as part of a residential treatment aftercare program in Atlanta, Georgia (Bassett, 2015). Emotionally Focused Couple Therapy (EFT) is the most empirically validated and widely used attachment-informed

therapy for couples and one of two extensively empirically validated couple therapies (Johnson, 2003; Johnson, Hunsley, Greenberg, & Schindler, 1999). EFT was first described in the literature in 1985 and was developed by Susan Johnson and Leslie Greenberg (Johnson & Greenberg, 1985). EFT was originally based on an experiential, humanistic and family systems approach to therapy (Johnson & Whiffen, 1999). EFT developed during the same period as Hazan and Shaver's (1987) research on adult attachment theory. Through clinical observation, Greenberg and Johnson began to consider the role of attachment within couple relationships and started integrating attachment concepts into their model (Johnson, 2003).

EFT is now considered an "attachment-oriented" model and Susan Johnson states that EFT is attachment theory's "clinical arm" (Johnson, 2009; Johnson & Wittenborn, 2012; Sprenkle, 2012). EFT therapists today conceptualize patterns of distress using an attachment framework (Halchuk, Makinen, & Johnson, 2010; Johnson, 2009). More specifically, couple problems are understood in terms of attachment insecurity and separation distress (Johnson, 2003; Johnson & Whiffen, 1999). From this perspective, couple problems cannot be addressed without acknowledging the need for safe emotional engagement (a secure base) within the relationship (Johnson, 2003).

The theoretical extension of EFT posits that addiction is an attachment issue, arguing therapist should help couples create healthy dependency within their relationships as an alternative to addictive regulation strategies (Landau-North et al., 2011). They understand that substance use behaviours are inevitably connected to the attachment relationships between romantic partners. Understanding addiction as an attachment issue has been well supported elsewhere in the literature (Brennan & Shaver, 1995; Flores, 2006; Thorberg et al., 2011).

Other therapeutic models

There are few studies on therapeutic models other than BCT that treat couples in the context of addiction. One existing model is brief couples therapy that uses integrated solution-focused, cognitive behavioural, and family systems techniques (Li, Armstrong, Chaim, & Shenfeld, 2007). This model focuses on goal setting and stages of change. Unlike BCT this is a harm reduction model. A randomized control trial of this model compared brief couples therapy to a group couple therapy model. In this study 20 of the 27 couples recruited completed treatment. At the six-month follow up there was significant improvement for both groups, but comparatively there were no significant differences between groups. Individual and group couple therapy appeared to be equally effective. No other studies were located that used brief couple therapy (individual or group).

The other non-BCT couples intervention that has been studied is Systemic Couples Therapy (SCT). SCT is an integrated model that used structural, strategic, behavioural, and Bowenian concepts of family therapy. It was developed to treat females who have a substance addiction and their partners, and focuses on patterns and themes from the substance-dependent's family of origin (Nelson, McCollum, Wetchler, Trepper, & Lewis, 1996). The goal of this therapy is to help the addicted partner improve their primary relationship and in turn, foster their ability to meet treatment goals. There are multiple phases within 12-week SCT (assessment, goal setting, consolidation, etc.) however it is less structured than BCT (Nelson et al., 1996).

McCollum, Lewis, Nelson, Trepper, and Wetchler (2003) conducted a study examining the effectiveness of SCT in the context of female drug dependent clients and their partners. Participants were randomized into three treatment conditions: Systemic Couple Therapy (SCT), Systemic Individual Therapy (SIT) and standard treatment as usual (TAU). While therapy only

occurs with the individual in SIT, like SCT, the focus of the therapy is altering negative couple patterns. Results were women in SIT and SCT did better than the TAU group at six months and one year post-treatment (McCollum et al., 2003). The results of this study suggested the potential benefit of a systemic focus with this particular population; however replication is needed, as this was the only study found using this model in the context of addiction.

Rationale for the current study: EFT with addictions

There is a substantial body of research that has found benefit in the inclusion of couples in the context of addiction treatment. Drug abuse is initiated and maintained within a family context (Rowe, 2012). Recovering from an addiction is not an individual process; rather it requires both intra and interpersonal restoration (Finzi-Dottan, Cohen, Iwaniec, Yaffa-Sapir, & Weizman, 2003). The inclusion of romantic partners in treatment can both assist an individual in attending addiction treatment, while also providing an opportunity to address issues in the couple that may serve to maintain or exacerbate the addictive disorder. Furthermore, the inclusion of romantic partners provides an important space to address the non-addicted partner's own mental health concerns or challenges.

A missing link in substance dependence intervention is a strong link between the development of the disorder and the treatment approach. For this study, attachment and the resulting capacity to self-regulate will be considered in the application of a proposed adaptation to EFT for addiction. Attachment and self-regulation were chosen because they are developmental capacities that are developed in a relational context (Bowlby, 1979; Hull & Slone, 2004). Additionally, unlike the other factors listed (social and physical environment, stressors, etc.), these capacities are amenable to change in response to intervention (Allen, Fonagy, & Bateman, 2008; Johnson & Greenman, 2006).

There are clear links between attachment style, self-regulation, and substance addictions. Existing addiction treatment models do not address the relationships among these concepts. Research on attachment theory has outlined individual differences in attachment needs and emotions (Johnson & Zuccarini, 2010). The predominant insecure attachment styles of individuals with substance addictions are dismissing or avoidant (Kassel et al., 2007). Insecurely attached individuals do not know how to seek effective support when they are distressed (Wittenborn et al., 2012). They are unable to self-regulate through their close relationships and may instead use substances as a means of regulation (Padykula & Conklin, 2010). An insecure attachment makes it difficult and even threatening for individuals with an addiction to read their partner's nonverbal cues or consider their emotional mind (Savov & Atanassov, 2013).

Addiction perpetuates a lack of responsiveness from and accessibility to one's romantic partner. Individuals living with an addiction tend to isolate themselves from others, despite longing for connection. While an individual may use substances in isolation, their actions impact their ability to relate to their partner. Mutual support within a relationship can act as the antidote to addiction, working to create comfortable and positive emotional bonds within the couple relationship. Developing skills to maintain health regulatory attachments and deal with relationship conflicts is particularly important for individuals with addiction (Flores, 2006). While dependency has been culturally pathologized (Walant, 1995), care and interdependency within the couple can create a vital space for couple recovery from addiction.

Existing couple therapy treatments and research in the context of addiction are primarily behavioural interventions. While research demonstrated positive results using these models, most clients entering addiction treatment return to addiction treatment multiple times (Office of Applied Studies, 2000). For example, of clients admitted to the U.S. public treatment system in

1999, 60% were re-entering treatment; 23% for the second time, 13% for the third time, 7% for the fourth time, 4% for the fifth time, and 13% for the sixth or more time (Office of Applied Studies, 2000). In particular, BCT for the treatment of substance addiction is seen to not sustain treatment effects over time (Fletcher, 2013). Behavioural models may not adequately address underlying mechanisms through which individuals become addicted to substances and couples become distressed. Other treatment options for clients merit consideration and research.

There is a continued need for effective and time limited treatments for individuals with substance addictions and their romantic partners. Treatment including significant others is seen to improve treatment retention and outcome (couple satisfaction and abstinence) (McKay & Hiller-Sturmhoefel, 2011). Interestingly, researchers have found an individual's relational and social stability is more predictive of the longer-term sustainability of treatment gains, than the severity or chronicity of their addictive disease (e.g. Vaillant, 1988). More studies that focus on strengthening a couple's relational functioning in the context of addiction are needed. Current models of couple therapy in the context of addiction fail to consider the implications of attachment, trauma, and self-regulation on the experience of couples where one partner has a substance addiction. Treatment that does not consider the underlying contributors and developmental processes inherent in the presenting problem may fail to adequately address it (Kazdin, 2007). While EFT may not be a suitable approach for some couples, offering an experiential, attachment-focused and systemic treatment could provide a potential treatment model for couples with an addiction in their relationship.

EFT is the only current treatment model that directly addresses attachment. Attachment is an underlying mechanism of the development of the capacity to self-regulate; both are factors associated with the development of addictions and are amenable to change through therapy

(Fonagy, 2008; Gergely & Unoka, 2008). While grounded in humanistic existential theory, EFT integrates attachment concepts within its interventions and has demonstrated success with diverse populations including: couples living with cancer, sexual abuse survivors, couples with chronically ill children and couples experiencing low sexual desire (Baucom, Shoham, Mueser, Dauieuto, & Stickle, 1998; Halchuk et al., 2010; MacIntosh & Johnson, 2008). Specifically, research suggests that EFT is efficacious in creating secure attachments in distressed couples (Bradley & Furrow, 2004; Clothier, Manion, Gordon-Walker, & Johnson, 2001). Baucom et al., (1998) conducted a meta-analysis of empirically supported couple and family models and found that in the three studies reviewed EFT was superior to wait list control groups. EFT was also equally effective or better than the comparison groups of Behavioural Couples Therapy and a version of EFT that included a communication skills portion (Baucom et al., 1998). To this writer's knowledge, there is only one other outcome study looking at EFT in the context of addiction (Bassett, 2016). EFT appears to be a relevant possibility for addiction treatment. EFT suggests an impact on attachment, which may lead to changes in self-regulation as a result of the developmental processes that link the development of secure attachment to the eventual development of self-regulation capacities. EFT could provide a beneficial therapeutic context for couples to address and alter attachment, and self-regulation capacities and this deserves more rigorous testing.

Current Study

There is an increased understanding of the devastating impact that addiction can have on developing strong and healthy relationships in a couple (Nelson & Sullivan, 2007). There is also evidence that strong interpersonal relationships may support recovery for an individual with a substance addiction (Stanton & Shadish, 1997). The purpose of this study was to evaluate the

EFT extension as adapted for addictions (Landau-North et al., 2011) in working with couples where one partner has a substance addiction. A replicated case study design was used with four cases. The adapted EFT model was implemented and quantitative analyses explored the impact of the intervention on attachment oriented behaviours, and self-regulatory capacities. Additionally, I explored the impact of the intervention on couple satisfaction over the course of treatment and the process of change through a qualitative thematic process analysis. Results from this study provide important information on the use of EFT in this context, and lay the foundation for larger randomized intervention studies in the future.

EFT Model

EFT is focused on a couple's emotional experiences and posits that emotion is a primary attachment behaviour that organizes how an individual experiences self and other in their romantic relationship (Johnson et al., 1999). EFT is focused on the "here and now" responses between partners, and uses enactments to encourage more adaptive ways of relating (J.L. Furrow & Bradley, 2011; Johnson, 2005). Enactments restructure or "act out" problematic interactions within the therapy session to help couples interact in a new way (Denton, Johnson, & Burleson, 2009).

The EFT therapist asks partners to share attachment-related emotions, needs, and fears with one another to create new ways of communicating that will foster secure attachment (Johnson & Whiffen, 1999). They work to slow down the couple's interactions to facilitate connection and expand experiences of relating and communicating with one another (Johnson, 2009). If there is an absence of responsiveness from one's partner, unmet needs and damaging interactions can occur (Johnson, 2011). According to the theory, the EFT couple therapist provides a secure base for change to occur within the couple and helps partners begin to regulate

their reactive emotions (Johnson, 2003). The therapist does this by creating a respectful and collaborative alliance with the couple (Johnson, 2003).

The therapist's role in EFT is to act as a "process consultant" for the couple. The therapist is responsive to each partner's needs, and acts as both the expert and a collaborator. In this way, the therapist works to facilitate adjustments in attachment interactions and support the emotions that occur within these interactions (J.L. Furrow & Bradley, 2011). In order to create safety for emotional exploration, a secure therapeutic alliance with clients is imperative in EFT. EFT uses three stages of change:

1. De-escalation of problem interaction cycles.
2. Restructuring interactional patterns to facilitate needs and wants.
3. Consolidation, new solutions are applied to old problems, and new positions and attachment behaviours are integrated (J.L. Furrow & Bradley, 2011).

These three stages are built upon using nine steps:

Stage 1	**1.** Create an alliance and delineate conflict issues in the struggle
	2. Identify the negative interactional cycle
	3. Access unacknowledged feelings and attachment needs
	4. Reframe problem in terms of underlying emotions and needs
Stage 2	
	5. Promote identification with disowned needs and aspects of self
	6. Promote acceptance of partner's experience
	7. Facilitate the expression of unmet needs and wants
Stage 3	**8.** Facilitate the emergence of new solutions
	9. Consolidate new positions (Johnson, 2004).

EFT and addictions

In 2011, Landau-North, Johnson and Dalgleish provided a theoretical extension of EFT for couples with addiction. They view addiction as an attachment issue, arguing therapists should help couples create healthy dependency within their relationships as an alternative to addictive regulation strategies (Landau-North et al., 2011). They argue substance use behaviours are connected to the attachment relationship between romantic partners. Given this attachment framework, these theorists highlight the pace of EFT may need to be much slower to be attentive to the inner experiences of both partners (anxious and/or avoidant attachment) (Landau-North et al., 2011). As a result, EFT with couples in the context of addiction may need to be longer than the typical 15-20 sessions recommended in traditional EFT. Landau-North et al., (2011) outline specific additions to be made to the traditional EFT model when treating a couple in the context of addiction.

Intake

Following the guidelines of this theoretical extension, the individual with the addiction must acknowledge they have a problem and must have already have taken active steps to address the addiction before beginning couple therapy (Landau-North et al., 2011). Similarly, the "level and chronicity" of the addiction needs to be examined to ensure the feasibility of couple therapy. The researchers interpreted this to mean couples were well enough to attend therapy weekly. In this study, all four participants with substance addictions had completed a treatment program, and had sustained a period of abstinence (three months) before starting treatment. A rigorous intake screening was completed to ensure that couple therapy was appropriate for each couple. As stipulated in the extension, the therapist was vigilant about assessing for violence, anger problems, depression, and self-harm (Landau-North et al., 2011).

Stage One

In Stage One, the EFT therapist identified the compulsive responses and patterns of the substance addiction as a key part of the problem interaction cycle. Landau-North et al. (2011) posit addiction is both a cause and effect of relationship distress. Using their extension, they suggested that addiction be framed as part of the couple's negative cycle, and be discussed as something the couple can defeat together. Before beginning Stage Two, the therapist must make sure the addiction is being contained (determined by requesting participants to self-report) (Landau-North et al., 2011).

Stage Two

In Stage Two, the therapist explores and distils deeper emotions with the couple, looking for ways to create more open and responsive communication (Landau-North et al., 2011). Primary emotions that are linked to addictive responses are explored at this point, and contextualized as attachment needs, fears, and expectations within the individual's model of self and other (Landau-North et al., 2011). Sadness, fear of rejection, abandonment, shame, and feelings of inadequacy are explored and contextualized as unmet attachment needs that contribute to the addiction (Landau-North et al., 2011). Addictive responses can be framed as attempted solutions to "emotional starvation and despair" and attempts at self-regulation (Landau-North et al., 2011, p.203).

Stage Two should also involve creating positive interactions using enactments (Landau-North et al., 2011). Reaching out to one another in the couple is framed as an alternative to addictive behaviour (Landau-North et al., 2011). Loving connection between the couple is then structured as a corrective alternative to self-regulating through addictive strategies (substance use).

Stage Three

In the consolidation stage of this EFT extension, partners narrate a story of the distress in their relationship, and how they were able to repair it. Landau-North et al. (2011) recommend the couple be encouraged to create a story about the addiction and its impact on the couple relationship, including how problems connected to the addiction still emerge and how they are now able to deal with these problems having explored them in therapy. During this stage the therapist will help the couple develop a relapse prevention plan and will evaluate with them how to notice triggers and emotional states that may contribute to relapse (Landau-North et al., 2011).

EFT: Limitations

It is necessary to acknowledge potential limits to using EFT when engaging with couples where there is a substance addiction. EFT assumes that couples are attending therapy with a commitment to changing their relationship and to work on mutual goals (J.L. Furrow & Bradley, 2011). This assumption can be difficult to meet given the potential instability of individuals living with addiction. In practice, a rigorous intake procedure was needed to determine readiness for a treatment as specific as EFT. If a person had not already sought out treatment for the substance addiction, the emotionally activating application of EFT would be an inappropriate fit. EFT is also an inappropriate treatment in the case of violent relationships.

Methodology

Research Strategy: Replication Case Study, Multiple Cases

This case study aimed to provide an exploratory perspective on EFT in the context of couples with substance addictions. A case study is a common research method used often in psychology and social work to contribute to knowledge of individual or group phenomena (Yin, 2009) Exploratory case study research can aid in theory building (Yin, 2009), which was a good

fit for this research which aimed to evaluate an extension of a treatment model. The particular case study methodology chosen was a multiple case study using replication of the EFT theoretical extension across four cases (Yin, 2009). To complete a replicated case study, two or three cases are recommended (Yin, 2009). This design was chosen to closely examine the complexities of couples within EFT and to provide intricate details of the therapy process. As it had not yet been tested, the EFT extension had no clear set of outcomes, so the study was replicated across four couples to allow for comparison. This case study integrated mixed methods including a descriptive assessment of quantitative measures, and a thematic analysis of qualitative data. Without this preliminary case based research, future empirical studies will not have a base upon which to build.

Four couples were recruited for this study. Baseline demographic data were gathered from each of the four couples. A quantitative assessment was carried out, before, throughout, and after treatment using psychometrically validated measures (Kazdin, 2011). EFT was introduced with one couple at baseline. In order to stagger the baseline, the second couple remained at baseline until the first couple reached Stage Two of EFT. The second couple then began treatment, and the third couple began treatment when the second couple reached Stage Two. Finally, the forth and final couple began treatment when the third couple reached Stage Two. Treatment was terminated between 18-26 sessions (the standard number of sessions for EFT is 15-20 sessions). Couples waited at baseline between three and six weeks depending on when they self-referred for the study. Because this was an exploratory study, the exact number of sessions each couple required was decided in conjunction with the therapist and the couple.

Participant Recruitment

Couples for this study were recruited through the outpatient department of an addiction rehabilitation centre in Montreal. Posters and advertisements explained that a research project examining the effectiveness of EFT with couples where one partner has a substance addiction was underway and that selected participants could participate in couple therapy free of charge. All prospective participants were screened using the following screening procedure. Couples needed to meet the following inclusion criteria:

1) As outlined in the proposed model by Landau-North et al, (2011) the partner with substance addiction needed to be currently involved in, or have sought treatment for their substance addiction. For the purposes of replication in this study, the eight week Head Start group therapy program at the Centre de Réadaptation en Dépendance Foster had to be completed by the substance addicted individual before beginning couple therapy.
2) The couple must have been living together for at least one year.
3) Both partners had to be interested in attending weekly therapy for a period of up to six months.
4) Couples needed to consent to have their sessions videotaped or audiotaped.
5) No self-reported physical violence in the couple relationship.
6) No self-reported current suicidal ideation.

Participants

Five couples expressed interest in the study and completed the intake assessment. Four couples met the criteria for inclusion. Each partner with a self-reported addiction had attended treatment at the referring outpatient treatment centre. Three participants had also attended inpatient treatment through the same program. All four participants who had attended addiction treatment had primarily been exposed to cognitive behavioural therapy and motivational

interviewing. Prior to the study, none of the couples had been treated using EFT. Given the contextual nature of the replicated case study approach, each couple will be described here. Participants will be referred to as Couple A, Couple B, Couple C, and Couple D[1].

Couple A had been together thirteen years; Andre (38), a tradesman reported that he had been addicted to cocaine for twenty years. He did not graduate from high school and was incarcerated in his twenties for drug trafficking. Growing up, his father was an alcoholic and he did not remember at what age he started his own substance use. Antonia (33) worked in healthcare and met Andre shortly after immigrating to Canada from a Middle Eastern country. The couple reported that their main relationship issues were, from Andre's perspective, "communication and understanding," and from Antonia's perspective, "responsibility, being committed, prioritizing, and being organized". When therapy started, Andre had not used substances in three months. Throughout treatment Andre continued to attend the peer support group Alcoholic's Anonymous (AA). Couple A attended therapy for 18 sessions.

Couple B had been together thirty-five years. Bridget (53) worked full time in administration. Bob (56) reported he had been addicted to cocaine and alcohol for seven years, however Bridget stated that addiction had been an "on again off again" issue for Bob throughout much of their marriage. At the time of the study, Bob worked full time in information technology. Both of Bob's parents were alcoholics and he remembered having his first drink at the age of 10. The couple had attended therapy both together and individually on and off for the past few years. At the time of starting therapy, Bob was three months sober from cocaine and alcohol and was also attending a peer support group regularly (AA). Couple B attended therapy for 25 sessions.

[1] *All participant names have been changed to pseudonyms and identifying details have been altered to preserve anonymity.*

Couple C had been together for three and a half years. Claire (age 57) worked in education, and Carlos (age 64) worked in technology. Both had been married previously. Claire's marriage had ended after thirty years, and she cited infidelity as one of the reasons for the dissolution of the relationship. Carlos was also married before, with his marriage ending after twenty-eight years. He also stated that his partner's infidelities were a main reason for the divorce. Claire grew up with an alcoholic father. Carlos struggled with his alcohol use for 50 years, but only began seeking treatment in the past few years after starting his relationship with Claire. The couple identified trust and intimacy as their main relationship issues. Both partners attended therapy before participating in the study; after a relapse that occurred during treatment, Carlos started attending a peer support group. Couple C attended therapy for 26 sessions.

Couple D had been together 33 years. Donna (age 55) was an entrepreneur, and Derek (62) was retired. Derek reported that he had been addicted to alcohol for 25 years, and Donna could not recall a time when her husband's alcoholism did not impact their relationship. Derek and Donna had both attended individual therapy for the past three months, and Derek had recently finished an inpatient treatment program. The couple described their main issues as "communication" and "understanding each other's needs". While in therapy, Derek attended a recovery maintenance group and occasional peer support meetings. Couple D attended therapy for 20 sessions.

Therapists and Setting

In order to ensure replication in this exploratory study, I was the therapist for the four cases. I am a PhD candidate in Social Work and have completed an AAMFT accredited couple and family postgraduate diploma. I have ten years experience working with couples, families, and individuals, and seven years experience working in addictions. I received training in EFT

from Dr. Heather MacIntosh a couple therapy researcher who was trained by Dr. Sue Johnson. Therapy sessions were conducted in a private office at McGill University. All sessions in the study were audiotaped and Dr. Heather MacIntosh supervised the therapy weekly. The EFT manualized treatment model was followed and implementation checks were performed in order to ensure treatment fidelity. The supervisor reviewed segments of the tape to make sure that the treatment model was implemented correctly.

Data Collection

The goal of this case study was to explore the extension of EFT to couples with addiction through intense analyses of four clinical cases and to understand the process of the EFT model within this particular context. In particular, outcomes in attachment, self-regulation, couple satisfaction, and trauma symptoms were measured. Data were gathered at specifically identified intervals in a systematic fashion. Self-report measures were given before beginning EFT and again when EFT was terminated. These measures included the *Dyadic Adjustment Scale (DAS),* (Spanier, 1976), *The Experiences in Close Relationships-Relationship Specific Scale (ECR-RS)* (Fraley, Heffernan, Vicary, & Brumbaugh, 2011), *Difficulties in Emotion Regulation Scale* (Gratz & Roemer, 2004), and the *Trauma Symptom Inventory 2nd Edition* (Briere, 2010*).* Participants were also asked to complete a short questionnaire developed by Sue Johnson entitled "*Understanding Your Negative Cycle*" at the end of the fifth session (Johnson, 2004), and lastly couples were asked to complete a *Post-session Resolution Questionnaire* at the end of each therapy session (Orlinsky & Howard, 1975). These measures will be explained in the following section. All sessions in the proposed study were audiotaped. It was essential that measures be clear, numerous, objective, psychometrically valid, sensitive and collected systematically from

baseline. Measures were chosen for their psychometric properties and for their validity in measuring the concepts outlined.

Self-report Measures

Self-report measures were used to measure four variables within this study: Relationship satisfaction within the couple, attachment style, self-regulation, and trauma. Self-report measures offered a direct assessment of the participant (Kazdin, 2003). Couples also completed a demographic questionnaire designed to inquire about the basic demographics of the participants. Within this questionnaire couples were asked to disclose their main motivations or presenting problems for seeking couple therapy. Participants were also asked about any known diagnoses, mental health concerns, and any medication they may be taking that could interfere with their ability to attend therapy.

Couple Satisfaction was measured using the *Dyadic Adjustment Scale* (DAS) (Spanier, 1976). The DAS is the most widely used self-report measure of couple satisfaction and is seen to have consistent psychometric properties (Carey, Spector, Lantinga, & Krauss, 1993; Graham, Liu, & Jeziorski, 2006). The DAS is a 32-item scale that asks the participant questions about agreement and disagreement with their partner on a 6-point Likert scale with a range from "Always Agree" to "Always Disagree". Scores range from 0-151, with higher scores indicating higher dyadic adjustment. These scores distinguish between distressed and non-distressed partners with cut-off scores ranging between 92 and 107 (Graham et al., 2006; Spanier, 1976). The author reports a reliability of .96 (Cronbach's alpha) (Spanier, 1976).

Attachment was measured using the *Experiences in Close Relationships-Relationship Specific* (ECR-RS) Scale. The ECR-RS is a 9-item self-report measure, which assesses attachment in 4 domains: relationships with romantic partners, friends, father, and mother (Fraley et al., 2006).

Scoring provides information on both relationship-specific attachment and general attachment. ECR-RS scores have good reliability of .86 (Cronbach's alpha) (Dalgleish, Johnson, Burgess Moser, Lafontaine, Wiebe & Tasca, 2015).

Self-regulation was measured using the *Difficulties in Emotion Regulation Scale* (DERS) (Gratz & Roemer, 2004). The DERS is a 36-item self-report measure that measures emotion regulation and dysregulation. Participants use a 5 item Likert Scale to rate how often statements apply to them. Subscales assess six dimensions of emotion regulation difficulties. This measure has average to strong reliability (.93 internal consistency, .80 cronbach's alpha for subscales) (Gratz & Roemer, 2004).

Trauma was measured in each partner using the Trauma Symptom Inventory-2nd Edition (TSI-2) (Briere, 2010) which evolved from the Trauma Symptom Inventory (TSI) (Briere, 1995). The TSI-2 is a 136-item self-report that measures posttraumatic stress and other trauma related symptoms. Higher scores indicate greater distress. Additionally, the TSI-2 assessed attachment, suicidality, and somatic preoccupations. The TSI is a widely used assessment of traumatic symptoms and the author reports a reliability of .87 (Cronbach's alpha) (Briere et al., 1995). While the 2nd version of the TSI is still relatively new, it has demonstrated good reliability and validity in preliminary studies (Runtz, Godbout, Eadie, & Briere, 2008).

In-session Change was measured using the *Post-Session Resolution Questionnaire (PSRQ)* (Orlinsky & Howard, 1975). This is a 4-item measure used to evaluate in-session change and demarcate the best sessions in a therapy treatment. This instrument has been used in other studies to identify best sessions (e.g. Makinen & Johnson, 2006). Sue Johnson's (2004) questionnaire "*Understanding Your Negative Cycle*" was also provided to participants at the end of session five to gain more data on each participant's understanding of therapeutic process. The initial

questionnaire package and post questionnaire package each took about one hour to complete. Questionnaires provided after each session took less than five minutes to complete.

Research Procedures

Ethics approval was provided by the McGill Ethics Review Board and the Comité d'Ethique de la Recherche en Dépendance (CÉRD) prior to data collection. Each participant was provided with an informed consent form that emphasized that participation in the study was voluntary and that they may withdraw at any time. Confidentiality of participants was protected and couples were assigned numbers. All research data is stored in a locked cabinet in a locked room, and any electronic data is password protected.

Data Analysis

A thematic analysis was used to consider the ways in which EFT as applied to an addiction population may differ from the standardized treatment manual. A thematic analysis is a method used to identify, analyse and track patterns (themes) within the dataset (Braun & Clarke, 2006). Both theoretical and inductive coding were used (Braun & Clarke, 2006; Thomas, 2006). All sessions were analyzed and the processes in the sessions compared to the treatment manual proposed by Landau North et al. (2011) and the original EFT manual were considered. These theoretical factors were coded, including the stages and steps of EFT in each session and specific EFT interventions. These themes were compared with both the theoretical extension and the normative EFT treatment model in terms of timing of events, and client response to events. Inductive themes were also coded (Braun & Clarke, 2006), which were the data driven themes that emerged in the therapeutic process that could not be predicted.

Self-report measures were scored and clinically significant change was defined as an improvement or decline of one standard deviation (SD), or a change that led to movement out of

the clinical range of a measure (Jacobson & Truax, 1991). As the sample was very small, no quantitative analyses were conducted. However, these measures were considered in terms of clinical change in each couple from baseline and assessed for themes and factors that should be considered for future research.

Potential Limitations

It is important to note the potential limitations of this study. As a replicated case study, the sample size is very small making results impossible to generalize. Case studies are further limited by their highly contextual nature. There were also limitations in having the first author as the provider of the treatment. Despite model implementation checks with the author's supervisor, there is a possibility for bias. Protective factors including income and education could impact couple therapy results. Furthermore, without a control group it is difficult to know whether the intervention determined reported outcomes, or whether various other couple factors including years together, chronicity of substance addiction, time at baseline, or economic situation impacted outcomes.

Manuscript Outline

As this is the first study to examine the theoretical extension of EFT for addictions, there was important data produced that could help inform future research and adaptations of EFT in this context. Results are presented here in a three-article manuscript.

The first article will examine and report general findings of the study. The objective of this study was to provide preliminary exploration for the proposed adaptation of EFT in the context of couples with substance addictions as proposed by Landau-North et al., (2011). Specifically, this article will describe and explore the phenomenon of EFT in the context of couple addictions.

How the proposed extension of EFT compared to the normative model of EFT is analysed and general themes are discussed. Recommendations for further adaptations to the model are made.

Using data from the study, the second article explored the process of working with slips and relapses in the context of Emotionally Focused Therapy for couples dealing with substance addictions. Addiction treatment inevitably involves discussion of relapse, however, how to manage relapses while in treatment is often absent from the literature. Discussion will focus on relapses as they occurred in the study, including diverse responses amongst couples as well as recommendations for further adaptations to the EFT model.

Finally, the third article examined existing literature and drew from the replication case study to better understand how success is defined in addiction treatment and couple therapy. Diversity in what constitutes a positive treatment outcome was present in the study conducted using a theoretical extension of Emotionally Focused Therapy (EFT) for couples in the context of addiction. Some couples focused on substance abstinence as a measure of success, while other couples employed other metrics of success including trust, and improved communication. Potential implications of these findings are discussed.

Conclusion

Conducting an intensive replicated case study of EFT in the context of couples where one partner has a substance addiction provided important information on this particular model and may inform how we treat couples with substance addictions in the future. Landau-North et al's (2011) theoretical extension of EFT not only addresses the issues confronted by an addiction in the relationship, but also considers the issues present in the couple that have exacerbated the symptom. The following manuscripts will articulate the complexities of working with couples

using a theoretical extension of EFT and will detail the data that emerged throughout the replicated case studies.

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Manuscript One: Emotionally Focused Therapy in the Context of Addictions: A Replication Case Study

Abstract

Substance addictions represent a serious social problem in North America, negatively impacting family relationships and couple functioning. Research is increasingly considering the potential for couple therapy as a model within this context. Issues presented by an addiction can be exacerbated by other issues present in a couple relationship. Using a replication case study design, this research study explored a proposed theoretical extension of Emotionally Focused Couple Therapy (EFT) in the context of substance addictions. Four couples were recruited and a detailed analysis of the therapeutic process and their experiences is presented. Comparisons between the normative EFT treatment model and the theoretical extension are made, and recommendations are provided for further adaptations to the model. Results from this study indicate the important place of couple therapy in addiction treatment.

Introduction

Substance addictions are an ongoing social problem in North America, negatively impacting family and couple relationships. There are compelling reasons to provide couple therapy in the context of addiction. The inclusion of romantic partners in treatment can assist individuals in attending addiction treatment, while also providing an opportunity to address couple issues that may serve to maintain or exacerbate the addictive disorder (Heinz, Wu, Witkiewitz, Epstein, & Preston, 2009). Furthermore, the inclusion of romantic partners provides an important venue to explore the non-addicted partner's own concerns or challenges including the impact of their partner's addiction. Addiction recovery is not an individual process; rather it requires both intra- and interpersonal restoration (Finzi-Dottan, Cohen, Iwaniec, Yaffa-Sapir, & Weizman, 2003). This research study was designed to explore a proposed theoretical extension of Emotionally Focused Couple Therapy (EFT) in the context of substance addictions, using a replication case study design.

Literature Review

Couple therapy in the context of addictions has been well researched. Timothy O'Farrell, William Fals-Stewart and colleagues and Elizabeth Epstein, Barbara McCrady and their research team have conducted over three decades of research on Behavioural Couples Therapy (BCT) in the context of drug and alcohol addiction. BCT theorists posit that family members' interactions with the person abusing substances can reinforce their substance using behaviour (Lam, Fals-Stewart, & Kelley, 2009). This approach theorizes that if couples are happier and improve their communication, there will be a lower chance of relapse (O'Farrell & Clements, 2012). From this perspective, relationship functioning and substance dependence are reciprocal (Powers, Vedel, & Emmelkamp, 2008). Behavioural Couples Therapy currently comprises the vast majority of

empirical studies on couple therapy in the context of addiction (O'Farrell & Clements, 2012; Ruff, McComb, Coker, & Sprenkle, 2010; Shadish & Baldwin, 2005; Stanton & Shadish, 1997).

That said, BCT targets behaviours in couple relationships and does not address interpersonal factors that could contribute to the etiology of addictive disorders (eg. attachment, trauma, etc.). In 2011 an extension of Emotionally Focused Couple Therapy was proposed to treat couples living with substance addictions (Landau-North, Johnson, & Dalgeish, 2011). EFT is the only current couple treatment model that directly addresses attachment. This extension merits testing, as while attachment and addiction have been linked in the literature (Flores, 2004), there is a need for research on their relationship. While EFT may not be a suitable approach for some couples, offering an experiential, attachment-focused and systemic treatment could provide a potential treatment model for couples with an addiction in their relationship.

Emotionally Focused Couple Therapy

Emotionally Focused Couple Therapy (EFT) is the most widely used attachment-informed therapy for couples and one of only two couple therapies that has been subject to extensive empirical validation (Johnson, 2003a; Johnson, Hunsley, Greenberg, & Schindler, 1999). EFT was first described in the literature in 1985 (Johnson & Greenberg, 1985) and efficacy has been demonstrated with diverse populations, including couples living with cancer, sexual abuse survivors, and couples experiencing low sexual desire (Halchuk, Makinen, & Johnson, 2010; MacIntosh & Johnson, 2008). EFT was originally based on experiential, humanistic, and family systems approaches to therapy (Johnson & Whiffen, 1999) with the importance of attachment in relationships being included as the model evolved (Johnson, 2003b).

EFT conceptualizes distress using an attachment framework (Halchuk et al., 2010; Johnson & Wittenborn, 2012; Sprenkle, 2012). More specifically, couple problems are understood in

terms of attachment insecurity, separation distress, and cycles of self perpetuating negative interactions (Johnson, 2003c; Johnson & Whiffen, 1999). From this perspective, couple problems cannot be addressed without acknowledging the need for safe emotional engagement within the relationship (Johnson, 2003c). Studies have noted that EFT may help couples develop greater attachment security (Bradley & Furrow, 2004; Clothier, Manion, Gordon-Walker, & Johnson, 2001).

Emotionally focused couple therapy and addiction

Contemporary addiction treatments may not be targeting the mechanism through which the substance problem develops and is maintained (Adams, 2008; B. Alexander, 2010; Kazdin 2007). Building on the foundations of EFT, in 2011, Landau-North, Johnson and Dalgleish proposed a theoretical extension of EFT for couples dealing with addictions, which posits that addiction is an attachment issue, and suggests that therapists help couples create healthy dependency within their relationships as an alternative to addictive strategies of self-regulation (Landau-North et al., 2011). They suggest that substance-use behaviours are connected to the attachment relationships between romantic partners and they provide a model to address these issues within the couple therapy context. That addiction could be understood as an attachment-related issue has been discussed in the literature (Flores, 2004), however, further research is needed to examine this potential.

Currently, only one outcome study has looked at EFT in the context of addiction (Bassett, 2014). This study was conducted with two participants (and their romantic partners) after completing inpatient treatment and did not directly follow the theoretical extension proposed by Landau-North et al. (2011). Bassett (2014) found EFT fostered attachment security and created change in dyadic satisfaction. Landau-North-et al. (2011) suggest that EFT appears to be an

appropriate model for addiction treatment, because it suggests that intervening and improving attachment security within the individual and couple may lead to changes in self-regulation. Self-regulation, attachment, and couple distress are highly correlated with addictive behaviour (Baucom et al., 1998; Höfler & Kooyman, 1996; Padykula & Conklin, 2010).

Steps and Stages

The authors of the theoretical extension suggest that, in the context of addiction, the pace may need to be slower than is otherwise normative for EFT, to be attentive to the additional complexities that may arise (Landau-North et al., 2011). They hypothesize that in the context of addiction, therapy with couples could be extended past the 15-20 sessions recommended in traditional EFT. According to the guidelines of the extension, the individual with the addiction must acknowledge that they have a problem and already have taken active steps to address the addiction before beginning couple therapy (Landau-North et al., 2011). The type of treatment the addicted partner is receiving for their addiction also needs to be known to minimize any conflicts with using EFT simultaneously, should there be an incompatibility. The therapist needs to be vigilant in assessing for violence, anger problems, depression, and self-harm (Landau-North et al., 2011). The following section will describe the stages and steps in EFT (see Figure 1), highlighting the elements specific to the extension by using italics. The normative EFT model involves clients in three stages of change, broken into nine steps.

Figure 1. Emotionally Focused Therapy: Steps and Stages.

Stage	Step & Description
I Assessment & Delineation of Problematic Cycles/ De-escalation	1. Create an alliance and delineate conflict issues in the struggle. 2. Identify the negative interactional cycle. 3. Access unacknowledged feelings and attachment needs. 4. Reframe problem in terms of underlying emotions and needs.

II Re-engagement/ Softening	5. Promote identification with disowned needs and aspects of self. 6. Promote acceptance of partner's experience. 7. Facilitate the expression of unmet needs and wants.
III Consolidation	8. Facilitate the emergence of new solutions. 9. Consolidate new positions.

Stage One. In Stage One, the therapist works with couples to de-escalate their problem interaction cycles. This is done through four steps: 1) creating an alliance and delineating conflict issues in the struggle; 2) identifying the negative interactional cycle; 3) accessing unacknowledged feelings and attachment needs; and 4) reframing the problem in terms of underlying emotions and needs (Johnson, 2004).

In the extension for working with substance addiction, the recommended alterations to Stage One include the EFT therapist identifying the compulsive responses and patterns of the substance addiction as a key part of the problem interaction cycle. Landau-North et al. (2011) posit that addiction is both a cause and effect of relationship distress, suggesting that addiction be framed as part of the couple's negative cycle, and that it be discussed as something the couple can defeat together. Before beginning Stage Two, the therapist must also make sure the addiction is being contained (Landau-North et al., 2011).

Stage Two. The second stage of change in EFT is focused on restructuring interactional patterns in the couple to facilitate the partners being able to respond to each other's needs and desires. This is completed through three steps: 5) promoting identification with disowned needs and aspects of the self; 6) promoting acceptance of one's partner's experience; and 7) facilitating the expression of unmet needs and wants (Johnson, 2004).

In Stage Two, the therapist links primary emotions to addictive responses, and contextualizes these behaviours as attachment needs, fears, and expectations within the

individual's model of self and other. Sadness, fear of rejection or abandonment, shame, and feelings of inadequacy are explored and contextualized as unmet attachment needs that contribute to the addiction (Landau-North et al., 2011). Addictive responses can be framed as attempted solutions to "emotional starvation and despair" and attempts at self-regulation (Landau-North et al., 2011, p. 203). Stage Two should also involve creating positive interactions using enactments (Landau-North et al., 2011). Reaching out to one's partner is framed as an alternative to addictive behaviour. Loving connection between the partners is structured as a corrective alternative to self-regulation through strategies of addiction.

Stage Three. The final stage of EFT is consolidation, where new solutions are applied to old problems. In this stage, new interactional positions and attachment behaviours are integrated (J.L. Furrow & Bradley, 2011). This is done in two steps: 8) facilitating the emergence of new solutions; and 9) consolidating new positions (Johnson, 2004).

Landau-North et al. (2011) recommend that the couple be encouraged to create a story about the addiction and its impact on their relationship, including how problems connected to the addiction still emerge and how the couple is now able to deal with these problems, having explored them in therapy. During this stage, the therapist will help the couple develop a relapse prevention plan and will help them to evaluate emotional states that may contribute to a relapse.

Objectives

The objective of this mixed methods replication case study was to provide a preliminary exploration of the proposed adaptation of EFT for couples dealing with substance addictions, as proposed by Landau-North et al. (2011). Specifically, the purpose of this study was to describe and explore the use of EFT for couples in the context of addictions. As this theoretical extension

was previously untested, this study contributes novel research. It also addresses a dearth of research on attachment, addiction, and couple therapy.

Methodology

Approval was received for this study, from the Research Ethics Board of McGill University and the Comité de la Recherché en Dépendence. All sessions were audiotaped and transcribed.

Recruitment

Given the recommendation of at least 15-20 sessions of EFT for cases of addiction (Landau-North et al., 2011), and the difficulty in finding and retaining participants for a long-term study, it was necessary to use a small sample of four couples, which also allowed for in-depth analysis. Four couples were recruited from a Quebec addiction treatment centre.

All prospective participants were screened using a standardized telephone screening procedure. As outlined in the proposed model by Landau-North et al, (2011) the partner with substance addiction needed to be currently involved in, or have sought treatment for their substance addiction. For the purposes of replication in this study, an eight-week outpatient program at the referring treatment centre had to be completed by the substance-addicted individual before beginning the study. The couple needed to have been living together for at least one year. Both partners had to be interested in attending weekly therapy for a period of up to six months. Exclusion criteria were self-reported physical violence in the couple relationship, or current suicidal ideation. If both partners satisfied the inclusion criteria, they were invited for an initial intake session to meet the researcher and complete initial questionnaires.

Intervention

The first author of this paper provided the selected participants with couple therapy free of charge. The first author has an AAMFT accredited postgraduate diploma in couple and family therapy, seven years of addiction treatment experience, and has received training in EFT. The EFT manualized treatment model was followed and implementation checks were performed in order to ensure treatment fidelity. The supervisor, a trained EFT therapist, reviewed random segments of the therapy sessions, using the EFT implementation checklist to ensure that the treatment model was implemented with fidelity.

Study design

This case study aimed to provide an exploratory perspective on EFT in the context of couples with substance addictions. Case study methodologies are used often in psychology and social work to contribute to knowledge of individual or group phenomena where in-depth examination of single or multiple cases may yield important information about a particular, poorly understood phenomenon (Yin, 2009). Exploratory case study research can aid in theory building (Yin, 2009), which was a good fit for this research which aimed to evaluate a novel extension of an already validated treatment model. The particular case study methodology chosen was a multiple case study using replication of the EFT theoretical extension across four cases (Yin, 2009). To complete a replication case study, two or three cases are recommended (Yin, 2009). We chose to recruit four cases to provide a buffer in the case of drop out, which did not occur.

This method was chosen in an effort to focus on context, themes, and the *how* of therapeutic process (Mason, 2007; Yin, 2009). As it had not yet been examined, the EFT extension did not have a clearly articulated hypothesis in relation to outcomes, so the study was replicated across four couples to allow for comparison. This case study integrated mixed

methods including a qualitative analysis of quantitative measures, and a thematic analysis of the therapeutic process.

A thematic analysis was used to consider the process of the extension of EFT for addictions as well as to examine the specific stages and steps of EFT utilizing these extension interventions. A thematic analysis is a method used to identify, analyse and track patterns (themes) within the dataset (Braun & Clarke, 2006). Thematic analysis organizes clinical data into patterns, with the eventual goal of adding to theory, or contributing to models of change (Taylor & Bogdan, 1984).

Both theoretical and inductive coding were used (Braun & Clarke, 2006; Thomas, 2006). All sessions were transcribed and then analyzed with the processes in the sessions considered in relation to the treatment manual proposed by Landau North et al. (2011) and the original EFT manual. Coding, included examining the stages and steps of EFT in each session and the use of specific EFT interventions. These themes were compared with both the theoretical extension and the normative EFT treatment model in terms of timing of events, and client response to events. Inductive themes were also coded (Braun & Clarke, 2006), which were data driven themes that emerged in the therapeutic process that could not be predicted.

Responses to quantitative measures were collected at intake and immediately following the last therapy session. As the sample was very small the statistical power would not be sufficient for traditional statistical analyses. Therefore, we utilized the reliable change index (RCI). The RCI defines clinically significant change as an improvement or decline of one standard deviation (SD), or a change that led to movement out of the clinical range of a measure (Jacobson & Truax, 1991). The data from these measures were also examined to identify themes and factors that might be considered for future research.

Procedure

The implementation of EFT was staggered to allow for couples to have moved into the second stage of EFT prior to the start of the next couple. It was hypothesized that this would ease comparison across cases (Kazdin, 2011). EFT was introduced with the first couple at baseline. To stagger the baseline, the second couple remained at baseline until the first couple reached Stage Two of EFT. The second couple then began treatment, the third couple started treatment when the second couple reached Stage Two, and so on, until all four couples had commenced treatment. Couples waited between three to six weeks at baseline for treatment to begin. Each case was replicated following the same protocol (Yin, 2009) in an effort to provide data on both the outcome and the process of change associated with EFT.

Measures

Baseline data were gathered from each of the four couples, including demographic information. Assessment was carried out before, during, and after treatment using psychometrically validated self-report measures (Kazdin, 2011). Measures assessed couple satisfaction, attachment, self-regulation, and trauma symptoms. Outcome measures were analyzed to assess the clinical significance of change.

Couple satisfaction was measured using the Dyadic Adjustment Scale (DAS) (Spanier, 1976). Reliability is strong at .96 (Cronbach's alpha) (Spanier, 1976; Graham, Liu, & Jeziorski, 2006). The DAS is the measure of couple satisfaction most often used in studies of the efficacy of EFT; therefore it was chosen to allow for comparisons with other EFT research.

Attachment was measured using the Experiences in Close Relationships Scale-Relationship Specific (ECR-RS). This 36-item self-report measure assesses attachment in four domains of relationships with romantic partners, friends, father, and mother (Fraley et al., 2006). ECR-RS

scores have good reliability of .86 (Cronbach's alpha) (Dalgleish, Johnson, Burgess Moser, Lafontaine, Wiebe & Tasca, 2015). The ECR-RS also measures global attachment as dismissing, fearful, preoccupied, or secure (Fraley et al., 2011).

Emotion-regulation was measured using the Difficulties in Emotion Regulation Scale (DERS) (Gratz & Roemer, 2004). Subscales assess six dimensions of difficulties in emotion regulation. This measure has average to strong reliability at .80 (Cronbach's alpha) (Gratz & Roemer, 2004).

Given the strong associations between substance addiction and a history of trauma, the significant impacts of trauma on the process of EFT (MacIntosh & Johnson, 2008) and the significance of traumatic symptoms to the treatment process, history and symptoms of trauma were assessed both before and after treatment (Farley, Golding, Young, Mulligan, & Minkoff, 2015; Najavits, Weiss, & Shaw, 1997). Trauma symptoms were measured for each partner using the Trauma Symptom Inventory-2nd Edition (TSI-2) (Briere, 2010). The TSI is a widely used assessment of traumatic symptoms, and its author reported a reliability of .87 (Cronbach's alpha) (Briere et al., 1995). The TSI-2 has demonstrated good reliability and validity in preliminary studies (Runtz, Godbout, Eadie, & Briere, 2008).

Results

Participants

All four couples met the criteria for inclusion. Each partner with a self-reported addiction had attended treatment at the referring outpatient treatment centre. Three participants had also attended inpatient treatment through the same program. All four participants who had attended addiction treatment had primarily been exposed to cognitive behavioural therapy and motivational interviewing. Prior to the study, none of the couples had attended EFT. Given the

contextual nature of the replicated case study approach, each couple will be described here. Participants will be referred to as Couple A, Couple B, Couple C, and Couple D[2].

Couple A had been together thirteen years; Andre (38) reported that he had been addicted to cocaine for twenty years. He did not graduate from high school and was incarcerated in his twenties for drug trafficking. Growing up, his father was an alcoholic and he did not remember at what age he started his own substance use. Antonia (33) worked in healthcare and met Andre shortly after immigrating to Canada from a Middle Eastern country. The couple reported that their main relationship issues were, from Andre's perspective, "communication and understanding," and from Antonia's perspective, "responsibility, being committed, prioritizing, and being organized". When therapy started, Andre had not used substances in three months. Throughout treatment Andre continued to attend the peer support group Alcoholic's Anonymous (AA). Couple A attended therapy for 18 sessions.

Couple B had been together thirty-five years. Bridget (53) worked full time in administration. Bob (56) reported he had been addicted to cocaine and alcohol for seven years, however Bridget reported that Bob had struggled with addiction "on and off" for much of their marriage. At the time of the study, Bob worked full time in information technology. Both of Bob's parents were alcoholics and he remembered having his first drink at the age of 10. The couple had attended therapy both together and individually on and off for the past few years. At the time of starting therapy, Bob was three months sober from cocaine and alcohol and was also attending a peer support group regularly (AA). Couple B attended therapy for 25 sessions.

Couple C had been together for three and a half years. Claire (age 57) worked in education, and Carlos (age 64) worked in technology. Both had been married previously. Claire grew up

[2] *All participant names have been changed to pseudonyms and identifying details have been altered to preserve anonymity.*

with an alcoholic father. Carlos struggled with his alcohol use for 50 years, but only began seeking treatment in the past few years after starting his relationship with Claire. The couple identified trust and intimacy as their main relationship issues. Both partners attended therapy before participating in the study; after a relapse that occurred during treatment, Carlos started attending a peer support group. Couple C attended therapy for 26 sessions.

Couple D had been together 33 years. Donna (age 55) was an entrepreneur, and Derek (62) was retired. Derek reported that he had been addicted to alcohol for 25 years, and Donna could not recall a time when her husband's alcoholism did not impact their relationship. Derek and Donna had both attended individual therapy for the past three months, and Derek had recently finished an inpatient treatment program. The couple described their main issues as "communication" and "understanding each other's needs". While in therapy, Derek attended a recovery maintenance group. Couple D attended therapy for 20 sessions.

Compliance

Couples attended therapy between 18-25 sessions, which was higher than the norm in standardized EFT (15-20 sessions) (Johnson et al., 2005). As suggested by Landau North et al., (2011) additional sessions may be needed when one partner is in recovery from a substance addiction. The goal was to continue to the third stage, ninth step of EFT (Johnson et al, 2005), however, only one couple continued to this stage. Three of the four couples discontinued therapy before the third stage, when they stated they had met their treatment goals and were ready to terminate. Full details of the termination processes will be discussed below. The following section will summarize each step in the process of EFT and will highlight any differences between the EFT provided to these couples and the proposed model, along with any characteristics of the therapy provided to these couples that did follow the extension of EFT. One

couple did not tolerate couple therapy using the EFT model; however, further adaptations were made and the couple remained in therapy until they felt they were ready to terminate. The rationale for these adaptations will also be discussed.

Stage One

Step One. In the first step of EFT, a vital goal is the creation and maintenance of a strong and safe therapeutic alliance (Johnson et al., 2005). In this case study, three of the four couples appeared to quickly develop a therapeutic alliance. This was evidenced by a rapid engagement in the therapeutic process, and these couples frequently commented that participating in the study/therapy was a positive opportunity for them, as in the past they had been unable to attend couple therapy to discuss the impact of substance abuse on their relationship.

Forming an alliance with Couple D was more challenging. Despite being provided with a thorough rationale and the opportunity to discuss his concerns, Derek was sceptical about couple therapy and the fact that the therapy was part of a research study. He wanted his participation in the therapy to be useful and relevant for the study but was also adamant that he did not want to explore the past and wanted to keep therapy present-focused. Derek had a significant trauma history and became overwhelmed and shut down when the therapeutic process focused on exploring emotions. Donna was distressed by Derek's response and worried whether or not he wanted to participate. After about six sessions the therapist, in consultation with her supervisor, decided to adapt the EFT model to incorporate more behavioural interventions, including cognitive behavioural therapy and psychoeducation, in an effort to titrate the level of affect in sessions and to support Derek in the gradual development of emotion regulation capacities. An alliance was solidified at this point, and was maintained until termination. Adaptations to the therapeutic model for this couple will be discussed further in the results section.

The first step in EFT is to identify relationship conflict between partners (Johnson et al., 2005). To accomplish this, one of the first therapeutic tasks is to achieve de-escalation, or a reduction in couple conflict, through helping the couple gradually understand and begin to slow down and interrupt the negative interaction cycle in which the couple has been trapped. Couples in this study did not enter therapy in an escalated state, which differs from what EFT anticipates as a starting point for treatment. In all four cases, couples had been navigating addiction issues in their relationships for years and the non-addicted partners presented as burned out; the conflict in the couples was no longer escalated. In fact, it appeared that the couples were habitually in a state of containment for fear that any conflict might lead to relapse. Couples did not fight in sessions, and listened to their partners quietly, only interjecting when prompted. As Carlos said in session five in reference to his relationship, "It's cold here between us". Interestingly, the non-addicted partners presented as no longer pursuing change in their partners. For example, Bridget noted:

> I'm like a zombie in this thing. I'm only going to expend energy on the things that I can control and the things that I can't control? I have to let it go, because otherwise I'm just gonna burn out (se. 3).

Donna said, in reference to starting therapy, "I'm just really not myself anymore and … I'm not fun and I worry a lot and I'm going like, I should be happier because this is good right?" (se. 1).

The model developed by Landau-North et al. (2011) posits that addiction is both a cause and effect of relationship distress. While all of our couples entered therapy distressed (see Table 1), they did not enter in an escalated state. It appeared that the distress caused by the addiction was linked to couples being more passive and disconnected in their interactions with one

another. We also wondered whether this lack of escalation was connected to a chronic and underlying fear that any escalation might trigger relapse.

Step Two. The second step in EFT is to identify the negative interaction cycle in which issues identified between the couple get expressed, framing the substance addiction as playing a key role in the development and maintenance of problem interactions in the couple (Johnson et al., 2005; Landau-North et al., 2011). All four couples were able, with time, to identify their negative interaction cycle as related to the addiction. Addictive behaviours were described as regulators in emotionally distressing interactions, or as initiating a negative interaction cycle after a relapse led to a lack of trust or was experienced as an attachment injury.

> In Couple A, Andre and Antonia described their negative interaction cycle to the therapist:
>
> Andre: I'm the guy who throws the sawdust in the fire … yeah I go, and then she doesn't talk to me? Oh that's the worst. Then it's show time.
>
> Antonia: I'll start swearing … and sometimes, and it comes out, I don't mean it, but because he's doing it … (se. 4).

The couple had a harsh way of communicating with one another (swearing, insulting), which could result from Andre's drinking, but occurred most frequently when Andre was feeling unheard or rejected by Antonia. Antonia also identified that if Andre relapsed she would punish him by detaching and ignoring him, reinitiating the negative interaction cycle.

With Couple B, the negative interaction cycle was centred on trust and substance addiction. Bridget's worry that Bob was not being truthful caused her to pursue him, this pursuit aggravated Bob, making him feel unaccepted by his wife, and caused him to withdraw. In session three, the therapist highlighted this:

Therapist: I think maybe, I mean that dynamic that you create together where you avoid sharing for fear of it being anxiety provoking for Bridget, and then you end up feeling irritated, that whole cycle that happens, if you knew that you would get a different response, maybe your impetus for sharing would be different.

Bob: Yeah.

Therapist: I think one of the ways you coped is by saying nothing, kind of pushing it down.

Bob: And that's what the drugs were about too (se. 3).

Here Bob articulates how his addictive behaviour is linked to his negative interaction cycle with Bridget. Bob's drug use was a self-regulating tool he used to cope with feeling inadequate.

Couple C directly connected their negative interaction cycle to Carlos' addiction:

Claire: Carlos' way of handling big emotional issues or anything like this was to walk away or to flee, you know? And I think that … drinking is another way to walk away and flee, and leave, you know? (se. 6).

As a response to a fear that Carlos would leave and abandon the relationship, Claire would not open up to him or tell him about her fears. She stated, "I'm afraid he's gonna say, oh my God, you know? It's too much" (se. 6). Drinking maintained distance in the relationship, as Carlos was content to collude with Claire's avoidance.

Couple D identified their negative interaction cycle as being triggered when Derek shut down and was no longer emotionally available to Donna. When this occurred, Donna felt very anxious and would often pursue Derek. Derek articulated that this cycle often began when he was not feeling good about himself. These negative feelings would often arise after a relapse:

Derek: Well I think this week is a little bit in that cycle … I'm not having a good week and it shows, you know.

Donna: Yeah, well the cycle I see is that … when something's not happy, he … is … I say something and he says almost the opposite.

Derek: I was in non-listening mode … the wheels are going around really fast (se. 7).

Couple D were able to see how the addiction contributed to their negative interaction cycle.

Step Three. The third step of EFT involves accessing emotional states related to attachment that underlie the position each partner takes in the cycle (Johnson et al., 2005; Landau-North et al., 2011). All eight participants were able to access these emotions, and could see why they adopted their position in the cycle. For example, with Couple C:

Claire: We'll work through this together; I believe in you, I want a future with you, I want the future we've talked about, I know I pull back, I know myself, because I'm afraid.

Carlos: I feel it too (se. 3).

Claire acknowledged how fear kept her distant from Carlos. Carlos responded to Claire supportively, acknowledging how frightened Claire was to get close.

Similarly, Bridget was able to access the fear that determined her position in the negative interaction cycle with Bob when she said:

I prepare myself for the worst, so if it happens I was expecting it, if it doesn't, well then good, but I'm still so fearful because everything … that's been going bad has happened, like it always comes true on the negative you know? (se. 3).

Step Four. The fourth step in EFT is to reframe the couple problem in terms of the characteristic cycle, unacknowledged emotions, and attachment needs (Johnson et al., 2005; Landau-North et al., 2011). For example, the therapist said to Claire, "You want to take good care of yourself, you want to keep yourself safe... so in some ways Carlos' addiction keeps you protected because you have to kind of step back and keep your distance" (se. 3). The couple

accepted this reframing, and both could see how the cycle was connected to the addiction. Carlos commented later in the therapy about how difficult it was to step outside of this cycle saying, "It takes time … it's like trying to crash diet when you've been overeating all your life" (se. 8).

This step was also attempted with Couple D, when the therapist tried to reframe Donna's attempts to connect with Derek about his emotional needs and to understand where his "non-communication" mode comes from.

> Therapist: So you're saying I want to help take care of you, or want to look out for you in these situations, but I want to know more about how to help you with that. Is that it?
>
> Donna: yeah…
>
> Derek: First of all, you don't throw the past in people's faces, don't throw it back in your own face either, because it doesn't help. It doesn't help you and it doesn't help me (se. 7).

Here, Derek quickly shut down. He accused Donna of bringing up the past. He was unable to tolerate sharing his feelings with Donna and the step was quickly derailed. He rejected Donna's desire to offer support, frequently telling her that she "couldn't possibly understand."

Stage Two

In Stage Two, the therapist worked with couples to change their interactional positions and restructure their bond together (Johnson et al., 2005). Couples became more escalated in this stage. This appeared to develop as they became more able to access their emotions; the primary emotion that emerged was anger, which had been absent in Stage One. Three couples were able to explore these primary emotions and see how attachment needs contributed to the patterns of addiction. As mentioned, Derek was not able to access primary emotions easily in sessions. It appeared that Derek's trauma history impacted his ability to access emotions and attachment needs. This was evidenced by the appearance of severe dysregulation when Derek tried to

discuss his feelings. It was at this point in the therapy that the model was further adapted for Couple D.

Step Five. The first step in Stage Two (step five in EFT) is to access disowned or implicit needs, emotions, and models of self, for example sadness, fear of rejection, abandonment, shame, and feelings of inadequacy (Johnson et al., 2005). The progress through this step was particularly striking in the case of Couple C. Claire accessed her anger for the first time in therapy:

> Claire: I said, okay … I want to bring this up, because I think what happened was… like, I sensed, well I know, I was … was … angry that you reacted that way … and I felt like, you know, I'm trying to find opportunities to adjust to both our needs, you know? (se. 12).

Until this point, Claire had been unable to tell Carlos about her anger. She often masked anger in disappointment or avoidance, so sharing this implicit need was significant. After discussing this shift, Claire said, "I really felt … I really felt great. I really felt great because, you know, you had … he didn't say maybe exactly what I had, what I would have liked, but he listened" (se. 12).

Bob also demonstrated a shift in his ability to access feelings of shame and inadequacy when he shared his desire for Bridget to trust him. He reported feeling frustrated when she second-guessed the things he said:

> Bob: It feels like it's never enough … It's a heavy hit, cause it's like … it's like treading water in the middle of the ocean and saying, do I give up? (se. 4).

Feeling inadequate was triggering for Bob. It caused him to feel like giving up (and relapsing) might be easier than sitting with the discomfort of Bridget not trusting him.

Initially, Andre struggled with this step, and Antonia often shared her frustration that he would become angry instead of telling her how he felt. For example, she said, "He doesn't feel comfortable, he doesn't want to reach out, I mean I can't do the job for him, but that's what I feel

…" (se. 12). Over time, Andre developed more trust with Antonia, and she worked to reassure him that she would support him if he reached out. In reference to a slip that occurred, Antonia described Andre reaching out afterwards, accessing his shame and sharing it with her:

Antonia: He told me, he told me he didn't feel good.

Andre: I told her it wasn't cool … I'm no fun, that's definitely not going to work (se. 17). This was significant, as Andre struggled to express emotions and would often act out in anger when he was feeling ashamed or inadequate.

Step Six. In the sixth step, the therapist promotes each partner's acceptance of one another's experience (Johnson et al., 2005). This can be done through the use of enactments, which restructure or "act out" problematic interactions within the therapy session to help couples interact in a new way. For example, Carlos told Claire he could tolerate her feelings. The therapist helped the couple share this through an enactment:

Therapist: Can you tell Claire that, can you say, I can handle hearing the tough stuff?

Carlos: Yes ... I handle that ...

Therapist: I can tolerate hearing how hurt you are ...

Carlos: Yes, I can tolerate that … and she knows, just she wanted to hear from me now ... I can tolerate whatever you tell me ... You know ... (se. 8).

Couple B were able to accept one another's emotional experiences. Although Bob struggled with Bridget's lack of trust in him, he could understand her fear around taking risks with him. Specifically, he acknowledged that it was difficult for Bridget to be honest with him when she worried her anger would trigger him to relapse. Bob responded to this fear, saying:

Anything that you tell me, I probably already know, so it's not going to hurt me anymore. Yeah it will make me feel bad, I may be quiet for a little while, cause I'm gonna think about it, but it's not gonna make me go out and use… at all (se. 5).

Bob shifted toward trying to understand where Bridget was coming from.

Step Seven. The seventh and final step in Stage Two is to help facilitate each partner's expression of needs and desires to restructure the couple interactions based on their newly acquired understanding. For example, with Couple A, each partner was able to see what they wanted and were able to support one another.

Therapist: It makes me think of what we talked about before, where you had the worry that Antonia wasn't on your team, right? And this is such a beautiful example of you saying you know if I'm doing this, I'm doing this with Andre.

Antonia: Right … yeah …

Therapist: How does that feel for you?

Antonia: I didn't tell him before …

Andre: Oh, it feels good (se. 17).

Addicted partners were also able to discuss their needs around addiction and cravings. This helped the couples move away from a position of blame, towards approaching the addiction as a shared problem to solve. For example, in reference to being asked to a dinner where there would be alcohol Bob noted, "I felt very insecure all of the sudden so I called Bridget and talked to her" (se. 14).

Stage Three

Stage Three is the integration and consolidation stage (Johnson et al., 2005). Only one of the couples, Couple B, completed Stage Three. Their process will be discussed below. Couples

A, and C completed Stage Two and terminated therapy at this point, in consultation with the therapist. While Couple A was not able to reach Stage Three as defined by the theoretical extension, they repaired distress in their relationship, and both partners were able to reach out to one another in a way they had not done previously. They terminated therapy after step seven, as both were able to facilitate the expression of unmet needs and wants. Couple A reported positive change throughout therapy and were happy with their progress at the time of termination. In Couple C, Carlos struggled with relapses toward the end of treatment; Claire experienced these slips and relapses as attachment ruptures and a replication of the negative interaction cycle. As a result, the couple was unable to move through Stage Three, and terminated therapy in Stage Two, step six (promoting acceptance of partner's experience). The couple accepted one another's experience with the exception of relapses, which occurred near the end of therapy.

At termination, the couple were pleased with the progress they had made in terms of being able to identify and share emotional needs and wants with one another; however, Claire worried what would happen to their relationship if Carlos continued to relapse. Couple D did not complete Stage Three, as previously discussed; the therapist opted to employ more behavioural interventions in an effort to titrate Derek's heightened affect. At termination, the couple felt they had progressed and done an "important piece" of work together. Couple B completed Stage Three. At the beginning of therapy, Bob felt aggravated by Bridget's worry and would withdraw from her. By Stage Three, the couple was able to take new positions in the cycle, soften blame, and consolidate new interactional positions. As Bridget stated, "I actually said to him, if it's humanly possible to fall in love with somebody all over again, I feel like I'm falling in love with you again" (se. 13).

Step Eight. In step eight, the couple facilitates the formulation of new stories and new solutions to old problems. Bob and Bridget were able to narrate the story of distress in their relationship and how they were able to repair it. After a disagreement Bridget noted, "He apologized after, which was nice … he apologized and he gave me a hug. 'Cause, um, he was falling back into those old patterns that make me tense?" (se. 18).

Step Nine. In step nine, the couple consolidates new cycles of behaviour and moves towards termination. Couple B developed a relapse prevention plan, which was an important change moment in the therapy. At the beginning of therapy, Bridget could not tolerate conversations about relapse, as it was too terrifying to consider. By the end of this stage, Couple B were ready to terminate.

Self-Report Measures: Descriptive Outcomes

Relationship Satisfaction. Using the DAS, change in relationship satisfaction was observed from pre-to post-therapy (Table 1). In Couples A and B, all four participants moved out of the clinically distressed range. In Couple C, Carlos also moved out of the clinically distressed range, whereas Claire did not have a significant improvement in couple satisfaction. In Couple D, Donna moved out of the clinically distressed range, however Derek did not.

Table 1

Dyadic Adjustment Scale Pre- and Post-Test Results

DAS Score	Pre-test		Post-test	
	Male Partner	Female Partner	Male Partner	Female Partner
Couple A	84	85	100*	112*
Couple B	97	95	117*	113*
Couple C	96	86	114*	94
Couple D	88	78	90	105*

Distressed = 70-97

* Clinically significant change

Note. Dyadic Adjustment Scale documented in Spanier, 2004.

Attachment. The ECR-RS Scale (Fraley et al., 2011) (Table 2) Global attachment styles (dismissing, preoccupied, fearful, or secure) did not change for any participants between pre-test and post-test. Significant change was only observed for Bridget, with reductions in anxiety and avoidance scores.

Table 2

Experiences in Close Relationships Scale Pre- and Post-Test Results

	Identifiers	Global Attachment Style		Relationship Avoidant Score		Relationship Anxiety Score	
		Pre-test	Post-test	Pre-test	Post-test	Pre-test	Post-test
Couple A	Antonia	Dismissing	Dismissing	1.0	1.0	1.0	1.0
	Andre	Preoccupied	Preoccupied	1.0	2.0	1.0	1.17
Couple B	Bridget	Dismissing	Dismissing	3.33	1.17*	4.67	2.00*
	Bob	Dismissing	Dismissing	2.00	1.50	2.00	1.33
Couple C	Claire	Secure	Secure	3.67	2.83	3.67	5.00
	Carlos	Dismissing	Dismissing	2.00	2.00	1.67	1.00
Couple D	Donna	Secure	Secure	4.50	3.33	3.33	3.67
	Derek	Dismissing	Dismissing	2.33	3.00	1.00	1.67

Lower scores = lower anxiety or avoidance
*Clinically significant change
Note. Experiences in Close Relationships Scale documented in Fraley et al., 2006.

Emotion Regulation. The DERS (Gratz & Roemer, 2004) was compared from pre-test to post-test conditions (Table 3). With the exception of Claire and Carlos, all participants had a slight decrease in their reported score; however, no clinically significant change in emotion regulation was identified.

Table 3

Difficulties in Emotion Regulation Scale Pre- and Post-Test Results

	Names	Pre-test	Post-test		Pre-test	Post-test
Couple A	Antonia	75	73	Andre	89	81
Couple B	Bridget	82	78	Bob	94	82
Couple C	Claire	63	65	Carlos	60	68
Couple D	Donna	110	92	Derek	51	50

Note. Difficulties in Emotion Regulation Scale documented in Gratz and Roemer, 2004.

Trauma. All eight participants reported that they had experienced some form of traumatic experience in early childhood or adolescence. These experiences included loss of a parent, addiction issues in the family, parents with mental illness, and exposure to family violence. Trauma scores from the TSI-2 (see Table 4) identified that both Donna and Bridget did not score in the clinical range on the trauma scale at the end of treatment.

Table 4

Trauma Symptom Inventory-2 Pre- and Post-Test Results

	Names	Posttraumatic Stress (Pre-test)	Posttraumatic Stress (Post-test)
Couple A	Antonia	41	41
	Andre	60	64
Couple B	Bridget	64	56*
	Bob	48	55
Couple C	Claire	50	54
	Carlos	37	40
Couple D	Donna	60	56*
	Derek	48	42

*Clinically significant change
Note. Trauma Symptom Inventory-2 documented in Briere, 2011.

Themes

A thematic analysis of all transcribed sessions revealed four primary themes. These are discussed in this section along with detailed descriptions of the therapeutic adaptations for Derek and the need for therapy in the context of addictions to be flexible.

In comparing the extended implementation of EFT to what is expected in the conventional EFT model, in the first stage none of the couples entered therapy escalated. This impacted the multiple baseline start time for each couple, as they progressed to Stage Two of EFT earlier than anticipated. All four couples were able to identify their negative interaction cycle within the first five sessions; however, they did not escalate until they moved into stage two. Escalation began to occur as difficult emotions were accessed and couples felt comfortable

taking risks in accessing unmet attachment needs. We hypothesized that this difference was related to partner burnout and a shared fear, in the couple, that strong emotions might trigger relapse. A discussion of this potential is an important addition to the theoretical extension, as it differs notably from the normative model.

Another theme that emerged was an ongoing need for addiction psychoeducation by both partners in the therapy, which was not accounted for in the proposed extension model. All couples came into therapy with many questions and misunderstandings about addiction, addictive behaviours, and substance-use recovery. The therapist continually provided psychoeducation, particularly in the beginning sessions, and after a relapse occurred.

The incongruence between aspects of the treatment extension and trauma symptoms also emerged as a theme, particularly with Couple D. The theoretical extension did not address how to treat or adapt the model for highly traumatized individuals. Couple D stayed in therapy but, as discussed, treatment required modifications to adapt to Derek's difficulty with tolerating any heightened affect. In particular, Derek was unable to discuss anything that occurred in the past without shutting down. It was felt that the integration of behavioural interventions such as goal setting and identifying the cognitive distortions experienced while trying to stay abstinent, as well as a reduction of interventions focused on exploration of emotion and attachment that triggered dysregulation would be the most effective and least disruptive approach to treatment for this couple. The therapist integrated these interventions in an effort to respond to the couple's desire to stay in therapy while being unable to fully engage with the model as it was presented.

Finally, the theme of slips and relapses emerged. Slips or relapses refer to a return to substance use, with slips typically referring to a one-time or short-term relapse. Participants used these words interchangeably. Three of the four participants with addictions relapsed or slipped

during the course of therapy. While one couple did not report any relapses, all participants discussed fears and misunderstandings about slips and relapses. Slips and relapses also provoked diverse responses among participants; some were fearful to share with their partner about the experience, whereas others were able to discuss with one another and move forward. How to manage slips and relapses was not addressed in the theoretical extension, and should be considered in future adaptations.

Discussion and Recommendations

This exploratory case study explored the application of the proposed extension of EFT in the context of addictions (Landau-North et al., 2011). All four couples completed a course of treatment and terminated therapy in Stage Two or Stage Three. DAS scores indicated that couple satisfaction improved for most participants. While all participant scores increased, Claire and Derek remained in the distressed range at the end of therapy. Given what the therapeutic process involved for both Claire and Derek, this is not surprising. Claire found Carlos' relapses distressing, particularly as they occurred towards the end of therapy. While the couple was ready to terminate therapy, Claire continued to be unresolved about Carlos' relapses. Meanwhile, Derek had difficulty tolerating therapy with Donna, and suggested at the end of therapy that he might consider ending the couple relationship.

Given that changing one's attachment style has been likened to learning a new language (Flores, 2004), it is not surprising that global attachment style did not change for any participant in the study. Nonetheless, it is important to highlight the result, that these interventions were not successful in moving insecure participants into secure attachments with their romantic partners. Bob's and Bridget's anxiety and avoidance scores decreased at the end of therapy, which we

would expect given that, as a couple, they moved through all three stages of EFT. Both partners also discussed increased security with one another.

There was no clinically significant change in self-regulation among participants, as measured by the DERS. Couple D was interesting in this regard, as Derek reported high levels of self-regulation on the DERS, whereas Donna reported great difficulty self-regulating on the DERS; these reports were not consistent with their clinical presentation. When emotions were expressed in therapy, Derek shut down, whereas Donna emoted freely and reflectively. It is possible that Derek's responses on the DERS are indicative of emotional suppression as opposed to an accurate report of his capacities for self-regulation. Derek's ECR indicated dismissive attachment and some avoidance in his relationship score, which supports this interpretation of his DERS score. The slight reduction on the DERS could be regression to the mean. Also, shifts in emotion regulation are related to changes in attachment patterns (Deklyen & Greenberg, 2008) may be unrealistic in a shorter-term therapy like EFT.

Traumatic early childhood experiences and other critical incidents were reported in the therapy, but were largely absent from self-report (both pre- and post-intervention) in the TSI-2 (Briere, 2011). Andre, Bob, Claire, and Carlos had slight increases in their trauma scores at post-test. It is difficult to infer why this occurred, but the emotionally activating nature of EFT might have led to increased insight and more disclosure on the report measure or, alternatively, the therapy could have exposed participants to more traumatic memories.

While the study followed the theoretical extension closely in the course of therapy, with the exception of Couple D, some adaptations are needed for future work. The reciprocal relationship between trauma and addiction has been well studied, and research continues to find that traumatic childhood experiences of maltreatment are definite risk factors in the etiology of

addiction and other mental health issues (Enoch, 2011). As observed in this study, aspects of EFT may be too destabilizing for some individuals with histories of trauma. Further adaptation is needed, to account for the relationship between active trauma symptoms and addiction.

Explicit inclusion of psychoeducation is an important addition to the extension, because couples enter therapy with a variety of therapy experiences, as well as exposure to many conflicting theories about addiction and recovery. The role of the non-addicted partner is complicated, as many worry about being co-dependent, or enabling their partner to use or relapse.

The theoretical extension did not account for slips and relapses. While the extension stated that ongoing substance use should cease by Stage Two, there was no stated rationale for this, nor was instruction provided concerning what to do if slips occurred after Stage Two. Three of the four couples participating in the study experienced slips; however, they sought outside support (counselling or peer support groups) and discussed the slips in therapy. The couples did not want to suspend therapy after a slip, but rather wanted to process its impact. An adaptation of the extension should address how to navigate slips and relapses, especially as they have the potential not to derail the therapy, but rather to become an important part of the therapeutic process.

Finally, this exploratory study revealed differing interpretations by participants of what constitutes treatment success. Couple B terminated therapy in Stage Three, at the end of the manualized treatment model. While they were arguably the most "successful" participants, in that they experienced no substance use throughout treatment, reported increased couple satisfaction, and completed the treatment model, other couples measured success differently (MacIntosh & Butters, 2014). For example, at the end of the therapy, Couple D discussed splitting up, as Derek had gained more insight about their relationship and his addiction. While

this indicated lower couple satisfaction, both partners felt positively about it. The processes experienced by participants highlighted how outcomes in the context of addiction and couple therapy were personal and contextual. Future work should examine how success is evaluated in couple therapy and addiction.

Limitations

This study had important limitations. As a replication case study, the sample size was very small - results from four couples are impossible to generalize. Replication case studies are further limited by their highly contextual nature. There were also limitations in having the first author as the provider of the treatment. Given that Landau-North et al. (2011) model is a proposed model, not a validated model, there are no current measures against which one might be assured that they are following the model with fidelity. Despite model implementation checks with the author's supervisor to assess adherence to the EFT model, there was a possibility for bias, oversight or differences in interpretation between the authors of the proposed EFT extension and the administrators of the model in this study. Also, the finding that the treatment fit the model could be an artefact of the therapist/researcher knowing the model. Furthermore, without a control group it is difficult to know whether the intervention determined reported outcomes, or whether various other couple factors including years together, length of substance addiction, time at baseline, or economic situation may have impacted outcomes.

Conclusion

Ultimately this intensive, replication case study provided insight into this extension of EFT for couples where one partner has a substance addiction, and raised important considerations concerning the treatment of couples with substance addictions. Couples in this study were able to attend and complete treatment, even while navigating slips and other

relationship challenges associated with substance addiction. While the extension applied was appropriate and accessible to most participants in the study, important themes and recommendations emerged for the future. Adaptations of the model should consider trauma histories of participants, provide psychoeducation on addiction, and address the potential for slips and relapses while in treatment. Applying the theoretical extension of EFT by Landau-North et al. (2011) not only addressed the issues presented by an addiction, but also considered the issues present in the couple that have exacerbated this symptom. Couple therapy has an important place in addiction treatment, and this study demonstrated the possibilities Emotionally Focused Therapy and its future adaptations offer in this context.

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Chapter One Conclusion

The first manuscript in this study explored results of the replication case study and included a thematic analysis. One of the themes discussed, was slips and relapses and a lack of information on how to address their occurrence in the context of EFT and substance addictions. Given the centrality of relapses and slips during the study, the second manuscript will expand on the question of how to address relapses and slips in couples therapy for addictions. Three out of four couples in the replication study reported slips or relapses over the course of treatment. Each couple negotiated these occurrences differently, which highlighted interesting questions about how to integrate relapses and slips into addictions treatment for couples. The scarce literature on this topic will be discussed, and recommendations for further adaptations to the EFT extension will be offered.

Manuscript Two: Navigating Relapses in Couple Therapy for Addictions, Results From A Case Study

Abstract

Addiction treatment unavoidably entails working with relapses. In the context of couple therapy, discussion of relapses can become an integral part of the treatment process, as each partner is impacted and interprets relapses differently. Drawing on data from a replication case study that used a theoretical extension of Emotionally Focused Therapy for couples dealing with substance addictions, this paper addresses slips and relapses as they occur in the context of couple therapy. Incorporating what was observed in the replicated case study, a proposed model for addressing relapse in the context of Emotionally Focused Therapy is offered.

Keywords: *relapse, couples therapy, emotionally focused therapy, addiction, slips, substance abuse*

Introduction

Treating individuals and their families living with addictive disorders inevitably means dealing with the occurrence of relapses. The purpose of this study was to explore the process of working with slips and relapses in the context of couple therapy using a theoretical extension of Emotionally Focused Therapy (EFT) for couples dealing with substance addictions. Given the chronic nature of addictive disorders, relapse is a common outcome during substance abuse treatment (National Institute on Drug Abuse, 2012). Relapses are a dynamic process wherein an individual returns to substance use after a period of abstinence (Dimeff & Marlatt, 1998; Marlatt, 1985). The term relapse comes from the medical field where it referred to returning to a disease state after a period of remission (Rahill, Lopez, Vanderbiest, & Rice, 2009). Marlatt (1985) first distinguished lapse from relapse in the literature in an effort to move away from the "all or nothing" disease model of addiction (Marlatt, 1985). Social Workers and clients have labelled relapses as a more long-term return to substance use, whereas "slips" or "lapses" are described as shorter, context specific events (Brownell, Marlatt, Lichtenstein, & Wilson, 1986). After a slip or lapse, individuals typically return to abstinence, and relapses are also seen to decrease as a function of time (Kirshenbaum, Olsen, & Bickel, 2009).

The chronic relapsing nature of addiction

Addiction is a chronic relapsing disorder that has largely been treated as an acute disorder (Brandon, Vidrine, & Litvin, 2007). Individual treatment for someone with a substance addiction can span a decade with three to four episodes of care, with substance use occurring on average for 27 years (Leshner, 1997; Vaillant, 1988). While many individuals (40-60%) recover from substance addiction and maintain abstinence (McLellan, Lewis, O'Brien, & Kleber, 2000), many factors which have influenced the onset of the addiction can interfere with sustained recovery.

Some of these factors include pre-existing genetic traits, psychiatric risk factors, peer culture, social milieu, gender, education, employment, and parental care (Menicucci & Wermuth, 1989; Zeinali, Sharifi, & Enayati, 2011). Research indicates that most individuals living with an addiction need at least three months in treatment to reduce or stop substance use, with many individuals requiring longer treatment (National Institute on Drug Abuse, 2012). Because addictions are chronic and complex, treatment that focuses solely on the pattern of consumption and ignores other potential comorbidities is likely to be ineffective (Musalek, 2013).

While most individuals will return to a period of abstinence after a relapse, regardless of intervention or treatment model, relapses will occur. Addiction treatment and recovery is not a linear process. Most individuals start treatment, stop treatment, return to treatment, and over time will relapse and slip (DiClemente, 2015; Loneck, McGovern, Wrisley, & Drake, 2005). While individuals attending inpatient treatment may be in an environment where they do not relapse for an extended period of time, after returning home, most treatment attendees will experience a relapse (McLellan et al., 2000). An individual's relapse process will inevitably impact their family life, and if they have a partner, their romantic relationship.

Several studies evaluating the chronicity of relapses in treatment have emerged in the literature. In a study drawing data from seven multisite studies in the United States, during the year after treatment, one in four participants remained abstinent and one in ten reported using alcohol moderately (W. R. Miller, Walters, & Bennett, 2001). In another example, in a study of 1222 adults attending outpatient treatment for substance abuse, only 34% of the sample remained abstinent for 12 or more months (Scott, Dennis, Laudet, Funk, & Simeone, 2011). Similarly another sample found relapse rates to be 40% for individuals who attended treatment (Moos & Moos, 2006). Rates of relapse across five groups in another study ranged from 37% to 78%

(Loneck et al., 1996). Sellman (2010) reports that fewer than 10% of people with drug addiction will have continuous abstinence following treatment. While there is variance across studies, the consistent finding is relapses occur frequently, even after receiving treatment.

Relapses occur because individuals lack an effective coping response in high-risk situations, and as a result believe they will see an increase in their expectation for a positive outcome if they return to their drug use (Dimeff & Marlatt, 1998). The more stressors in an individual's environment, the more likely they will relapse (Law et al., 2016). However, relapses can often provide the addicted individual with important information that drives them towards making change (Marlatt, 1985) and starting treatment programs which assist them in beginning to feel strong and sober. That said, as time goes on and an individual is confronted with the stressful realities of their day-to-day life, relapses could become a common experience. The initial honeymoon period rarely lasts (Sweet & Miller, 2016).

Clinician attitudes towards relapse

Relapses in therapy are not always well received by social workers and other treatment providers. While the field acknowledges addiction as a chronic illness conceptually, not all treatment approaches address this in practice (Arria & McLellan, 2012). Some programs will cease treatment or threaten ending treatment if an individual continues to relapse. As Arria and McClellan (2012) highlight, there are few options for clients attending addiction treatment, and when clients do not comply with what is available they are assumed to be unmotivated to change. Contemporary discourse continues to describe addictive behaviour as unsavoury and individuals living with addictions continue to be stigmatized. For example one writer describes addiction as "insidious" and the substance abuser as having "excuses" and a "belligerent

attitude" (Cook, 2010, p.4). Additionally, relapse has been viewed as treatment failure, whereas abstinence has been valued as treatment success (Rahill et al., 2009).

These belief systems largely emerged from the 12-step movement (started in 1935) that viewed relapses as a sign the individual was not yet "ready" to quit drinking (Adams & Eastwood, 1992). The main purpose of Alcoholics Anonymous (AA) and other 12-step programs is to stay sober and to help others do the same (Pagano et al., 2009). AA provides individuals with a recovery community wherein problem drinkers (or drug users) can abstain, and also experience spiritual and emotional development (Hoffmann, 2003; Trice & Roman, 1970). 12-step programs promote affiliative relationships and provide positive attachments for individuals. This structure works well for many individuals (Vaillant, 2014). While peer support programs are effective for numerous individuals in meeting their treatment goals (Tonigan & Beatty, 2011)**,** the heightened focus on sobriety over all else is not appropriate for everyone. As addiction treatment evolves and our understanding of the etiology of addiction improves, it is clear that abstinence is not realistic or even desired for many individuals (Marlatt, Blume, & Parks, 2001).

Managing relapse in therapy

Despite widespread acknowledgment of the frequency of relapses and slips within and outside of treatment, the authors found a dearth of literature detailing how to navigate these realities. Relapse prevention literature is focused on how to prevent relapses during treatment, and on aftercare when treatment has finished (Carroll & Onken, 2005). To the authors' knowledge, little work exists that details *how* to approach relapses that occur in treatment. For example, Cognitive Behavioural Therapy (CBT), one the most researched theories used to treat drug addiction (National Institute on Drug Abuse, 2012) recommends that in behavioural

therapy, clinicians should help clients recognize decisions that could lead to relapse (Carroll, 1998), however, no explicit discussion was found on how to treat relapses with clients when they occur. This could be in part, because many studies on substance abuse interventions include urinalysis, meaning individuals are incentivized to remain abstinent while receiving the intervention, as they are tested weekly or bi-weekly. Additionally many other studies use inpatient participants, meaning substance use is more easily avoided during treatment. These contexts along with a focus on relapse prevention and abstinence may have influenced an absence of discussion on managing in-treatment relapse in research, practice guidelines and treatment manuals.

While stereotypes and discrimination against individuals living with chronic relapsing addiction continue to exist, the old AA adage, "Come back when you're motivated" is no longer an acceptable response to a relapse (Sellman, 2010). It is important to move away from viewing addictions and treatment outcomes as a dichotomy of sober or not sober (W. R. Miller, 2015; van der Woerd, Cox, Reading, & Kmetic, 2010). Instead, social workers need to find ways to work with relapses and slips, and to reframe these experiences as possibilities for change in therapy. Some clinicians are moving towards working with clients to implement relapse prevention plans. DiClemente (2016) posits that relapse should not be conceptualized as a failure, but rather as continued change. In doing so, he suggests clinicians may view their role differently with clients. If clinicians are more open to working with clients through their relapses, clients may feel less ashamed, and treatment retention and success rates may improve.

Treatment that is accepting of relapses, as part of the addiction recovery process is necessary, particularly with recent evidence suggesting the effectiveness and importance of offering harm reduction approaches to clients. As Musalek (2013) discussed, some individuals

are not able or willing to participate in abstinence oriented treatment. Research on the effectiveness of harm reduction highlights the possibility that some individuals may only be willing to engage in an intake-reduction approach to their treatment. Intake-reduction (using less of the substance) works for many individuals. For example, Miller and Wilbourne (2002) examined 35 clinical trials of behavioural self-control training and found that 48 brief interventions demonstrated evidence that it is possible for heavy drinkers to moderate their substance use. Similarly, the Bruges model developed in Belgium acknowledges different choices for different clients with their controlled drinking program (de Shazer & Isebaert, 2004). Individuals treated using this model may choose to attend an abstinence based group or a controlled drinking group. Clients are free to switch groups at any point during their treatment, and neither group is valued over the other (de Shazer & Isebaert, 2004).

Other treatment practices need to incorporate these realities, and find ways to support couples navigating addictions in their relationships. Musalek (2013) writes, "It must always be remembered that it is not the disorder itself that is to be treated but only ever the individual who is afflicted by it" (p.637). Treatment goals that do not reflect the realities of the individual living with the addiction will not be effective. When relapse happens clinicians should explain the chronic nature of the addiction to their client, and continue treatment (Arria & McLellan, 2012; National Institute on Drug Abuse, 2012). Those who relapse during outpatient treatment are significantly less likely to complete treatment than those who do not relapse (Loneck et al., 1996). The reasons for this, however, are not clear. Encouraging clients to continue treatment after a relapse is an important component of social work practice.

Working with relapses in the context of couples

Attitudes towards relapse in the context of couple relationships arose largely out of the co-dependency model that responded to women living with alcoholic husbands in the 1980's. The co-dependency model emphasizes there is something pathological about a spouse who forms a relationship with a person who has a substance addiction (Hurcom, Copello, & Orford, 2000). From this perspective, close involvement with an addicted partner risks enabling behaviour and co-dependency. Co-dependency literature warns the romantic partner about facilitating their partner's use of substances (Rotunda, West, & O'Farrell, 2004). A common argument in the co-dependency model is the non-addicted partner should emotionally detach from their loved one (Casey, 2008; A. Miller, 1988). These perspectives pathologize the existence of interdependency within a couple. If partners wish to continue to live together when one partner has a chronic relapsing addiction, ways of managing relapses in a couple need to be further developed.

Discussions of co-dependency and enabling continue to be prevalent in treatment centers today. That said, research results have demonstrated the higher number of supports individuals have, the more likely they will be able to maintain abstinence, whereas the fewer supports, the more likely they are to relapse (Harris, Fallot, & Berley, 2005; van der Woerd et al., 2010). Individuals stay abstinent longer when they are in positive, supportive relationships. A recent study on "we" language (meaning that the couple spoke using "we" as opposed to "I") hypothesized that greater "we" language would be associated with less relationship distress and would predict better drinking outcomes at later time points (Hallgren & McCrady, 2016). They found that more "we" language in the couple predicted a greater increase in abstinent days during subsequent weeks of treatment, and predicted more abstinent days, relative to baseline, over the 6-month follow-up period (Hallgren & McCrady, 2016). Similarly Giordano, Clarke and Furter's (2014) study found that family attachment was a protective factor that reduced the

likelihood of increased relapse days; every one unit increase of family attachment corresponded with a 3.2% decrease in the odds of a multiple day relapse. They concluded clinicians should address family issues in treatment, while working from a collaborative standpoint (Giordano, Clarke, & Furter, 2014). Intervening with an individual's family system warrants attention (Holland et al., 2016). The more clinicians work with family members, the more families can be used as a source of support for the addicted individual. There is little written on how to address relapses in this context. While existing literature on couple therapy and addiction addresses that slips and relapses may happen, there is scarce information on how to deal with them in treatment.

Barbara McCrady, a well-known researcher and developer of the Alcohol Behavioural Couples Therapy (ABCT) model wrote about the potential for relapse prevention within a couple relationship (McCrady, 1989). She noted that if a client drank, both the client and the partner still have the opportunity to respond in a way that prevents further drinking. While the partner of an addicted individual might engage using a positive coping response in the face of a relapse, there is also a possibility they may have a "non-facilitative" response to their partner's cravings which increases the likelihood of future relapses (McCrady, 1989). McCrady (1989) recommended non-addicted partners learn to detect risks and signs of relapse, and support positive coping methods.

Similarly, Timothy O'Farrell, productive researcher in the field of couple therapy and addiction discussed his model of Behavioural Couples Therapy (BCT) wherein he acknowledges that relapse in early treatment is the rule as opposed to the exception (O'Farrell & Schein, 2000). The clinician should discuss the relapse as a possible learning experience, and use the therapy to encourage the couple to follow a recovery contract together where the addicted individual pledges to remain sober, one day at a time (O'Farrell & Schein, 2000). From O'Farrell's

perspective, abstinence must be sustained before a couple can focus on improving couple and family relations. BCT is also based on the premise that the non-addicted partner should reward abstinence by expressing support for their partner's efforts each day their partner remains sober (O'Farrell, 2015). BCT continues to be regarded as a therapy that aids not only couple relationships, but also addicted individuals in relapse prevention (Wesley, 2016).

While writers within this literature do acknowledge relapses will occur in early treatment, these behavioural models advocate for avoiding discussion of anything other than the addiction until the addiction has been "managed". Similarly, Landau-North, Johnson et al., (2011) in their theoretical extension of EFT for addictions highlighted that the addiction should be "managed" before beginning Stage Two of the therapy. However, no clear description of this process was outlined. Given what we know about the chronic relapsing nature of addiction, many couples would never be in a place where they could speak about their relationship issues if the prerequisite was abstinence. Furthermore, learning to tolerate and examine relationship conflict could offer important insight for individuals struggling with cravings and emotion dysregulation. Avoiding these topics seems counterintuitive in a change-oriented process.

Couple therapy in the context of substance addictions is primarily carried out when the addicted individual is abstinent. There is an absence of acknowledgement in treatment models of how to respond if a relapse occurs. More studies are needed in the context of couple and family interventions to address the experiences of relapse in treatment.

Emotionally focused couples therapy for addictions

Using data from a replication case study conducted with couples in the context of addiction, this paper will explore slips and relapses as they relate to couple therapy and addiction treatment more broadly. The study attempted to provide initial evaluation of a conceptual

extension of Emotionally Focused Couple Therapy (EFT) to treat couples in the context of addiction (Landau-North, Johnson, & Dalgeish, 2011). EFT is a manualized treatment model that conceptualizes couple problems in terms of attachment insecurity and separation distress (Johnson & Whiffen, 1999; Johnson, 2003). EFT has three stages, and nine steps (see Figure 1). The EFT clinician works with the couple as a process consultant with the goal of creating and consolidating safe emotional engagement (a secure base) within the relationship (Johnson, 2003). The extension of EFT theorises that addiction is an attachment issue, arguing that clinicians should help couples create healthy dependency within their relationships as an alternative to addictive regulation strategies (Landau-North et al., 2011).

Figure 1. Emotionally Focused Therapy: Steps and Stages.

Stage	Step & Description
I Assessment & Delineation of Problematic Cycles/ De-escalation	1. Create an alliance and delineate conflict issues in the struggle. 2. Identify the negative interactional cycle. 3. Access unacknowledged feelings and attachment needs. 4. Reframe problem in terms of underlying emotions and needs.
II Re-engagement/ Softening	5. Promote identification with disowned needs and aspects of self. 6. Promote acceptance of partner's experience. 7. Facilitate the expression of unmet needs and wants.
III Consolidation	8. Facilitate the emergence of new solutions. 9. Consolidate new positions.

Methodology

The McGill University Research Ethics Board and the Québec Comité de la Recherché en Dependence provided ethics approval for this study. A replication case study (Yin, 2009) was selected as the most appropriate methodology to allow for a close examination of the complexities of treating couples dealing with addictions with EFT. For this study, four couples

were recruited from an addiction treatment center in Québec. The first author of this paper provided the selected participants with couple therapy free of charge. The first author has an AAMFT accredited postgraduate diploma in couple and family therapy, seven years of addiction treatment experience, and has received training in EFT. The EFT manualized treatment model was followed and implementation checks were performed in order to ensure treatment fidelity. The supervisor reviewed segments of the tape to make sure that the treatment extension was implemented correctly.

The implementation of EFT was staggered to explore the intervention at each stage in depth (Kazdin, 2011). EFT was introduced with the first couple at baseline. In order to stagger the baseline, the second couple remained at baseline until the first couple reached Stage Two of EFT. The second couple then began treatment, and the third couple started treatment when the second couple reached Stage Two and so on, until all four couples had commenced treatment. Couples waited at baseline between three to six weeks. The same protocol was used to replicate each case in an effort to provide data on both the outcome and the process of change associated with EFT.

The proposed model suggested that any ongoing substance use should have ceased by the beginning of the second stage of treatment (Landau-North et al., 2011). The extension also stipulated that the clinician help the couple determine a relapse prevention plan in the third stage of EFT. While all four participants with substance addictions entered treatment sober, three participants, in three of the four couples, relapsed over the course of treatment. The extension did not address what to do if relapse occurred later on in therapy. In our study, the clinician, also the first author, in consultation with her supervisor, the second author, made the decision to continue

the treatment and to directly address relapses and slips with the couples using psychoeducation and an adaptation of EFT interventions as clinically appropriate when relapses or slips occurred.

Participants used language to describe their return to substance such as slips, lapses, and relapses, depending on the individual and how they understood their experience. For the purposes of discussion, relapse, lapse, and slip will refer to any drug or alcohol use over the course of the study. The absence of information on how to deal with slips or relapses using this approach highlighted the need to address this for future studies.

A thematic analysis was used to analyze the transcripts of sessions where relapses and slips were discussed, in particular the therapeutic approach to these occurrences and client responses. Key statements were identified in the sessions that focused on slips and relapses. Each session transcript was searched for the terms, "relapse" "lapse" "slip" "drank" and "used" to identify the portions of the transcripts where relapses and slips were discussed in session. Four themes emerged in discussions of relapse: relapses as a couple injury; guilt, shame and depression about relapse; relapse as part of the treatment process; and confusion about what to do after a slip. The unique combination of these themes highlighted the interconnectedness of relapse, shame, and relationship distress, as well as a lack of clarity for how to respond to a relapse as a couple. Each couple interpreted and processed relapses differently. Some couples saw relapses as an opportunity to discuss trust and closeness in their relationship whereas others viewed them as an attachment injury. An attachment injury refers to an abandonment or betrayal of one partner by the other at a critical moment (Halchuk, Makinen, & Johnson, 2010). Often these injuries trigger an earlier attachment injury inflicted by a caregiver. Using examples from the study, recommendations for dealing with relapses in couple therapy will be offered.

Table 1. *Utterances related to topic of slips and relapses by EFT Stage*

	Couple A	Couple B	Couple C	Couple D
Stage 1	46	18	39	70
Stage 2	25	17	111	93
Stage 3	-	10	-	-
Total	71	45	150	163

Participants

At the time of initiating therapy all four couples met inclusion criteria. Each partner with a self-reported addiction had attended treatment at the referring outpatient treatment centre. All four participants who had attended addiction treatment had been primarily exposed to cognitive behavioural therapy and motivational interviewing techniques. None of the couples had ever attended EFT sessions before participation in this study. Given the contextual nature of the replication case study, each couple will be described in some detail here. The couples will be referred to as Couple A, Couple B, Couple C, and Couple D.

Couple A had been together 13 years; Andre[3] (age 38) reported that he had been addicted to cocaine for twenty years. Andre's father was an alcoholic during his childhood and he did not remember at what age he started his own substance use. Antonia (age 33) met Andre shortly after immigrating to Canada from a Middle Eastern country. When therapy started, Andre had not used alcohol or cocaine in three months, and had been sober since completing treatment at an inpatient treatment facility (over three months sober). Throughout the treatment Andre continued to attend the peer support group Alcoholic's Anonymous (AA). Andre slipped three times during

[3] *All participant names have been changed to pseudonyms and identifying details have been altered to preserve anonymity*

the course of therapy, which occurred weekly for 18 sessions. During therapy, Couple A had 71 utterances about slips and relapses, with most utterances occurring in the first stage of therapy.

Couple B had been together 35 years. Bridget (age 53) was a college-educated woman who worked full time in an administrative position. Her husband Bob (age 56) reported that he had been addicted to cocaine and alcohol for seven years, however Bridget reported that Bob had struggled with addiction "on and off" for most of their marriage. Both of Bob's parents were alcoholics and he remembered having his first drink at the age of 10. The couple had attended therapy both together and individually on and off for the past few years. At the time of starting therapy, Bob was three months sober from cocaine and alcohol and was also attending a peer support group (AA). Bob did not report a relapse during the course of therapy (25 sessions). Couple B had 45 utterances about relapse throughout their treatment, which was the lowest number across the four couples.

Couple C had been together for three and a half years. Claire (age 57) worked in education, and Carlos (age 64) worked in technology. Both were previously married. Claire grew up with an alcoholic father. Carlos struggled with his alcohol use for 50 years, but only began seeking treatment in the past few years after meeting Claire. Both partners attended therapy before participating in the study, and after a relapse that occurred during treatment, Carlos began attending an abstinence based peer support group. Carlos reported three slips during the course of 26 weeks of therapy, and Claire suspected that Carlos underreported his relapses. Couple C had 150 utterances about slips and relapses throughout the course of therapy, which is synonymous with the higher number of relapses Carlos experienced compared to other participants.

Couple D had been together 33 years. Derek (age 62) reported that he had been addicted to alcohol for 25 years, and Donna (age 55) noted that she could not remember a time when her husband's alcoholism did not impact their relationship. Derek and Donna had both attended outpatient individual therapy for the past three months, and Derek had finished an inpatient treatment program approximately three months before commencing couple therapy. Donna had also attended individual therapy 13 years prior. While in therapy, Derek attended a recovery maintenance group and occasional peer support meetings. Derek struggled with relapse numerous times throughout the 20 weekly sessions of therapy. Couple D had 163 utterances about relapse throughout their treatment.

All participants had received prior treatment at the same agency. All addicted participants began the study after a period of at least three months of sobriety, three of the four addicted participants relapsed during the therapy process. The couples' described experiences of relapses and how to manage them in the relationship will be analysed here.

Review of slips and relapses as they occurred in the study

Considering individuals with addictive disorders have difficulty sustaining abstinence, it is expected to see relapses occur in long-term outpatient therapy. In the replication case study conducted using Landau-North et al,'s (2011) theoretical extension for EFT, relapses were a common theme.

Experiencing relapses as an attachment injury was the first theme that appeared in the data. Couples noted that relapses became intertwined with their feelings about one another. For example Claire said in regards to her fear that Carlos had relapsed and had not told her, "It's a problem. It's a problem... it's a problem. Because… the dishonesty is insidious and it invades everything. You know, so…" (se. 16). Claire went on to say, "I don't know… if… if because

he's struggling with his addiction and maybe is in survival mode… he doesn't understand how wounding it is when you betray someone" (se. 16). Claire experienced Carlos' relapses as a betrayal, and as an indicator that he was not willing to do everything he could to stay sober and make their relationship work. Claire often shared her fear she was enabling Carlos by staying with him. Donna also described feeling hurt after Derek relapsed. She said to him, "It's not something that [just] sets you back, it sets me back too, you know that it's not all about… it's about us, you know?" (se. 17). While Donna tried to understand where Derek's lapses came from, she experienced them as harmful to the couple and personally hurtful.

Guilt, shame and depression after a relapse emerged as another theme in the analysis. When the addicted partner relapsed, they described feeling ashamed and guilty, and some felt depressed. For example, Carlos said,

> I felt bad with myself, because I gave up… I gave up yeah, I was disappointed with myself, and for her… I have the emotions too because I start thinking about what happened… and it was like a big setback (se. 3).

Later in the therapy when he relapsed again he said,

> It was a very difficult thing to uh… to see her and I disappointed her, disappointed myself, you, and the whole thing… she wanted to understand why I did that, and then… how I put our relationship to a final… to a final situation like she didn't want to, she wanted to finish with me, and I… I... was feeling really bad (se. 19).

Carlos understood the impact of his relapse on Claire, and felt remorseful for hurting her. He explained, "The thing is before when I drank, I enjoyed before, now I don't enjoy, I feel guilty, it's like what am I doing? I don't like the feeling after, it gets me really depressed" (se. 22).

Relapses for Carlos became a reminder that he was failing at abstinence and was disappointing his partner. Even while in the process of relapsing, Carlos was feeling guilty and depressed.

Andre also spoke about his relapses being very emotionally difficult. He said, "I get depressed hard the day after, I have big downers, I can't sleep, I can't stay alone, I can't… the day after is bad for me" (se. 1). Andre noted the longer he was sober, the more depressing relapses felt. He was ashamed, and no longer enjoyed the experience of drinking and using.

Relapse as part of the process was a third theme. Couples discussed with the clinician how it was normal that lapses were going to happen. For example Donna said, "I understand that's not something that's gonna be fixed overnight, you know? And that we can't put a timeline on it and schedule lapses or whatever" (se. 5). Donna had insight that Derek would relapse, and she wanted to support him when he was lapsing, or at risk of lapsing. She echoed a similar sentiment later in the therapy saying, "The tough reality of how an addiction can be so hard to overcome and that progress will be slow, and lapses will inevitably occur, is something that I've accepted, I'm still learning how to cope" (se. 12). Donna considered how to manage her responses to Derek's lapses as opposed to how to manage the relapse itself.

Antonia was able to support Andre's recovery and was not devastated when he had his first lapse after several months of abstinence. She said, "So he's in the kitchen, so he turned to me and said, look, I drank. You know, I took it good. I said, okay hopefully its not gonna happen again, I said, look, it happens…you gave yourself up" (se. 1). Antonia was happy Andre was honest and she wanted to integrate the relapse as something that occurred and move on. Andre discussed the same relapse, acknowledging that it was a normal experience after completing inpatient treatment. He described the impact of the relapse on the couple saying:

> We're doing better, I'm okay with myself and she knows it. I still have old habits to change after 38 years, and 28 days isn't gonna change 38 years of habits you know what I mean, in a couple of months? But I see myself changing. I don't take things as hard too much… I understand it happened (se. 3).

Andre saw slips as part of his recovery process. He was very clear to point out that he viewed a brief return to drinking as a slip, "I'm not working on a relapse. If I do, I do a slip" (se. 4). Over the course of therapy, Antonia and Andre were able to discuss slips as they occurred in the couple relationship. When a slip occurred near the end of therapy the couple shared their progress about being able to discuss and integrate it:

> Andre: I told her and…
>
> Clinician: yeah… how did you feel?
>
> Antonia: well it's good
>
> Clinician: yeah…
>
> Antonia: and that his uh you know, he's realizing what uh… I don't know how it came about, but it's… positive (se. 17).

While Andre and Antonia were exposed to many different treatment approaches, they were both able to frame Andre's addiction recovery as a process that included slips, with the goal of longer periods of abstinence over time.

Confusion about how to respond to a relapse was the final theme. For example Donna said, "I don't know what is lapse and what is relapse and what my role in this is, and what my role isn't in this…" (se. 9). While Donna wanted to support Derek, she felt like she did not know how to help him, and how to identify what was happening. There was role confusion for her and she sought out a response from Derek to understand how to best support him. Claire expressed a

similar challenge and said, "I struggle with… um… the insecurity that uh… that Carlos may relapse. I'm not quite sure how to deal with that" (se. 17). For Claire the possibility that a relapse could happen was preoccupying, particularly because she was unsure how she should respond.

While Antonia did not feel as impacted by Andre's experiences with relapse, she did struggle to find a way to respond to him. She said, "Sometimes, you know when he, let's say he slips, or… you know it's a bit overwhelming and I don't know what to say" (se. 1). Antonia described feeling like she was supposed to have a particular reaction to Andre's relapse, but she felt ill equipped to respond to him. These excerpts identified the need to provide couples with support to navigate relapses together.

Discussion

William Miller (2015) states, "Addiction treatment has suffered from perfectionism" (p.976). As with any other chronic illness, individuals living with addiction need to be able to relapse without receiving the message they are failures, or they can no longer continue treatment with their partner. Relapse episodes need to be considered cumulatively over time, as opposed to "all-or-nothing" measurements of a single relapse (Dimeff & Marlatt, 1998). Dimeff and Marlatt (1998) cautioned against restarting an "abstinence clock" after a relapse, and suggest clinicians instead encourage positive changes over time. If slips and relapses can be discussed productively in session and both partners feel safe enough to do so, these discussions can serve as important components of addiction treatment. Addiction treatment needs to be an integrative experience wherein addiction, abstinence, or reduced consumption, are sub-goals to an overarching goal of living a self-determined life (DiClemente, 2015; Dimeff & Marlatt, 1998; Musalek, 2013).

Recommendations

The EFT approach works with couples to share attachment needs and fears, and to address a problematic interaction cycle that exists between the couple. In couples where there is an addiction, substance use is often wrapped up in old attachment wounds in the couple, and these can become reactivated when a relapse occurs. The open, emotional engagement encouraged by EFT creates an ideal context for exploring the occurrence of relapses. The following section will outline a proposed model for addressing relapse in the context of EFT, incorporating recommendations using what was observed and worked well in the replicated case study.

1. Create open dialogue around slips and relapses

Primarily, the clinician can encourage the couple to engage in an honest conversation about relapses and slips. This should include disclosure when a relapse occurs, and open dialogue around fears and concerns related to slips and relapses. The clinician can do this by being transparent with the couple at the beginning of therapy that the couple will not be kicked out of therapy if there is a relapse (a stated fear of two participants) and the most beneficial way to navigate a relapse is to talk about it. All four couples in the study were encouraged at the outset to discuss relapses in session if they occurred. Creating an open, non-judgmental environment to discuss relapses helps to remove some of the stigma and shame around a very normal process.

With Couple D, Derek was reluctant to discuss slips and relapses in session. The clinician considered this with him, and suggested that avoiding discussion of relapses did not help the couple come closer together. She said, "You relapse, you observe, you get upset and no one talks about anything… that just keeps the two of you further and further apart" (se. 4). Derek agreed with this and described that his reticence was tied to disappointment in himself, and feeling like

Donna would not be able to help him if he opened up to her. In this example, engaging in discussion about slips and relapses helped Derek share a fear he had in the relationship.

2. Allow couples to ascribe their own meaning to slips and relapses

In addiction treatment with couples, change needs to be focused on the couple relationship, as opposed to on the intervention or the clinician (DiClemente, 2015). The clinician should provide space for both partners to make their own meaning about the relapse. Couples should determine together how a lapse is described and understood. As Andre said, "There was a slip, I understood the slip but there's no relapse. There is no lapse" (se. 5). For Andre there is meaning in the difference between a slip and a relapse and this distinction is an important measurement as to how he is doing. The clinician needs to listen for the language ascribed to the lapse (relapse, slip, etc.) and discrepancies between how each partner describes what occurred.

In the case of Couple C there was often a discrepancy between how the individuals perceived the slip. Claire found a slip/relapse devastating, whereas for Carlos, it served as a reminder he had a problem and that drinking was no longer enjoyable for him. For example, Claire said, "I guess for me of course, uh… the thing to discuss would be the recent setback. That would be something I think that has uh… affected out relationship, and so I guess it would need to be talked about" (se. 3). While she was hesitant to risk sharing her feelings with Carlos, there was a necessity for this couple to process relapses. Later in the therapy Claire was able to articulate her challenge, saying, "Maybe I'm afraid, maybe I'm afraid of sharing my feelings with Carlos, about… about the whole… the addiction and and the role that… that trust plays in our relationship" (se. 16). Carlos shared with Claire the tenuous nature of his sobriety in the beginning of therapy. He said, "I try to do my best not to do… what, to consume again, but I don't want to make false promises… it's like the same thing to keep lying and lying you know.

What's the point?" (se. 3). Discussing relapses in therapy promotes honesty in the relationship, which is an important foundation for building trust and security.

Discussing relapses can also help to normalize both partners' experiences. Relapses can be discussed as something the couple or addicted person learns from:

> Andre: I went… I drank a few beers on Friday…. and I figured out, it was good that I did because it's not my trip any more.
>
> Clinician: okay…
>
> Andre: It wasn't, it wasn't fun…
>
> Clinician: You were able to stop yourself?
>
> Andre: Yeah… at… uh… um, it's just not fun any more (laughs)
>
> Clinician: Yeah…
>
> Andre: It's not like it used to, it's not a trip, or anything, the drinking it wasn't… it was like I don't know, maybe if uh, I'm in a party with 100 people it's different but… that trip that I used to do by myself…
>
> Clinician: So you learned something from it…
>
> Andre: Yeah it's not fun and it's not worth it (se. 17).

Similarly, Derek talked about gaining some insight about his relapses, and said, "that's something I can't really explain to Donna because it's something, you have to relearn yourself a little bit too, which I haven't really yet" (se. 6). These discussions are useful because they provide the couple with the tools to move away from shame and secrecy and start to address how to integrate what was learned from a relapse.

Couples need encouragement to set their own norms and goals around what substance use should look like within the relationship. This requires the clinician to listen carefully to what

their clients are telling them, while also remaining flexible to adjusting the treatment as both partners navigate their relationship and the addiction.

3. Provide ongoing psychoeducation on addiction

Another recommendation that emerged from the study was the importance of providing psychoeducation to couples about the chronic relapsing nature of addiction. All four couples in the case study shared different theories they had heard about addiction. For example Claire said, "I don't know… what's it going to take, you know often you hear that expression, the alcoholic has to hit bottom before things can change… I know that" (se. 19). Claire suspected that Carlos needed to have a "bottoming out" experience before he stopped relapsing, and this couple needed support to understand addiction as a chronic relapsing disorder. Similarly, Claire wondered if she should "detach with love" (se. 21) from Carlos, for fear of more heartache, however, she simultaneously acknowledged that she wanted to stay in the relationship despite Carlos' relapses. These are two small examples of many questions couples had about substance use and the treatment trajectory for addiction. Incorporating psychoeducation into the framework of a treatment model allows the clinician to address mythology about the meaning of relapse and provide important information on other facets of addictive disorders.

The clinician should work to normalize relapses as part of the addiction recovery process. For example, in the study, the clinician said to one couple after a lapse occurred,

> Alcoholism is going to be that nasty next-door neighbour who raps on the window at night, right? And has loud parties upstairs and tries to disturb the two of you, but how can you build your relationship so you keep him at bay? (se. 3).

Using the EFT extension, addiction is discussed as something the couple can defeat together, and relapses are framed as an additional obstacle for the couple to address and overcome.

4. Help the couple develop a relapse prevention plan and a relapse plan

The theoretical extension (Landau-North et al., 2011) states the clinician should help the couple determine a relapse prevention plan in the third stage of EFT. In the discussed study, only one couple made it to Stage Three, and they were the only couple that did not experience a relapse during treatment. Clinicians need to introduce relapse language right from the beginning of treatment. The clinician should continually discuss a relapse prevention plan and a relapse plan with couples, providing education on the chronic relapsing nature of substance addiction. A relapse plan sets a frame wherein the couple receives the message that relapses may happen, and therapy is a good place to talk about relapses. While a relapse *prevention* plan is important, it should be addressed earlier in the EFT extension so couples struggling with relapse in Stage One of EFT can discuss a prevention plan that can be reworked and modified as therapy progresses. This has the further benefit of participants hearing from their clinician that relapses may be a part of their treatment process. As discovered in the study, some individuals were still relapsing frequently and were not ready to outline a relapse prevention plan. Discussing a plan for their relapse was not predicting a future relapse, but rather helping the couple identify how they wanted to respond to a potential relapse.

In the case of Couple C, the clinician worked with the couple to develop both a relapse plan and a relapse prevention plan. One of Claire's biggest fears was Carlos not telling her that he had relapsed. The clinician worked with the couple to find ways Carlos could feel safe enough to tell Claire when he had relapsed, without fearing her rejection and anger. The clinician said, "Carlos, if you are struggling and you do end up slipping at some point down the road… is there a way that you would feel like you could be honest with Claire?" (se. 17). Carlos was unsure, Claire responded to this, telling Carlos she would be there for him in the event of a slip, and

encouraged him to reach out to her for support when he had cravings. While this was a challenge for this couple, the clinician introduced discussions of how the couple wanted to respond to both preventing a relapse, and dealing with a relapse itself.

5. Use attachment language

In this study, the clinician tried to work with couples through relapses discussing betrayals in the relationship as attachment injuries using the Attachment Injury Resolution Model (AIRM) (see Johnson, Makinen, & Millikin, 2001). For example, after an early relapse, to illustrate the betrayal Claire felt, the clinician said to Carlos, "the two of you have been dancing together for a few years, but each time that you slip or each time that you use, it's like you went off and you danced someone else" (se. 3). Later on in the therapy when another relapse occurred, the clinician encouraged Claire, the injured partner, to start connecting with Carlos who was becoming more accessible (Johnson et al., 2001):

> I hear you saying there has to be safety to have ups and downs, whatever those may look like, in a way that's honest with each other… it has to be okay for the two of you to have weaker moments when you're struggling and the ideal would be that in those moments you could reach for one another, as opposed to reaching for anything else (se. 16).

While relapses were particularly difficult for this couple, they worked to develop safety in the relationship to discuss their struggles with integrating relapse. With help, Claire was able to articulate the attachment significance of the relapse and Carlos was able to respond empathically (Johnson et al., 2001). The extension for EFT should incorporate the discussion of relapses using attachment language and the AIRM.

6. Respect the integrity of the couple and their desire to stay together in spite of an addiction

There is a need to continue to find ways to work with relapses in couple therapy. Many couples choose to stay together regardless of substance use. As Claire said, "I'm not ready to walk away right now… I'm not… I'm not you know? And that's… all of that is true Carlos" (se. 23). Similarly, Donna expressed the importance of having a place to talk about successes and setbacks in the relationship saying, "So it's great that we're back here and that we're continuing forward and everything and that I had a chance to tell him, you know that what he went through in terms of uh… a relapse is also for me… I go, that I went through like setbacks too because of it" (se. 17). Incorporating these setbacks and encouraging the couple to share in the process together creates the opportunity for relationship support even in the context of an addiction.

If a couple is working towards abstinence, gradually longer periods of abstinence and shorter, less severe episodes of substance use should be the goal (W. R. Miller, 2016). A new standard that values a reduction in symptoms should be used (McLellan et al., 2000). Relapse prevention should focused on making a lifestyle change as a couple rather than solely on substance use or abstinence (McGovern et al., 2005). Working with couples is vital so that individuals can make change through developing relationships other than their existing relationship with substances (P. J. Adams, 2015).

Conclusion

Using a thematic analysis to explore the findings from a replicated case study (Fletcher & MacIntosh, submitted), this paper offers recommendations for treating and working with relapses in the context of couple therapy. There is a risk of substance abuse treatment becoming punitive in the case of relapse which could cause clients to avoid seeking treatment or returning to treatment after a relapse (Stone, 2015). In this study, one couple expressed all progress being undone as a result of a relapse. A paradigm shift is needed in how we conceptualize addictions

and relapses in couple therapy. There is an absence of literature on how to deal with slips and relapses during the treatment process. While research confirms relapses will happen in treatment, integrating and supporting the occurrence of relapses in the treatment process has not been well studied. A treatment approach that does not consider relapses as part of the process, risks doing a disservice to clients. In the context of relapses, there needs to be more treatment options as opposed to fewer. Ending therapy, or warning clients when there are slips in couple therapy is not only unrealistic, it may encourage dishonesty in therapy if the couple feels they cannot disclose a relapse. While abstinence is a noble goal, each relapse needs to be reframed as progress as opposed to an immense setback.

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Chapter Two Conclusion

The second manuscript explored how slips and relapses have been discussed in the literature and how participants in the replication case study experienced them. One of the interesting findings in this exploration was that couples experienced relapses and slips differently. Some interpreted slips and relapses as a sign of treatment failure, whereas others viewed the occurrence as necessary to process in therapy and move on from. Slips and relapses are just one area of many where participant understandings of outcome differ. Typically in couple therapy in the context of addictions, outcomes centre on abstinence and improved couple satisfaction. While these were important indicators of successful outcomes for some participants, several participants expressed a broader definition of treatment success. The third manuscript will address what comprises a successful outcome in this context, and will draw from the voices of the eight participants in the case replication study.

Manuscript 3: Examining Perceptions of Positive Outcomes in Couple Therapy in the Context of Substance Addiction

Abstract

Success in couple therapy is often determined by a reported improvement in couple satisfaction and intimacy. In the context of addiction, couple therapy treatment needs to assess outcomes that expand beyond couple satisfaction. Drawing from existing literature and a replication case study that that examined a theoretical extension of Emotionally Focused Couples Therapy (EFT) for couples in the context of substance addiction, this paper will outline how success is defined in addiction treatment and couple therapy. Recommendations for a broadening in definitions of treatment success will be made.

Introduction

Couple therapy is generally considered successful when a couple stays together and improves intimacy and couple satisfaction. For couples dealing with addictions, the process of couple therapy can be complex and outcomes that expand beyond satisfaction are important to consider. This paper will look at existing literature and draw from a replication case study that examined a theoretical extension of Emotionally Focused Couples Therapy (EFT) for couples in the context of substance addiction, to better understand how success is defined in addiction treatment and couple therapy. Recommendations for diverse definitions of treatment success that consider context, client perception, and focus on problem exploration over problem resolution will be offered.

Couple therapy outcomes

Couple therapy became a known treatment modality in 1930. It emerged primarily with pre-married and married couples seeking guidance on marriage (Gurman & Fraenkel, 2002). The purpose of intervention was to give advice about couple problems using a practical, short-term approach (Gurman & Fraenkel, 2002). Due to a lack of research and development, couple therapy as a distinct model almost disappeared during the 1950's and 1960's (Gurman & Fraenkel, 2002). By the 1980's couple therapy had re-established itself as a treatment model with active research and theory development (Gurman & Fraenkel, 2002). Since this time, theories of intervention have been greatly refined, and today countless empirical studies on couple therapy approaches are conducted. As a result of this evolution, couple therapists no longer solely service clientele who want to make their relationship work better, they also treat many couples looking for ways to move out of their current relationship or with other less conventional goals for therapy.

There have been three systematic reviews of literature addressing how clinicians and researchers determine success in couples therapy (Christensen, Baucom, Thuy-Anh Vu, & Stanton, 2005; MacIntosh & Butters, 2014; Sanderson et al., 2009). The most recent review by MacIntosh and Butters (2014) examined eighty-one couple therapy outcome studies. They concluded that a greater diversity of outcome measures (not solely couple satisfaction measures) are being used the field. They also highlighted contexts that had previously been treated as individual issues are now being tested using couple interventions. Their review called for qualitative analyses that considers unexpected outcomes previously interpreted as negative outcomes.

Previously, definitions of successful outcomes in the context of couple therapy and the addictions have been focused on decreased substance use, and improved couple satisfaction. These outcome measures begin to define expectations of what constitutes *effective* treatment. In this paper, we will examine how clients define successful outcomes in couple therapy in the context of substance addictions. Results from our case study demonstrate what constitutes treatment success in this context needs to be broadened to incorporate the diverse ways clients interpret success. Many clients viewed positive outcome based on what was explored as opposed to what was solved. Considering diverse definitions of success can help clinicians broaden treatment expectations and move away from viewing unresolved couple issues, or continued substance use as treatment failure. Furthermore, clinicians can be more invested in problem exploration than problem resolution. These shifts will also encourage researchers to consider new methods to measure outcomes in couple therapy in the context of addictions.

Substance addiction individual treatment outcomes

Substance addiction outcomes are often narrowly defined in treatment studies. Substance addiction treatment emerged out the moral model of addiction where dependency on drugs and alcohol was thought to be the result of poor choices and bad behaviour (Boyd, Carter, & MacPherson, 2016). As a result, abstinence was often regarded as synonymous with positive outcomes for addiction treatment. Frequently, treatment failure is calculated by the number of days or times an individual fails to stay abstinent (Musalek, 2013). Valuing abstinence in substance addiction treatment in not without reason; clients who maintain abstinence are seen to have better psychosocial outcomes and improved relationship satisfaction (Fals-Stewart, Birchler, & O'Farrell, 1999; O'Farrell, Cutter, Choquette, Floyd, & Bayog, 1992; Tonigan & Beatty, 2011). However, given the goal of most individual addiction interventions is to have permanent or long-term abstinence, individuals who relapse during treatment threaten treatment efficacy (Brandon, Vidrine, & Litvin, 2007). As Miller (2015) writes, "We have imagined only two possible outcomes: success or failure, with the latter defined as relapse (to fall back into a former state)" (p.976). Other researchers argue that these short term evaluations of substance use outcome after treatment, neglect the long term recovery process of addictive disorders (Dupont, 2014).

A panel of substance addiction treatment and research experts assembled by the National Institute on Drug Abuse met in 2010 to determine other appropriate outcomes for addiction treatment. This panel recommended addressing two overarching outcomes; cravings, and quality of life (Tiffany, Friedman, Greenfield, Hasin, & Jackson, 2011). This was significant, because abstinence alone does not mean an individual has experienced improvement in other facets of their life. Abstinence does not determine emotional, interpersonal, or vocational wellbeing (Musalek, 2013). Individual substance use trajectories will differ across individuals and will be

impacted by content, substance of choice, and multiple environmental and interpersonal factors (Best et al., 2010). Knowing whether someone remained abstinent for a course of treatment tells us very little about an individual's substance use trajectory or the desired treatment outcome. For many clinicians and clients alike, abstinence is no longer the ultimate goal (Musalek, 2013).

A very small body of research has examined perspectives of treatment outcomes from both clients and therapists. Socially desirable indicators of change have been favoured over outcome indicators stated by substance users themselves (De Maeyer, Vanderplasschen, & Broekaert, 2009). One study of a methadone maintenance program suggested there is low concordance in terms of perspective on treatment outcome between clients and clinicians (Trujols et al., 2011). Another study that used nine focus groups to assess quality of life in a substance-addicted group found these individuals prioritized personal relationships and social inclusion over other outcome factors (De Maeyer et al., 2009). A lack of attention to client point of view may be indicative of valuing certain treatment outcomes over others. Researchers and clinicians must consider how clients themselves interpret addiction treatment and what they demarcate as treatment success.

Outcomes with couples in the context of addiction

Substance addictions are often equated with low couple satisfaction (Dethier, Counerotte, & Blairy, 2011; Joutsenniemi, Moustgaard, Koskinen, Ripatti, & Martikainen, 2011). Spouses and partners of individuals living with addiction have reported increased stress levels, as well as various mental health concerns (Landau & Garrett, 2014). Specifically, substance use may be more stressful for one partner than it is for another (Ladd & McCrady, 2016). That said, substance addiction in a relationship does not necessarily indicate poor relationship satisfaction

(Ladd & McCrady, 2016). Therapists need to be mindful to not assume relationship conflict is centred on the addiction.

The potential for complicated responses when an individual stops using a substance also requires consideration when discussing couple relationships in the context of addiction. In some cases substance use has been an integral part of a couple's attachment relationship. Both partners may experience some sense of loss when the substance is removed (Cox Jr., Ketner, & Blow, 2013). Having a partner's presence in a therapy setting may work to better motivate and support an individual who wishes to reduce their substance use (Walitzer, Dermen, Shyhalla, & Kubiak, 2013), however, diverse experiences and expectations need to be better understood. Considering couple outcomes that fall outside of increased couple satisfaction and decreased substance use creates more openness in therapy for couples to determine their own interpretations of therapy process and outcome.

Current study

In a replication case study using a theoretical extension of Emotionally Focused Therapy for couples in the context of addiction (Landau-North, Johnson, & Dalgeish, 2011) a diversity of outcomes were present and couples identified various outcomes as having been positive. These outcomes did not necessarily correspond to outcomes identified in the literature as positive, however, pointed to the importance of considering diverse interpretations of successful outcomes in this context. In many cases, participants valued problem exploration over problem resolution. EFT is a three stage, nine-step manualized therapy that conceptualizes patterns of distress using an attachment framework (see Figure 1) (Halchuk, Makinen, & Johnson, 2010; Johnson, 2009). Couple problems are understood in terms of attachment insecurity and separation distress (Johnson, 2003; Johnson & Whiffen, 1999). From this perspective, couple problems cannot be

addressed without acknowledging the need for safe emotional engagement (a secure base) within the relationship (Johnson, 2003).

Figure 1. Emotionally Focused Therapy: Steps and Stages.

Stage	Step & Description
I Assessment & Delineation of Problematic Cycles/ De-escalation	1. Create an alliance and delineate conflict issues in the struggle. 2. Identify the negative interactional cycle. 3. Access unacknowledged feelings and attachment needs. 4. Reframe problem in terms of underlying emotions and needs.
II Re-engagement/ Softening	5. Promote identification with disowned needs and aspects of self. 6. Promote acceptance of partner's experience. 7. Facilitate the expression of unmet needs and wants.
III Consolidation	8. Facilitate the emergence of new solutions. 9. Consolidate new positions.

Methodology

Four couples were recruited from a Quebec outpatient addiction treatment centre to participate in a course of manualized therapy using the theoretical extension of EFT (Landau-North et al., 2011). A replication case study design was used (Yin, 2009). The McGill University Research Ethics Board approved the research methodology. The first author of this paper provided the selected participants with couple therapy free of charge. The first author has an AAMFT accredited postgraduate diploma in couple and family therapy, seven years of addiction treatment experience, and has received training in EFT. The EFT manualized treatment model was followed and implementation checks were performed in order to ensure treatment fidelity. The supervisor reviewed segments of the tape to make sure that the treatment model was implemented correctly. Couple satisfaction, emotion regulation, and couple attachment were measured pre and post therapy. Post-session problem resolution was measured after each session.

Post Session Resolution Questionnaires from the first, seventh, fifteenth and final sessions were analyzed for each couple, as well as from the highest rated and lowest rated sessions. These questionnaires demonstrated snapshots of therapy process, and how individuals were experiencing the therapeutic process as it related to problem resolution. These particular sessions were chosen for analysis because the first and final session provided qualitative data to track session outcomes from the beginning to the end of treatment. The seventh session was chosen because following the EFT intervention model; by session seven couples should be into the second stage of EFT treatment and have delineated their problematic cycle, and deescalated conflict between one another (Johnson, 2004). The fifteenth session was chosen because the normative model of EFT occurs for a period of 15-20 sessions. Examining the fifteenth session provided an opportunity to observe how individuals interpreted progress in therapy at a point that would be nearing termination in normative EFT. These session results were compared with in-session content using a process analysis.

Results from this study provide important information on the use of EFT in this context, and set the stage for larger randomized intervention studies in the future. The researcher was fully immersed in the data, being involved with all stages of data collection and analysis, and conducting the therapy with each of the four couples. The researcher was supervised in the implementation of the EFT model and any deviations from or additions to the treatment were done in consultation with a supervisor.

Process Outcome Measures

In-session Change was measured using the *Post-Session Resolution Questionnaire (PSRQ)* (Orlinsky & Howard, 1975). This is a 4-item measure used to evaluate in-session change and demarcate the best sessions in a therapy treatment. This instrument has been used in other

studies to identify best sessions (e.g. Makinen & Johnson, 2006). PSRQs were compared to in-session content to consider what couples rate higher or lower based on their in-session experiences. Questionnaires with high ratings were considered as a statement of "success". Graphs of the PSRQs are included to demonstrate outcome self-reports throughout the therapy (see Figures 2-5).

Quantitative Outcome Measures

Outcome measures were analysed to assess clinically significant change. Clinically significant change was defined by an improvement or decline of one standard deviation (SD), or a change that led to movement out of the clinical range of a measure.

Couple satisfaction was measured using the *Dyadic Adjustment Scale.* The DAS (Spanier, 1976) is a self-report index of couple adjustment. A reliability of .96 (Cronbach's alpha) was reported by Spanier (1976). Scores range from 0-151, with higher scores indicating higher dyadic adjustment. These scores distinguish between distressed and non-distressed partners with the clinically distressed range noted between 70-97 (Graham, Liu, & Jeziorski, 2006; Spanier, 1976).

Attachment was measured using the *Experiences in Close Relationships-Relationship Specific* (ECR-RS) Scale. The ECR-RS is a self-report measure, which assesses attachment relationships with an individual's romantic partners, friends, father, and mother (Fraley et al., 2006). Scoring provided information on relationship-specific attachment. ECR-RS scores have good reliability of .86 (Cronbach's alpha) (Dalgleish, Johnson, Burgess Moser, Lafontaine, Wiebe & Tasca, 2015). The ECR-RS also measures global attachment as dismissing, fearful, preoccupied, or secure (Fraley, Heffernan, Vicary, & Brumbaugh, 2011).

Self-regulation was measured using the *Difficulties in Emotion Regulation Scale* (DERS) (Gratz & Roemer, 2004). The DERS is a self-report measure that measures emotion regulation and dysregulation. This measure has average to strong reliability (.93 internal consistency, .80 Cronbach's alpha for subscales) (Gratz & Roemer, 2004).

Participants

Four couples participated in the study. Given the contextual nature of a replicated case study, each couple will be described in some detail here. The couples are referred to as Couple A, Couple B, Couple C, and Couple D.

Couple A had been together 13 years; Andre[4] (38) reported that he had been addicted to cocaine for twenty years. Antonia (33) met Andre shortly after immigrating to Canada. When therapy started, Andre had not used alcohol or cocaine in three months, and had been sober since completing treatment at an inpatient treatment facility (over three months sober). Couple A attended therapy for 18 sessions.

Couple B had been together 35 years. Bob, (56) reported he had been addicted to cocaine and alcohol for seven years, and had also had struggled with addiction in the past. Bob and Bridget (53) have attended therapy both together and individually on and off for the past few years. At the time of starting therapy, Bob was 3 months sober from cocaine and alcohol and was also attending a peer support group regularly (AA). Couple B attended therapy for 25 sessions.

Couple C had been together for three and a half years. Both partners were previously married. Carlos (64) struggled with alcoholism for 50 years, but only began seeking treatment in the past few years. Both Carlos and Claire (57) attended therapy before participating in the study. Couple C attended therapy for 26 sessions.

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[4] *All participant names have been changed to pseudonyms and identifying details have been altered to preserve anonymity*

Couple D had been together 33 years. Derek (62) reported that he had been addicted to alcohol for 25 years, and Donna (55) noted that she could not remember a time when her husband's alcoholism did not impact their couple relationship. Derek had finished an inpatient treatment program approximately three months before commencing couple therapy. Couple D attended therapy for 20 sessions. All four couples remained in treatment until therapy came to a natural conclusion and termination was collaboratively agreed upon with the therapist. The length of the couple relationship, and length of the substance addiction should be considered when interpreting the following results.

Results

Outcome Measures

The Dyadic Adjustment Scale measured couple satisfaction pre and post treatment (see Table 1). Clinically significant change occurred when an individual's DAS score increased beyond one standard deviation (16 points) or if their DAS scores increased above the cut-off score for distress (98). Couple A and B had significant outcomes on couple satisfaction with all four participants moving out of the clinically distressed range. In Couple C, Carlos moved out of the clinically distressed range, whereas Claire did not have significant improvement in couple satisfaction. Similarly in Couple D, Donna moved out of the clinically distressed range, however Derek did not. Couple C and D struggled more significantly with relapse than the other two couples, which could explain these results. Both Carlos and Donna expressed how they saw benefit in discussing relationship challenges in session, which could also explain their reported improvement. The DAS scores reflected what was expressed in therapy. As a result of Carlos' recent relapses, Claire terminated therapy concerned about the future of their relationship.

Similarly, when Derek terminated therapy he was unsure what his future relationship with Donna would look like.

Table 1. *Dyadic Adjustment Scale Pre- and Post-Test Results*

DAS Score	Pre-test		Post-test	
	Male Partner	Female Partner	Male Partner	Female Partner
Couple A	84	85	100*	112*
Couple B	97	95	117*	113*
Couple C	96	86	114*	94
Couple D	88	78	90	105*

Distressed = 70-97
* Clinically significant change
Note. Dyadic Adjustment Scale documented in Spanier, 2004.

The *Experiences in Close Relationships-Relationship Specific* (ECR-RS) Scale measured attachment (See Table 2). No participants reported a change in global attachment style from pre-test to post-test, however some interesting changes were reported in terms of attachment related anxiety and avoidance in the couple relationship. Clinically significant change was measured if individual scores in the ECR-RS decreased beyond one standard deviation. Avoidance SD= 1.13 for men SD=1.21 for women. Anxiety SD= 1.10 for men, SD=1.13 for women. Significant change was observed for Bridget in both anxiety and avoidance scores. A significant *increase* in the anxiety score was observed for Claire, which could be attributed to the therapeutic process exposing insecurity about the relationship and her fear that Carlos would continue to relapse. This could suggest negative change, or could indicate change that is targeted in EFT: heightened emotional experience and expression, and in increased willingness to engage emotionally (Johnson & Talitman, 1997).

Table 2. *Experiences in Close Relationships Scale Pre- and Post-Test Results*

	Identifiers	Global Attachment Style		Relationship Avoidant Score		Relationship Anxiety Score	
		Pre-test	Post-test	Pre-test	Post-test	Pre-test	Post-test
Couple A	Antonia	Dismissing	Dismissing	1.0	1.0	1.0	1.0
	Andre	Preoccupied	Preoccupied	1.0	2.0	1.0	1.17
Couple B	Bridget	Dismissing	Dismissing	3.33	1.17*	4.67	2.00*

	Bob	Dismissing	Dismissing	2.00	1.50	2.00	1.33
Couple C	Claire	Secure	Secure	3.67	2.83	3.67	5.00
	Carlos	Dismissing	Dismissing	2.00	2.00	1.67	1.00
Couple D	Donna	Secure	Secure	4.50	3.33	3.33	3.67
	Derek	Dismissing	Dismissing	2.33	3.00	1.00	1.67

Lower scores = lower anxiety or avoidance
*Clinically significant change
Note. Experiences in Close Relationships Scale documented in Fraley et al., 2006.

Emotion Regulation was self-reported using the Difficulties in Emotion Regulation Scale (see Table 3). Average DERS scores for women are 77.99 (SD= 20.72) and for men 80.66 (SD= 18.79) (Gratz & Roemer, 2004). Higher scores indicated more difficulty in self-regulation. No significant change in emotion regulation was reported. While reasons for a lack of significant change in emotion regulation are unknown, it is important to report that the EFT intervention did not significantly impact emotion regulation.

Table 3. *Difficulties in Emotion Regulation Scale Pre- and Post-Test Results*

	Names	Pre-test	Post-test		Pre-test	Post-test
Couple A	Antonia	75	73	Andre	89	81
Couple B	Bridget	82	78	Bob	94	82
Couple C	Claire	63	65	Carlos	60	68
Couple D	Donna	110	92	Derek	51	50

Note. Difficulties in Emotion Regulation Scale documented in Gratz and Roemer, 2004.

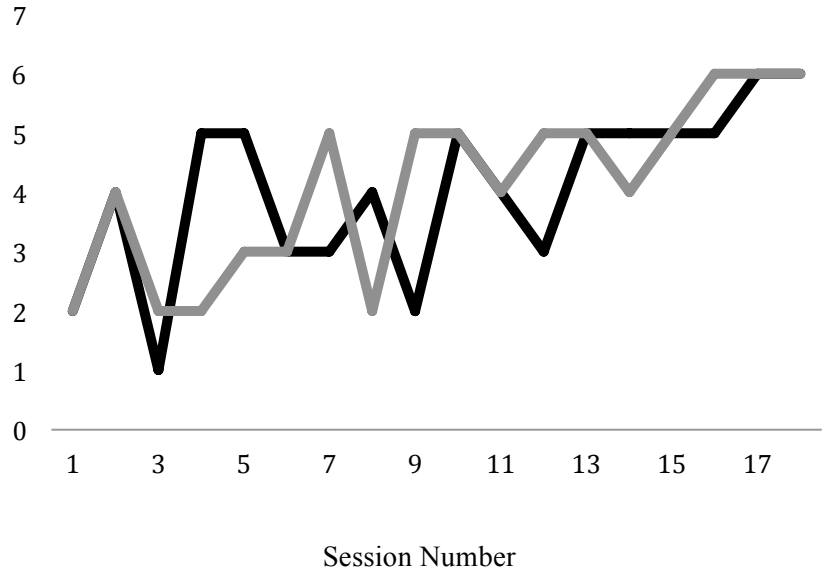
The descriptive measures used in this study described little clinically significant change from pre-test to post-test with the exception of dyadic adjustment (overall couple satisfaction). While individual factors of self-regulation and attachment did not change significantly for the majority of participants, most participants completed couple therapy outside of the clinical range for couple distress.

PSRQ Results

Another method used to better understand participant experience of outcome in therapy was to examine individuals *Post Session Resolution Questionnaires,* and compare these reports to what happened in the therapy session. In this study, PSRQ's were collected at the end of each

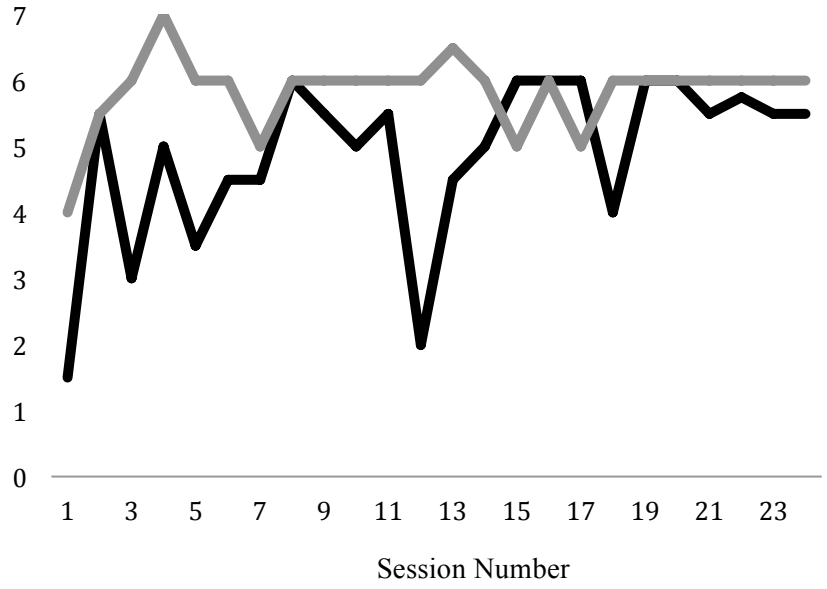
session, and self-reports of problem resolution were graphed for each couple to demonstrate self-reports throughout therapy (See Figures 2-5).

Figure 2. Post Session Resolution Questionnaire Couple A



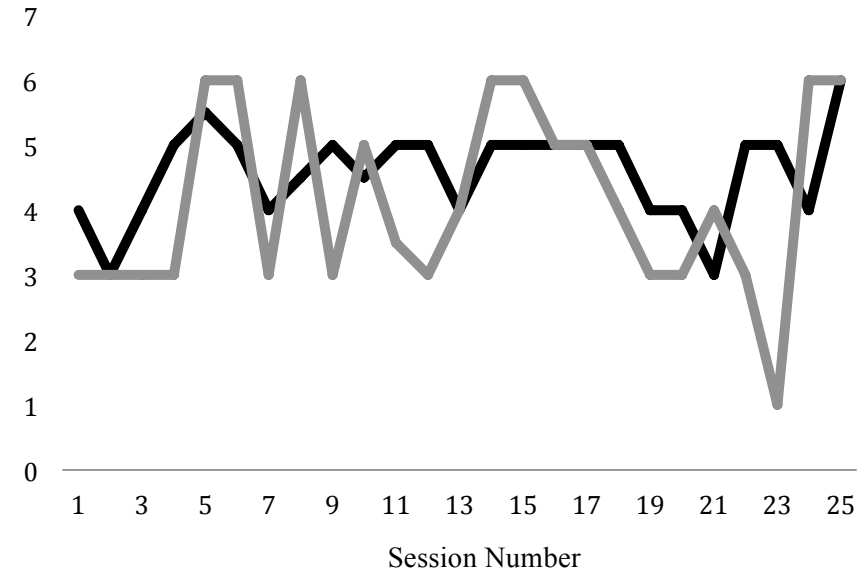
Antonia =black Andre=gray

Figure 3. Post Session Resolution Questionnaire Couple B



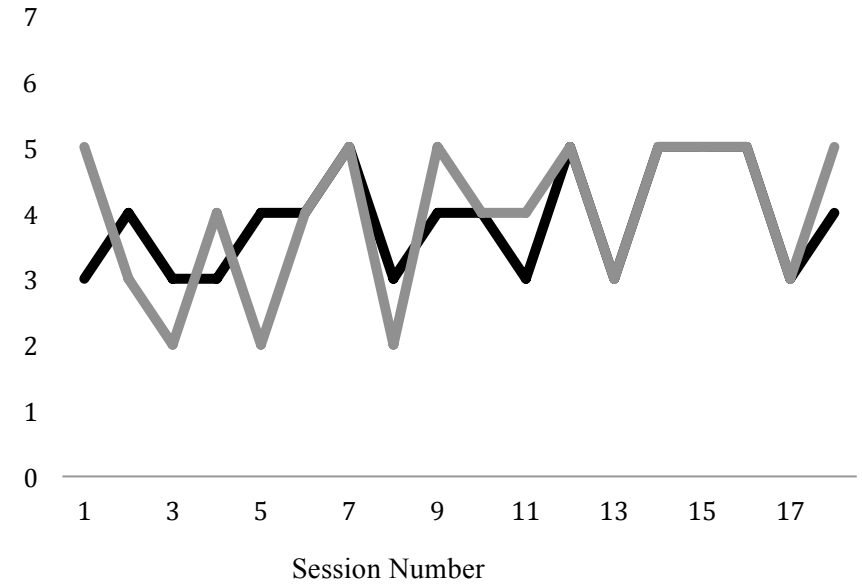
Bridget =black Bob= gray

Figure 4. Post Session Resolution Questionnaire Couple C



Claire=black Carlos= gray

*Figure 5.*Post Session Resolution Questionnaire Couple D



Donna=black Derek=gray

Best rated session- PSRQ

Best sessions were determined based on the PSRQ questions, *"How much progress do you feel you and your partner made in dealing with your issues in the session you have just completed?"* and *"Are you and your partner any closer to resolving your relationship issues*

than you were when you came to session today?" A similar theme ran across best sessions: couples rated sessions highest when they accomplished something difficult or new in a session, or when session content reflected on positive change (typically sessions closer to termination).

Lowest rated session- PSRQ

The lowest rated or "worst" sessions in this study appeared to result from conflict that happened during or outside of the session, and sessions that occurred immediately after a relapse. Of note for Couple B, session one was their lowest rated session based on the PSRQ questions *"How much progress do you feel you and your partner made in dealing with your issues in the session you have just completed?"* and *"Are you and your partner any closer to resolving your relationship issues than you were when you came to session today?"* Given that this couple completed all three stages of EFT and no relapses were reported throughout therapy, it makes sense that the beginning of therapy was when the couple felt the least resolved in terms of their presenting concerns. While this is an ideal trajectory where couples feel as though they are getting closer to resolving issues each session, a variety of diverse contextual factors contributed to the lowest session ratings. As with all self-reports, the PSRQ's captured how an individual was feeling about therapy on any given day. While some responses were unsurprising, such as questionnaires immediately after a relapse, others were unpredictable and related to the unique individual factors of the participant.

Session One- PSRQ

Session ratings were expected to be lowest in the beginning of therapy because couples typically enter therapy with conflict, or goals for change (Snyder & Halford, 2012). After the first session, all four couples rated problem resolution in the lower to middle range (on a scale from 0-7) marking problems as *"not at all resolved"* to *"somewhat resolved"*. In the first

session couples reflected on their relationship and shared how they thought therapy could be helpful for them. Communication, impact of addiction on the relationship, and reconnection as a couple were overarching themes discussed by the participants.

Couple A and B and C viewed communication as an overarching issue. Couple A's treatment goals were to improve communication with one another and support one another better in stressful situations. They both rated the first session low (2 out of 7). Couple B felt they did not know how to have conflict and wanted to work towards having difficult conversations. Couple C discussed negative communication patterns they often became stuck in.

Substance use and its impact on the couple was also an overarching theme in session one. Couple B believed most of their problems were a result of Bob's addiction. Bob and Bridget highlighted their main source of disagreement:

> Bob: Usually we find a common ground and we're okay with it.
>
> Bridget: Except for your drug use.
>
> Bob: Yeah…
>
> Bridget: There's no common ground there.
>
> Bob: No, no there's no common ground there (se. 1).

Drug use was the biggest source of conflict for the couple and Bob's abstinence was a shared goal. Bridget rated session one 1.5 out of 7 and Bob rated it 4 out of 7.

Similarly in session one, Couple C participant Claire said therapy,

> Could be an opportunity to explore the different issues, that could that affect our relationship in terms of addiction, and with an experienced, objective individual to guide us through all of those, those different um, ramifications, and hopefully have it strengthen the relationship (se. 1).

Claire wanted to use couple therapy as a place to discuss Carlos' substance addiction and how it impacted their relationship. Claire rated the first session 4 out of 7 and Carlos rated it 3 out of 7.

Finally, reengagement as a couple emerged as a desired treatment outcome for Couple D. Derek noted, "We both sort of have to relearn each other"(se. 1). His partner Donna agreed and the couple focused on how therapy could help them recover from what they viewed as the "aftermath" of the addiction. The first session was rated 5 out of 7 by Derek, and 3 out of 7 by Donna.

For some participants, beginning to discuss couple issues was positive, whereas others interpreted it as much more challenging. This was one example of how some participants viewed the process of discussing problems as positive, whereas others were focused on achieving a desired outcome (e.g. continued abstinence).

Session Seven- PSRQ

By the seventh session couples in EFT should be in Stage Two of EFT or moving into Stage Two (Johnson et al., 2005). Stage Two indicates couples have identified their negative interaction cycle and are working to take new interactional positions in the cycle (Johnson et al., 2005). Session ratings in the seventh session ranged from three to six depending on the participant. This placed all participants within the range of *"somewhat resolved"* or above when reporting on problem resolution.

Themes of progress and building trust were apparent with all four couples. Antonia expressed feeling good she and Andre were able to discuss topics that were previously "taboo topics". Andre shared he felt safest with Antonia, however, Antonia said, "sometimes I don't trust him"(se. 7). Bob and Bridget also noted progress. Bob said, "I am feeling better, okay a lot better and I am feeling like my old self"(se. 7). Bob had remained abstinent and felt this made

him a more clear-headed active participant in his relationship. Bridget stated, “There’s been great improvements”(se. 7).

Claire in Couple C also noted progress and said, “He said I’ve changed so much… I don’t even recognize the person I am now. I mean that… that’s like… yeah it’s phenomenal, it’s beautiful you know?” (se. 7) Donna and Derek were also reflective about their progress in therapy:

> Donna: Yeah, I mean I feel that since we’ve been coming here, there’s a lot more uh… opportunity, a lot more openness but it’s still a very tentative openness, like before I feel there wasn’t an openness you know? (se. 7)

Couples noted individual changes that were focused on how they related emotionally to one another.

For Couple C a re-evaluation of desired outcome also occurred in session seven. Claire said, “I assumed that once the person wasn’t drinking anymore, than that would be our biggest hurdle. But it’s not necessarily the biggest hurdle” (se. 7) Claire had associated abstinence with improvement in the relationship, however, she realized a lack trust and communication were bigger hurdles for the couple to overcome. While all four couples noted progress and rated this session within the range of *somewhat resolved,* their interpretations of problem resolution were different.

Session Fifteen- PSRQ

In the normative model of EFT, treatment typically ends between the fifteenth and twentieth session (Johnson et al., 2005). Examining PSRQ’s after the fifteenth session provided insight into how participants felt about problem resolution and treatment outcome at a later stage in therapy. All eight participants rated the fifteenth session highly. Six participants rated the

session as a five, which is above *"somewhat resolved"* on the problem resolution scale. Two participants (Carlos and Bob) rated the session as a six, which is just one point below *"totally resolved"* on the Likert Scale. Three participants rated this session the highest or as one of the highest (rated the highest along with other sessions) (Claire, Carlos, and Donna). While couples all reported sessions highly, no couple terminated after 15 sessions, and at this point in therapy, three of the four addicted partners had relapsed. While couples were still experiencing challenges, they rated discussion of these challenges highly. Themes of improved trust and a new ability to have difficult conversations and conflict emerged.

By session fifteen, Antonia noted a change in her ability to trust Andre. She stated, "I trust him 100% you know if I tell him oh what did you do today, it's not gonna…even it's something, say I didn't like... that's really good" (se. 15) This was a noted improvement from session seven. Couple B and C both discussed being able to have conflict with one another as a positive outcome in session fifteen. Couple B shared difficult feelings with one another, which was a pivotal change for the couple who previously avoided any conflict. Interestingly the couple had open conflict during the session, yet Bob rated this as one of his best sessions.

Couple C was also emotionally frank with one another in this session:

> Claire (to Carlos): The future we've talked about, I'm excited about. And so that's why I said to (Therapist) last week, I said I want to be able to have a disagreement with you… and it doesn't feel like a tsunami inside of me (se. 15).

This was similar to Couple B, where conflict was needed and welcomed within the couple. For both couples a positive outcome was the ability to work through difficult conversations and feelings together. They interpreted problem exploration in this session positively.

For Couple D, in session fifteen there was a shift wherein Derek was willing to discuss his feelings, something that had not occurred easily in previous sessions. Donna discussed her surprise that Derek was willing to be open with her:

> How do you feel inside right now that this type of stuff is so much more… easy for you to work out? You know, like where did this shift come? Whereas… I'm not talking months ago, like a couple weeks ago you were in such a different frame of mind you know? (se. 15)

During this session, Derek was positive and emotive, and once again described the purpose of the therapy as a space for the couple to "relearn" one another. This shift may have accounted for Donna having scored this session as her "best" session (closest to problem resolution).

Final Session- PSRQ

Each couple terminated at a different time, ranging from 18 to 26 weeks of therapy. Termination occurred in consultation with the therapist, and was largely directed by the clients and their assessment of the therapy process. All couples rated the final session high.

At termination (session 18) Couple A felt they had reached their goal of improving communication in the relationship. These gains were discussed in the final session:

> Therapist: You also have a really comfortable, nice way of being together
>
> Antonia: Yeah, that's what I like about it too; I don't have to hide anything
>
> Therapist: No, neither of you do
>
> Antonia: We're very honest (se. 18).

For Couple A, an improvement in trust was a positive outcome. Interestingly, substance use was mostly absent from their discussions of what positive change looked like in their relationship,

even though Andre was trying to stay sober, and did relapse during the course of therapy. A focus on abstinence as an outcome with this couple would have overlooked how Couple A defined treatment success.

In their final session (session 25) Bob and Bridget talked about the gains they made in therapy. Aside from Bob remaining abstinent, both partners had found new ways to cope in day-to-day life. Bob said, "I feel more at ease…whereas before I would have just avoided"(se. 25). For this couple, desired outcomes stated at the outset evolved from a focus on Bob's abstinence, to include the ability to have conflict with one another. While outcome measures on abstinence would have captured part of this couple's experience, how the couple determined treatment success is crucial. Learning to have conflict and demonstrate anger is not typically captured in treatment outcome measures.

In the case of Couple C, Carlos relapsed towards the end of therapy. Despite this, during the final session (session 26) both partners wanted to continue working towards confiding in one another more about their feelings, specifically about Carlos' addiction:

> Claire: We're both working to put the engine back in the car.
>
> Carlos: Because I want to drive the car…(se. 26)

While the substance addiction continued to negatively impact the couple, the couple wanted to continue the relationship. Couple C's initial goals for therapy were focused on substance use; however, the couple perceived there were positive therapy outcomes (increased ability to communicate anger and difficult feelings) despite ongoing relapses. Problem resolution did not occur for this couple, however, they both benefitted from problem exploration.

Donna and Derek were in a more tenuous position at termination (session 20), and described how the addiction continued to impact their relationship. Therapy had illuminated

aspects of their relationship that left Derek questioning whether he wanted to continue being with Donna in the long-term. Interestingly, both partners viewed this realization as positive and a new awareness that could benefit both individuals. While a desire to end a relationship is a valid outcome at the end of therapy, measurements for treatment outcome would not typically capture this as treatment *success*.

There were diverse outcomes at the termination of this case study; couples who felt they benefitted from having conflict and learning to express anger with one another, a couple who had improved relationship trust, and another couple who described feeling therapy potentially called the future of their relationship into question. Despite these differences, and unexpected outcomes, all four couples terminated when they were ready and rated their experience in therapy positively.

Discussion

McLellan et al., (2007) wrote, "An outcome domain is an area of life function or status measured at the patient level that is expected to be positively influenced by a treatment" (p.332). This study demonstrated that couples experienced outcomes very differently both within the couple and in comparison with other couples. In examining the reported results of the Post Session Resolution Questionnaire, it appeared that couples also interpreted in-session content in diverse ways. Upon closer examination, outcome interpretation can be understood through both problem resolution and problem exploration. For example, if there was a discussion about conflict or relapse in session, some couples interpreted the session negatively, whereas others reported the session to be productive and as moving them closer towards problem resolution. Differences existed between couples around how relapses were integrated, as well as how conflict was addressed within the relationship.

In beginning sessions participants defined that positive outcome in couples therapy would include improved communication, trust, and continued abstinence. Not all participants stated abstinence in their relationship as an overarching goal, however all four couples were committed to finding ways to navigate addiction as a couple. As therapy progressed, it became clear that some participants valued reduced substance use, and others valued abstinence. One partner achieving abstinence was not an explicit goal of therapy for all participants. Instead, goals around improved relational factors appeared at the forefront. For example two couples wanted to learn how to have conflict with one another, something they had avoided before attending therapy.

At the final session, session ratings were high across participants, with all eight participants reporting problem resolution. Each treatment trajectory, however, was unique. If outcomes were solely measured by increased couple satisfaction and decreased substance use, treatment would be deemed *effective* for only one couple. While treatment goals were different across couples and individuals, self-reports demonstrated that all participants experienced an improvement in problem resolution from beginning to end of therapy. These interpretations of problem resolution included outcomes as diverse as a couple who considered separation at the end of treatment. In other cases, improvements were reported despite relapses and couple conflict about substance use.

Important to consider, is in-session ratings appeared to fluctuate based on what happened in the session and how the couple responded to it. This is important, as arguably self-report measures taken pre and post treatment are also impacted by how the individual felt about their couple relationship and their own experience at that moment in time. Human relationships, particularly romantic relationships, are prone to ups and downs, and this needs to be considered

when comparing outcome measures. Furthermore, external factors, including conflict in other facets of an individual's life can also impact how they perceive a therapy session with their partner on any given day. Self-reports arguably capture one moment in an ongoing process as opposed to any kind of final outcome.

Similarly, Emotionally Focused Therapy targets emotional avoidance and encourages open affective responding in a couple's relationship. Pre-treatment scores were higher than post-treatment for some participants particularly on the ECR-RS anxiety domain. It is possible the treatment increased individual anxiety as a result of the heightened emotional experience of EFT. This may have targeted avoidant behaviour in participants, which led to more open and honest disclosure about outcome at the end of treatment. Also, emotion regulation changes on the DERS were insignificant. Shifts in emotion regulation are related to changes in attachment patterns, which may have been unrealistic for a shorter-term therapy like EFT. Although effort was made for close adherence to the model, therapist factors could also account for this lack of change. While we can only postulate, the complexity of measuring and determining outcome is clear. Individuals will inevitably have different assessments of what positive outcome is, and context will impact how they respond to outcome measurement.

Limitations

There were important limitations in this study. First, the highly contextual nature of case studies means that results cannot be generalizable, and can only comment on outcomes as experiences in these four specific cases. Also, having the first author as the provider of the treatment is a limitation. Despite treatment model implementation checks with the author's supervisor, there was a possibility for bias. Furthermore, without a control group it is difficult to know other factors that may have impacted outcomes, both measured and reported, or whether

various other couple factors including years together, length of substance addiction, time at baseline, or economic situation may have impacted outcomes.

Conclusion

A continued examination is needed of how we measure success in addiction treatment, versus the reality of addictive behaviour and couple relationships. In particular, the lens of couple therapy in the context of addiction cannot be focused solely on how the addiction plays out in the couple relationship, but rather expand its focus to address complex relational issues. What the couple wants to achieve in treatment is of great importance, and needs to be integrated into the therapy along with discussions of what role the addiction plays in the relationship. Furthermore, there is a need to consider how contextual factors for both partners impact the relationship and the ability to integrate addictive behaviours in the relationship. Expanding our understanding of what positive outcomes are in couple therapy in the context of addiction is necessary to capture the diversity of expectations amongst individuals seeking out and participating in couple therapy. Defining problem resolution as the measure of success neglects the benefit of exploring couple problems by helping couples move through whatever their evolving conflicts are. In the case of addiction, it also fails to capture the inevitability of relapse for most individuals. More qualitative research that teases apart the complexities of process, outcome, and what constitutes treatment success in couple therapy in the context of addiction is needed.

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Dissertation Conclusion

This dissertation evaluated a proposed theoretical extension of Emotionally Focused Couple Therapy (EFT) in the context of substance addictions. A replication case study methodology was used to allow for an intensive study of the proposed extension. Four couples were recruited from an addiction treatment centre in Montreal, Quebec. Couples attended 18-26 weeks of EFT in consultation with the therapist. Sessions were transcribed and pre and post measures were taken at the beginning and end of therapy. This intensive, replication case study provided insight into this extension of EFT for couples where one partner has a substance addiction, and raised important considerations concerning the treatment of couples with substance addictions. Dissertation results were presented in three manuscripts.

The first manuscript presented overall outcomes from the study including both self-report measures and a thematic analysis. Comparisons between normative EFT and the theoretical extension were made. On the whole, couples reported a significant increase in couple satisfaction, however for most participants emotion regulation and attachment were not found to change significantly between pre and post therapy. These results are important, because while EFT purportedly targets both emotion regulation and attachment, significant change was absent for the majority of participants. Future research should re-evaluate the impact of this intervention on emotion regulation and attachment.

As discussed in the first manuscript, while the theoretical extension appeared to be accessible to most participants in the study, important themes and recommendations emerged for future consideration. Primarily, adaptations of the model should consider trauma histories of clients, as EFT intentionally works to heighten client affect, and as observed in the study, this may become too destabilizing for individuals navigating active trauma symptoms. While clients

may be stable at the beginning of treatment, the affective processing that is integral to EFT treatment may activate trauma symptoms as therapy progresses.

Analysis of session transcripts also indicated a need for integrated psychoeducation throughout treatment. Many couples enter therapy without an understanding of substance addiction or treatment trajectory, and require psychoeducation to better understand what to expect and how to have realistic expectations for one another. Ongoing requests for information about addiction and substance use throughout the study illuminated an absence of needed psychoeducation. Future adaptations of the theoretical extension should include psychoeducation as a key component of treatment.

Finally, three out of the four participants living with a substance addiction reported relapses over the course of therapy. The theoretical extension did not account for relapses later in therapy. Given expressed motivation for treatment by all participants, in consultation with her supervisor the therapist continued therapy and integrated the processing of relapses into the therapy. Addressing slips and relapses needs to be incorporated into future adaptations of the EFT model.

Using findings from the replicated case study, the second manuscript provided recommendations for treating and working with relapses in the context of couple therapy. There is an absence of literature that addresses how to deal with relapses and slips during treatment. Couples had diverse responses to slips and relapses when they occurred during the course of therapy. For example, some couples regarded slips and relapses as part of the treatment process, whereas others were very upset and discouraged when slips and relapses occurred. While research confirms relapses will happen in treatment, integrating and supporting relapses in the treatment process requires further research. While abstinence is an important goal of many

individuals seeking addiction treatment, relapses that occur during treatment need to be processed and reframed as part of the process. In the study, many participants articulated that discussing relapses was actually advantageous to the treatment process and overall outcomes.

Finally, incorporating outcome results from the replicated case study, the third manuscript examined how success is measured in addiction treatment in comparison with the reality of addictive behaviour and couple relationships. This paper addressed the importance of discussing what the couple wants to achieve in treatment along with attention to what role the addiction plays in the relationship. Furthermore, there is a need to consider how contextual factors for both partners impact the relationship and the ability to integrate addictive behaviours in the relationship. This article considered an expanded understanding of what positive outcomes are in couple therapy in the context of addiction in order to capture the diversity of expectations amongst individuals seeking out and participating in couple therapy. Defining problem resolution as the measure of success disregards the lived experience of complex couples cycling through conflicts and problems. In many cases problem exploration, not solely problem resolution is an important part of therapeutic outcome. In the case of addiction, this focus also fails to capture the predictability of relapse for most individuals. This manuscript stressed the need for more qualitative research that teases apart the complexities of process, outcome, and what comprises treatment success in couple therapy in the context of addiction.

The goal of this study was to explore the extension of EFT to couples with addiction through the intense analyses of four clinical cases and to understand the process of the EFT model within this particular context. Couples in this study attended and completed treatment, even while navigating slips and other relationship challenges associated with substance addiction. The theoretical extension of EFT by Landau-North et al. (2011) addressed potential

couple problems impacted by an addiction, and considered issues present in the couple that have exacerbated the symptom. While this was an exploratory case study of a previously untested theoretical extension, interesting results emerged that merit further research and broader testing.

Future research could include adaptations to the theoretical extension, and more in-depth analysis of attachment, self-regulation and couple satisfaction. Study limitations could also be addressed in future research, including a larger sample size, multiple treating therapists, and the inclusion of a control group. Given that the sample in this study was heterosexual, predominantly white, and employed, future research that includes more diverse couples would also be beneficial.

The implication of these findings is significant, as they suggest the importance of client driven treatment that recognizes the diverse needs of couples and individuals. Results reiterate the importance of meeting couples where they are at, and responding to treatment needs as defined by couples. Also, findings indicate relapses are common in the context of couple therapy and addiction, however, do not necessarily indicate that individuals living with addictions are not prepared for, or committed to couple therapy. In fact, discussing relapses appeared to be beneficial for many couples in terms of moving forward and understanding one another better. Couple therapy has an important place in addiction treatment, and this study demonstrated the possibilities of Emotionally Focused Therapy and its future adaptations offered in this context.

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Appendix A: Recruitment Poster

Emotionally Focused Couple Therapy and Substance Use Disorder Study

Are you in a long-term committed relationship?

Are you or your partner living with a substance use disorder?

Have you or your partner completed the Head-Start program at CRD Foster?

Would you like to participate in a couple therapy study to help researchers and therapists discover new ways to work with couples in the context of substance use disorders?

A researcher at McGill University is studying how Emotionally Focused Therapy can help couples where one partner has a substance use disorder

For further information, please contact:
Kara Fletcher, M.S.W.
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School of Social Work,
McGill University
514 757-0502
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Appendix B: Informed Consent Form

INFORMATION AND CONSENT FORM
Addiction and Emotionally focused couple therapy, a replication case design

PhD Supervisor: Dr. Heather MacIntosh,
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Principal Investigator, Doctoral Candidate: Kara Fletcher
kara.fletcher@mail.mcgill.ca, (514) 757-0502

General Information

Purpose of this Research Project
This research project is designed to better understand Emotionally Focused Couple Therapy in the context of substance use disorders.

Major Procedures
If you meet our criteria for participation, you will be asked to take part in an interview that will last up to one hour and to fill out some questionnaires about you and your relationship that will take approximately one half an hour. After this you will be asked to attend approximately 15-20 weekly sessions of Emotionally Focused Couple Therapy. At the end of each session you will be asked to complete a short questionnaire and an additional short questionnaire will be given at the end of the 5th session. Each session will be audio or video recorded. Your participation in this study is voluntary and you may withdraw from this project at any time. Kara Fletcher, a PhD candidate in Social Work with post-graduate training in couple therapy and Emotionally Focused Therapy will conduct the interviews and the therapy. Dr. Heather MacIntosh, an Assistant Professor at McGill University and a registered clinical psychologist will carry out supervision of the therapy and research process.

Benefits
Benefits of taking part in this study are participating in 15-20 weeks of couple therapy free of charge. The results of this study will be used to determine better ways to assist couples where one partner has a substance use disorder.

Risks
The risks of the study may include experiencing uncomfortable feelings associated with the therapeutic process. Should this occur, referrals will be provided back to the resources you have access to (e.g. CRD Foster) and any discomfort can also be discussed in the therapy sessions.

Confidentiality
Confidentiality of all tape or video recordings and written responses will be respected. Session recordings will be saved on a password protected computer kept in a locked cabinet in a locked office at McGill University. Any written material (questionnaires) will be kept in a locked cabinet in a locked office at McGill University. All written and recorded material will be coded

with a number and not identifiable by name. Data will be kept for the length of the research study and while the research project is written up. Identifiable information will be deleted once the study is over: all paper materials will be shredded, video and audio recordings will be deleted, and any electronic data files will be deleted from the hard drive of the computer. Only the principal investigator, and her supervisor (Dr. Heather MacIntosh) will have access to your name. McGill Research Ethics, the Comité d'éthique de la recherché en dependence (CERD) and FQRSC will have access to unidentifiable data.

In some situations, the investigator must break the confidentiality agreement. These exceptions are in cases of imminent danger to yourself or to others, and of disclosures of current child abuse.

Freedom to Withdraw

I have received a copy of this consent form for my own reference and I have read and understood it. I agree to participate in this research project if I am selected.

I also understand that my participation in this study is voluntary and I may withdraw from this project at any time and/or request that all study materials related to me (tapes, videos, email communications, transcripts and questionnaires) be erased or destroyed without penalty. Couples, who choose to withdraw from the study, can choose to continue couple therapy at no cost until treatment reaches its natural conclusion.

I,_____, am interested in participating in the research conducted by Kara Fletcher, Phd Candidate of the Department of Social Work at McGill University. I consent to the use of

Audio recordings YES □ NO □
Video recordings YES □ NO □

of interviews and couple therapy, and for my written responses to the questionnaires for the purposes of this research with the understanding that all information gathered will be confidential within the limits of the law and according to the ethical principles of the Research Ethics Board of McGill University, and the Comité d'éthique de la recherché en dependence (CERD) and that this information will be available only to those who are directly involved in the study. I know that during the course of this study I may refuse to answer any question for any reason. I am also aware that the researcher's data collection is intended for her doctoral dissertation and as such I may ask to withdraw my participation even after my involvement in the study is completed. I understand that I can request that the results of this study (the dissertation, or any publications from the dissertation) be sent to me. I understand that my compensation for participating in this study will be in the form of approximately 15-20 sessions of couple therapy with an EFT trained couple therapist free of charge.

Signature of Participant :_____ Date_____

Signature of Researcher:_____ Date_____

Any questions about the conduct of the research project should be directed to Principal Investigator:

Kara Fletcher (514-757-0502, McGill University)
kara.fletcher@mail.mcgill.ca
Principal Investigator

Or

Heather MacIntosh (514-398-7056, McGill University)
Heather.macintosh@mcgill.ca
Supervisor

Questions or concerns regarding your rights or welfare as a participant in this research study should be directed to:

McGill Research Ethics Manager at 514-398-6831 or lynda.mcneil@mcgill.ca

Or

Comité d'éthique de la recherché en dependence (CERD) at 514-385-1232 or cer.cdc@ssss.gouv.qc.ca

Or

Complaints Commissioner for CRD Foster : Jennifer Mascitto at 514-486-1304

Appendix C: Demographic Questionnaire

Participant No._____ M____ F____

1. How many years have you been in a relationship with your current partner?_____

2. Do you have any children and if so, how many and how old are they?_____

3. Do you have a substance use problem with drugs or alcohol and if so, for how many years? _____

4. Have you participated in previous individual therapy and, if so, for how long?
_____

5. What is your approximate gross family income (annual)?
(0-10,000) ___
(10,001-25,000) ___
(25,001-50,000) ___
(50,001-75,000) ___
(75,001-100,000) ___
(over 100,000)___

6. Please state your age (in years)_____

7. What is your present occupation?_____

8. Please indicate the highest level of education that you have completed to date:

_____ Grade 10 or less

_____ Grade 12 or less

_____ 2 years of post-secondary education

_____ Community college diploma program

_____ Bachelor's degree

_____ Master's degree

_____ Ph.D. degree

Appendix D: Dyadic Adjustment Scale

DYADIC ADJUSTMENT SCALE, (Spanier, 2004)

Subject No._____ M____ F____

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list. (Please a checkmark to indicate your answer).

		Always Agree	**Almost Always Agree**	**Occasion -ally Disagree**	**Frequently Disagree**	**Almost Always Disagree**	**Always Disagree**
1.	Handling family finances	_____	_____	_____	_____	_____	_____
2.	Matters of recreation	_____	_____	_____	_____	_____	_____
3.	Religious matters	_____	_____	_____	_____	_____	_____
4.	Demonstrations of affection	_____	_____	_____	_____	_____	_____
5.	Friends	_____	_____	_____	_____	_____	_____
6.	Sex relations	_____	_____	_____	_____	_____	_____
7.	Conventionality (correct or proper behavior)	_____	_____	_____	_____	_____	_____
8.	Philosophy of life	_____	_____	_____	_____	_____	_____
9.	Ways of dealing with parents or in-laws	_____	_____	_____	_____	_____	_____
10.	Aims, goals, and things believed important	_____	_____	_____	_____	_____	_____
11.	Amount of time spent together	_____	_____	_____	_____	_____	_____
12.	Making major decisions	_____	_____	_____	_____	_____	_____
13.	Household tasks	_____	_____	_____	_____	_____	_____
14.	Leisure time interests and activities	_____	_____	_____	_____	_____	_____
15.	Career decisions	_____	_____	_____	_____	_____	_____

		All The time	Most of the time	More Often Than Not	Occa-sionally	Rarely	Never
16.	How often do you discuss or have you considered divorce, separation, or terminating your relationship?	_____	_____	_____	_____	_____	_____
17.	How often do you or your mate leave the house after a fight?	_____	_____	_____	_____	_____	_____
18.	In general, how often do you think that things between you and your partner are going well?	_____	_____	_____	_____	_____	_____
19.	Do you confide in your mate?	_____	_____	_____	_____	_____	_____
20.	Do you ever regret that you married (or lived together)?	_____	_____	_____	_____	_____	_____
21.	How often do you and your partner quarrel?	_____	_____	_____	_____	_____	_____
22.	How often do you and your mate "get on each others' nerves"?	_____	_____	_____	_____	_____	_____

		Every Day	Almost Every Day	Occa-Sionally	Rarely	Never
23.	Do you kiss your mate?	_____	_____	_____	_____	_____

		All of Them	Most of Them	Some of Them	Very Few of Them	None of Them
24.	Do you and your mate engage in outside interests together?	_____	_____	_____	_____	_____

How often would you say the following events occur between you and your mate?

		Never	Less than once a Month	Once or twice a Month	Once or twice a Week	Once a Day	More Often
25.	Have a stimulating exchange of ideas	_____	_____	_____	_____	_____	_____
26.	Laughter together	_____	_____	_____	_____	_____	_____
27.	Calmly discussing something	_____	_____	_____	_____	_____	_____
28.	Work together on a project	_____	_____	_____	_____	_____	_____

These are some things about which couples sometimes agree and sometimes disagree. Indicate if either item below caused differences of opinions or were problems in your relationship during the past few weeks (Check yes or no).

	Yes	No	
29.	___	___	Being too tired for sex.
30.	___	___	Not showing love.

31. The dots on the following line represent different degrees of happiness in your relationship. The middle point, "happy", represents the degree of happiness of most relationships. Please circle the dot which best describes the degree of happiness, all things considered, of your relationship.

_____._____._____._____._____._____._____._____.___

Extremely Unhappy	Fairly Unhappy	A Little Unhappy	Happy	Very Happy	Extremely Happy	Perfect

32. Which of the following statements best describes how you feel about the future of your relationship?

_____ I want desperately for my relationship to succeed, and would go to almost any length to see that it does.
_____ I want desperately for my relationship to succeed, and will do all I can to see that it does.
_____ I want desperately for my relationship to succeed, and will do my fair share to see that it does.
_____ It would be nice if my relationship succeeded, but I can't do much more than I am doing now to help it succeed.
_____ It would be nice if it succeeded, but I refuse to do any more than I am doing now to keep the relationship going.
_____ My relationship can never succeed, and there is no more that I can do to keep the relationship going.

Appendix E: Experiences in Close Relationships- Relationship Specific

EXPERIENCES IN CLOSE RELATIONSHIPS- RELATIONSHIP SPECIFIC (Fraley et al., 2006)

This questionnaire is designed to assess the way in which you mentally represent important people in your life. You'll be asked to answer questions about your parents, your romantic partners, and your friends. Please indicate the extent to which you agree or disagree with each statement by circling a number for each item.

Please answer the following questions about your mother or a mother-like figure
---

1. It helps to turn to this person in times of need.
strongly disagree 1 2 3 4 5 6 7 strongly agree

2. I usually discuss my problems and concerns with this person.
strongly disagree 1 2 3 4 5 6 7 strongly agree

3. I talk things over with this person.
strongly disagree 1 2 3 4 5 6 7 strongly agree

4. I find it easy to depend on this person.
strongly disagree 1 2 3 4 5 6 7 strongly agree

5. I don't feel comfortable opening up to this person.
strongly disagree 1 2 3 4 5 6 7 strongly agree

6. I prefer not to show this person how I feel deep down.
strongly disagree 1 2 3 4 5 6 7 strongly agree

7. I often worry that this person doesn't really care for me.
strongly disagree 1 2 3 4 5 6 7 strongly agree

8. I'm afraid that this person may abandon me.
strongly disagree 1 2 3 4 5 6 7 strongly agree

9. I worry that this person won't care about me as much as I care about him or her.
strongly disagree 1 2 3 4 5 6 7 strongly agree

Please answer the following questions about your father or a father-like figure

---

1. It helps to turn to this person in times of need.
strongly disagree 1 2 3 4 5 6 7 strongly agree

2. I usually discuss my problems and concerns with this person.
strongly disagree 1 2 3 4 5 6 7 strongly agree

3. I talk things over with this person.
strongly disagree 1 2 3 4 5 6 7 strongly agree

4. I find it easy to depend on this person.
strongly disagree 1 2 3 4 5 6 7 strongly agree

5. I don't feel comfortable opening up to this person.
strongly disagree 1 2 3 4 5 6 7 strongly agree

6. I prefer not to show this person how I feel deep down.
strongly disagree 1 2 3 4 5 6 7 strongly agree

7. I often worry that this person doesn't really care for me.
strongly disagree 1 2 3 4 5 6 7 strongly agree

8. I'm afraid that this person may abandon me.
strongly disagree 1 2 3 4 5 6 7 strongly agree

9. I worry that this person won't care about me as much as I care about him or her.
strongly disagree 1 2 3 4 5 6 7 strongly agree

Please answer the following questions about your dating or marital partner.

Note: If you are not currently in a dating or marital relationship with someone, answer these questions with respect to a former partner or a relationship that you would like to have with someone.

---

1. It helps to turn to this person in times of need.
strongly disagree 1 2 3 4 5 6 7 strongly agree

2. I usually discuss my problems and concerns with this person.
strongly disagree 1 2 3 4 5 6 7 strongly agree

3. I talk things over with this person.
strongly disagree 1 2 3 4 5 6 7 strongly agree

4. I find it easy to depend on this person.
strongly disagree 1 2 3 4 5 6 7 strongly agree

5. I don't feel comfortable opening up to this person.
strongly disagree 1 2 3 4 5 6 7 strongly agree

6. I prefer not to show this person how I feel deep down.
strongly disagree 1 2 3 4 5 6 7 strongly agree

7. I often worry that this person doesn't really care for me.
strongly disagree 1 2 3 4 5 6 7 strongly agree

8. I'm afraid that this person may abandon me.
strongly disagree 1 2 3 4 5 6 7 strongly agree

9. I worry that this person won't care about me as much as I care about him or her.
strongly disagree 1 2 3 4 5 6 7 strongly agree

Please answer the following questions about your best friend

---

1. It helps to turn to this person in times of need.
strongly disagree 1 2 3 4 5 6 7 strongly agree

2. I usually discuss my problems and concerns with this person.
strongly disagree 1 2 3 4 5 6 7 strongly agree

3. I talk things over with this person.
strongly disagree 1 2 3 4 5 6 7 strongly agree

4. I find it easy to depend on this person.
strongly disagree 1 2 3 4 5 6 7 strongly agree

5. I don't feel comfortable opening up to this person.
strongly disagree 1 2 3 4 5 6 7 strongly agree

6. I prefer not to show this person how I feel deep down.
strongly disagree 1 2 3 4 5 6 7 strongly agree

7. I often worry that this person doesn't really care for me.
strongly disagree 1 2 3 4 5 6 7 strongly agree

8. I'm afraid that this person may abandon me.
strongly disagree 1 2 3 4 5 6 7 strongly agree

9. I worry that this person won't care about me as much as I care about him or her.
strongly disagree 1 2 3 4 5 6 7 strongly agree

Appendix F: Difficulties in Emotion Regulation Scale

Difficulties in Emotion Regulation Scale (DERS), (Gratz & Roemer, 2004)

Please indicate how often these items apply to you using the following scale:

1	2	3	4	5
Almost never (0-10%)	Sometimes (11-35%)	About half the time (35-65%)	Most of the time (66-90%)	Almost always (91-100%)

1. _____ I am clear about my feelings.
2. _____ I pay attention to how I feel.
3. _____ I experience my emotions as overwhelming and out of control.
4. _____ I have no idea how I am feeling.
5. _____ I have difficulty making sense out of my feelings.
6. _____ I am attentive to my feelings.
7. _____ I know exactly how I am feeling.
8. _____ I care about what I am feeling.
9. _____ I am confused about how I feel.
10. _____ When I'm upset, I acknowledge my emotions.
11. _____ When I'm upset, I become angry with myself for feeling that way.
12. _____ When I'm upset, I become embarrassed for feeling that way.
13. _____ When I'm upset, I have difficulty getting work done.
14. _____ When I'm upset, I become out of control.
15. _____ When I'm upset, I believe that I will remain that way for a long time.
16. _____ When I'm upset, I believe that I'll end up feeling very depressed.
17. _____ When I'm upset, I believe that my feelings are valid and important.
18. _____ When I'm upset, I have difficulty focusing on other things.
19. _____ When I'm upset, I feel out of control.
20. _____ When I'm upset, I can still get things done.
21. _____ When I'm upset, I feel ashamed with myself for feeling that way.
22. _____ When I'm upset, I know that I can find a way to eventually feel better.
23. _____ When I'm upset, I feel like I am weak.
24. _____ When I'm upset, I feel like I can remain in control of my behaviors.

25. _____ When I'm upset, I feel guilty for feeling that way.
26. _____ When I'm upset, I have difficulty concentrating.
27. _____ When I'm upset, I have difficulty controlling my behaviors.
28. _____ When I'm upset, I believe that there is nothing I can do to make myself feel better.
29. _____ When I'm upset, I become irritated with myself for feeling that way.
30. _____ When I'm upset, I start to feel very bad about myself.
31. _____ When I'm upset, I believe that wallowing in it is all I can do.
32. _____ When I'm upset, I lose control over my behaviors.
33. _____ When I'm upset, I have difficulty thinking about anything else.
34. _____ When I'm upset, I take time to figure out what I'm really feeling.
35. _____ When I'm upset, it takes me a long time to feel better.
36. _____ When I'm upset, my emotions feel overwhelming.

Appendix G: Understanding Your Negative Cycle

Understanding Your Negative Cycle- Susan Johnson

Couples get caught in "negative cycles" of interaction. A "negative cycle" is a repeating pattern of negative behaviors, thoughts and feelings that causes distress. You react to your partner's reactions and your partner reacts to your reactions and you go round and round in a never-ending negative cycle. Understanding and untangling your "negative cycles" is a first step in climbing out of distress. The exercise below will help you with this process.

When my partner and I are not getting along:

I often react by (describe behaviors)...

My partner often reacts to me by (describe behaviors)...

When my partner reacts this way, I often feel...

When I feel this way I, see myself as....

When I feel this way I long for or need...

When I react the way I do, I guess that my partner feels...

Describe your repeating negative cycle (include how you and your partner trigger each other's feelings, thoughts and behaviors)...

Appendix H: Post-Session Resolution Questionnaire

POST-SESSION RESOLUTION QUESTIONNAIRE

Couple No._____ M____ F____ Session No._____

1. Was the issue that you and your partner worked on today the same or related to the issue that you brought into counselling ? Please circle one of the following:

1…..…….2……..…….3……..….4……...5

Very Different Different Related Similar Same

2. How much progress do you feel you and your partner made in dealing with your issues in the session you have just completed? Please circle one of the following:

1…..…….2……..…….3……..….4……...5

A Great Deal of Progress Considerable Moderate Progress Some Progress No Progress

3. Are you and your partner any closer to resolving your relationship issues than you were when you came to the session today? Please circle one of the following:

1…..…….2……..…….3……..….4……...5

Very Much Considerably Moderately Somewhat Not at all

4. How resolved do you feel right now in regard to the concerns you brought into counselling? Please place a tick in the appropriate box.

1…..…….2……..…….3……..….4……...5…….…….6….……7

Not at all Resolved Somewhat Resolved Totally Resolved

Appendix I: Trauma Symptom Inventory II

TSI-2
John Briere PhD, 2011

In the last 6 months, how often have you experienced:	0	1	2	3
	Never			Often

1. Nervousness
2. Sadness
3. Feeling mad or angry inside
4. Nightmares or bad dreams
5. Trying to forget a bad time in your life
6. Feeling like you were in a dream
7. Not being honest with someone
8. Aches or pains
9. Bad thoughts or feelings during sec
10. Wishing you were dead
11. Not letting people get to know you very well
12. Felling like you don't know who you really are
13. Doing something self-destructive during or after an argument
14. Feeling so irritable after a trauma that you got into physical fights with strangers
15. Trouble getting to sleep or staying asleep because you were feeling tense
16. Feeling hopeless
17. Trouble controlling your temper
18. Just for a moment, seeing or hearing something upsetting that happened earlier in your life
19. Not letting yourself feel bad about the past
20. People saying that you don't pay enough attention to what's going on around you
21. Regretting something you said or did
22. Nausea or an upset stomach
23. Having sex with someone you hardly knew
24. Attempting suicide
25. Feeling abandoned or rejected
26. Being easily influenced by others
27. Becoming so upset that you had to do something dramatic to calm yourself down
28. Because of a trauma in your past, not being able to eat or drink anything for days
29. Feeling afraid of certain things, even though there probably wasn't any real danger
30. Being so depressed that you didn't feel like eating
31. Getting angry about something that wasn't very important
32. Flashbacks (sudden memories or images of upsetting things)
33. Stopping yourself from thinking about the past
34. Feeling like you were outside of your body
35. Feeling unhappy about something
36. Lower back pain
37. Feeling anxious about sex

38. Fantasies about dying
39. Feeling uncomfortable when someone got too close
40. Not knowing yourself very well
41. Calming yourself down by eating more than you should
42. Having flashbacks many times a day, every day, for several weeks at a time
43. Feeling jumpy
44. Feeling so depressed that you avoided people
45. Having angry thoughts
46. Violent dreams
47. Trying to block out certain memories
48. Feeling like there were two or more people inside of you
49. Being in a bad mood
50. Indigestion
51. Wanting to have sex with someone who you knew was bad for you
52. Intentionally overdosing on pills or drugs
53. Worrying that someone didn't like you any more
54. Getting talked out of things too easily
55. Doing something that you shouldn't have down because you were so upset
56. Being so frightened by a bad memory that you were temporarily paralyzed
57. Worrying about things more than you needed to
58. Feeling worthless
59. Yelling or telling people off
60. Suddenly feeling like you were back in the past when something bad happened
61. Trying not to have any feelings about something that once hurt you
62. Feeling like things weren't real
63. Making a mistake
64. Muscle spasms
65. Problems in your sexual relations with another person
66. Feeling so hopeless that you wanted to die
67. Keeping people at a distance
68. Feeling like there is no "real you" inside of yourself
69. Throwing or hitting things because you were out of control of your feelings
70. Memories of a trauma that were so upsetting that you fainted or passed out
71. Watching out for danger
72. Low self-esteem
73. Getting angry when you didn't want to
74. Your heart suddenly going fast when you were reminded of a bad thing
75. Trying not to think about something upsetting from your past
76. Not feeling like your real self
77. Worrying about something
78. Ringing in your ears
79. Not protecting yourself during sex when you probably should have
80. Trying to kill yourself, but then changing your mind
81. Worrying that people don't really care about you
82. Your opinions changing when you were with other people
83. Punishing yourself so you would feel like guilty

84. Having so much trouble concentrating after a trauma that you forgot where you lived
85. Your mind going over and over things that might go wrong
86. Feeling depressed
87. Thoughts or fantasies about hurting someone
88. Sudden disturbing memories when you were not expecting them
89. Trying not to think or talk about things in your life that were painful
90. "Spacing out"
91. Saying something negative about someone behind his or her back
92. Chest pain
93. Sexual problems
94. Suicidal thoughts
95. Avoiding relationships with people
96. Not being sure of what you want in life
97. Doing something violence because you were so upset
98. Since a traumatic event, not having much memory about the past
99. Having trouble paying attention to things because you were so tense
100. Not enjoying things that other people enjoy because you were so depressed
101. Starting arguments or picking fights
102. Suddenly being reminded of something bad
103. Pushing painful memories out of your head
104. Having trouble remembering the details about something bad that happened to you
105. Feeling impatient with someone
106. Difficulties swallowing
107. Getting into trouble because of sex
108. Doing something dangerous and hoping you might die
109. Feeling like someone didn't pay enough attention to you
110. Needing other people to tell you what to do
111. Doing something exciting to stop yourself from having bad feelings
112. A memory that was so upsetting that you couldn't do simple things, like walk or dress yourself
113. Feeling afraid you might die or be injured
114. Feeling bad about yourself
115. Wanting to hit someone or something
116. Memories of the past that won't go away
117. Staying away from certain people or places because they remind you of something
118. Finding yourself someplace and not knowing how you got there
119. Dizziness
120. Feeling ashamed about your sexual feelings or behavior
121. Thinking about killing yourself
122. Not needing people
123. Getting confused about what you thought or believed
124. Intentionally hurting yourself (for example, by scratching, cutting, or burning) as a way to stop upsetting thoughts or feelings
125. After a bad thing happened, feeling irritable or easily angered
126. Hating yourself
127. Wishing you weren't so angry all of the time

128. Getting upset when you were reminded of something from your past
129. Not letting yourself have upsetting thoughts
130. Feeling like you were watching yourself from far away
131. Trouble keeping your balance
132. Being sexual when it probably wasn't a good idea
133. Trying to end your life
134. Not asking for something you wanted because you might be rejected or turned down
135. Not trusting your own thoughts or feelings when people disagreed with you
136. Doing something that you shouldn't do as a way to stop feeling empty or upset