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Attachment-Based Family Therapy and Emotion-Focused Therapy for Unresolved Anger: The Role of Productive Emotional Processing

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A growing body of research suggests that emotional processing is a central and common change mechanism across various types of therapies (Diener & Hilsenroth, 2009; Foa, Huppert, & Cahill, 2006; Greenberg, 2011). This study examined whether 10 weeks of attachment-based family therapy (ABFT), characterized by the use of in-session young adult–parent dialogues, were more effective than 10 weeks of individual emotion-focused therapy (EFT), characterized by the use of imaginal dialogues, in terms of facilitating productive emotional processing among a sample of 32 young adults presenting with unresolved anger toward a parent. This study also examined whether greater amounts of productive emotional processing predicted more favorable treatment outcomes. In contrast to our expectations, we found significantly more productive emotional processing in individual EFT than in conjoint ABFT. Results also showed that while both treatments led to significant and equivalent decreases in unresolved anger, state anger, attachment anxiety, and psychological symptoms, only ABFT was associated with decreases in attachment avoidance. Although amount of emotional processing did not explain the unique decrease in attachment avoidance in ABFT, greater amounts of productive emotional processing predicted greater decreases in psychological symptoms (but not other outcome measures) across both treatments.

Keywords: emotional processing, emotion-focused therapy, attachment-based family therapy

Clients often present for therapy with unresolved anger toward a parent. Sometimes the anger is the result of an event, or series of events, in which the client felt betrayed, humiliated, coerced, or abused by his or her parent (Lazarus, 1991). In other instances, the anger stems from ongoing perceived parental neglect, invalidation, or empathic failure, leading the angry individual to feel essentially unseen or unloved. Typically, the angry person blames his or her parents for such ruptures in the relational bond and responds by either attacking and/or avoiding contact with them (del Barrio, Aluja, & Spielberger, 2004; Lazarus, 1991). Unresolved anger can persist for months, or even years, and destroy the very fabric of the relationship.

This study compared the outcome and process of two empirically based experiential therapies commonly used to target unresolved anger: Emotion-focused therapy (EFT; Greenberg, 2002,

2011) and attachment-based family therapy (ABFT; Diamond, Diamond, & Levy, 2014). EFT is an individual therapy combining client-centered principals (e.g., unconditional positive regard, empathy, and genuineness), gestalt techniques (e.g., two-chair and empty-chair dialogues), and other experiential methods in order to evoke core maladaptive emotions (e.g., shame, fear), transform them by evoking adaptive emotional responses (e.g., assertive anger, sadness, and compassion), and activate adaptive relational action tendencies. These emerging adaptive emotional responses and action tendencies are incorporated into a new view of the self and others, and used to transform personal narratives (Greenberg, 2006, 2012). Individual EFT has been shown to be effective in the treatment of depression (Ellison, Greenberg, Goldman, & Angus, 2009), trauma, and interpersonal injuries (Paivio & Pascuale-Leone, 2010).

ABFT is a family-based intervention model rooted in structural family therapy (Minuchin, 1974) and attachment theory. Like EFT, ABFT therapists utilize client-centered, emotion-focused, and other experiential interventions in order to develop a strong therapeutic alliance, evoke primary adaptive emotions, and identify core relational themes. Once strong alliances have been developed with all family members during individual sessions, therapists initiate in vivo enactments between family members during conjoint sessions (i.e., attachment episodes). In the context of these attachment episodes, the young adult is helped to express previously avoided primary adaptive emotions (e.g., assertive anger, sadness) and unmet attachment needs (e.g., need for care or autonomy) directly

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to her/his parent, and parents are helped to respond in an empathic, nondefensive, validating manner. Such episodes are thought to facilitate productive emotional processing, change interactional patterns, and transform working models (i.e., representations) of self and others, leading to a more secure attachment (Diamond et al., 2014). ABFT has been found to be efficacious in a number of clinical trials for depressed and suicidal adolescents (Diamond et al., 2014).

Comparing EFT and ABFT is informative because, while both treatments emphasize therapist-offered conditions such as empathy, attunement, validation, and safety, and both treatments emphasize the importance of using experiential methods to facilitate productive emotional processing, they differ in terms of some of the central techniques they use to promote productive emotional processing. They also differ in terms of the purported role of productive emotional processing in the therapeutic change process.

In the context of EFT, unresolved anger is understood as either primary adaptive anger that has been blocked and therefore not fully processed, or as secondary, defensive anger that arises as a means for coping with other, more threatening emotions such as fear, sadness and shame (Greenberg & Safran, 1989; Greenberg & Paivio, 1997; Greenberg & Pascual-Leone, 2006; Pascual-Leone, Gilles, Singh, & Andreescu, 2013). Primary adaptive anger is an emotion that people naturally experience when their boundaries have been violated. In some cases, however, primary anger is interrupted or thwarted. This can occur when environmental responses to the anger are negative (e.g., critical or threatening) and disconfirming. When primary adaptive anger is interrupted or blocked, it remains unresolved thus leaving the individual chronically frustrated. The anger continues to exist, in a conscious or an unconscious form; is easily triggered; and vacillates between being overregulated (i.e., suppressed) or underregulated (e.g., expressed in an explosive, aggressive manner), further decreasing the likelihood that the individual will be heard or have his or her needs effectively met.

Secondary defensive anger evolves as a response to another emotion rather than as the person's immediate, spontaneous response to the environment (Greenberg & Safran, 1989). It is best understood as an attempt to use one emotion to regulate or avoid another more threatening or vulnerable emotion. For example, one might avoid or attenuate feelings of loss and deep sadness associated with abandonment by focusing, instead, on blaming and being angry with the abandoning other. While in the short term such blaming, rejecting anger feels empowering and protects one's sense of self (Greenberg & Safran, 1987, 1989; Greenberg, 2002), in the long run it is maladaptive. When parents feel criticized, blamed, or ignored, they are likely to respond in kind, further injuring the young adult and/or leaving him/her with even less emotional support (Coyne, 1976). Moreover, by focusing on their anger rather than accessing and fully experiencing underlying primary adaptive vulnerable emotions (e.g., sadness and loss), young adults are deprived of essential information required to identify their needs and get these needs met. This leaves them psychologically, emotionally, and interpersonally stuck (Greenberg & Malcolm, 2002; Paivio & Greenberg, 1995).

The essential change mechanism in EFT is to productively process interrupted or avoided primary emotions. Specifically, productive emotional processing in EFT involves moving from global distress or secondary anger into primary maladaptive emo-

tions such as fear or shame, followed by the activation of primary adaptive emotions such as assertive anger, sadness, or compassion. Experiencing previously blocked primary adaptive anger or sadness helps to transform primary maladaptive shame or fear and facilitates access to associated unmet needs (e.g., need for care, support, validation, and protection; Pascual-Leone & Greenberg, 2007). This process, which involves arousing emotions, and helping the client become aware of, express, regulate, and make sense of their emotions, essentially uses core primary adaptive emotions to transform secondary and primary maladaptive emotions (Greenberg, 2011; Lane, Ryan, Nadel, & Greenberg, 2015). According to the productivity scale (Greenberg, Auszra, & Herrmann, 2007), productive emotional processing occurs when the client: attends to and experiences a primary emotion; symbolizes the emotion; accepts rather than fights the emotion; is able to regulate the emotion; takes responsibility for owning the emotion; and is able to differentiate the emotion from other felt emotions.

A number of studies have found a link between productive emotional processing and treatment outcome in EFT. In one study of depressed clients, increases in expressed emotional arousal from early to midtherapy, and levels of midtherapy emotional arousal, were found to be correlated with treatment outcome, particularly when such emotional processing occurred in conjunction with reflective processing (Missirlian, Toukmanian, Warwar, & Greenberg, 2005). Along the same lines, Greenberg, Auszra, and Herrmann (2007) found that the arousal of primary adaptive emotions discriminated between better and poorer outcome cases, while simple emotional arousal per se did not. More recently, Auszra, Greenberg, and Herrmann (2013) found that productive emotional processing during the working stage of therapy predicted symptom reduction, above and beyond both high emotional expression and the quality of the therapeutic relationship.

In order to promote productive emotional processing, emotion-focused therapists use a variety of interventions, including empathic responses, focusing, and gestalt-based techniques such as two-chair and empty-chair dialogues. Empty-chair dialogues are essentially imaginal enactments, during which clients imagine their parents sitting across from them in an empty chair while speaking directly to them, in the first person. This therapeutic procedure is designed to experientially arouse maladaptive emotions associated with the parent, thus making them more available for processing and transformation (Greenberg, 2012).

Like in individual EFT, therapists in attachment-based family therapy also strive to help clients come into contact with, express and make meaning of their primary adaptive emotions, including previously avoided hurt, loss, fear, and assertive anger. Likewise, ABFT therapists strive to help clients come in contact with previously unexpressed and unmet attachment needs, such as the need for care and validation of self. However, in contrast to EFT, in ABFT productive emotional processing is not conceived of as an end in and of itself, but rather as a way to prepare the young adult to communicate their previously unexpressed primary adaptive emotions and unmet attachment needs *directly* to their parents in conjoint therapy sessions. The intent of such dialogues, which are in essence in vivo enactments, is to facilitate corrective attachment experiences between the young adult and his or her parent.

Corrective attachment experiences with parents occur during episodes in which young adults feel, often for the first time, like their parent is accurately attuned to and validates their experience

of the attachment rupture (e.g., abandonment, neglect), including primary adaptive emotions such as loss, sadness, fear, and assertive anger. In order to increase the likelihood of successful attachment dialogues, both the young adult and the parent are first thoroughly prepared separately during preliminary individual sessions (see Diamond, Diamond, & Levy, 2014 for more details about such preparation). Attachment episodes typically begin with the young adult expressing global distress or rejecting anger to his or her parent. With the support and guidance of the therapist, parents are helped to remain nondefensive, empathic, and curious, urging their adult child to elaborate upon his or her feelings. Such nondefensive, empathic responses from parents communicate care, interest, and openness. As a result, the young adult typically responds by accessing heretofore unexpressed primary maladaptive or adaptive emotions such as fear, shame, assertive anger, and grief. In response to hearing their young adult's pain, and legitimate but unmet attachment needs, parents tend to become even more empathic and validating. In some cases, they explicitly take responsibility for any role they may have played in their child's suffering. The act of directly expressing one's affect to one's parent, and the experience of having that affective experience accurately mirrored and validated by the parent, both promotes productive emotional processing and enhances young adult-parent attachment. In terms of promoting productive emotional processing, emotion that in the past had been off-limits with the caregiver and, in turn, off-limits to the young adult him/herself, is now tolerable and possible to both communicate to one's parents and acknowledge to one's self (Fosha, 2000). In terms of enhancing the attachment relationship, the parent's responsive communication and empathy convey an understanding of his or her young adult's needs, intentions, and emotional world. This coordinated state with the parent, during which the young adult senses that he or she matters to, and impacts upon, his or her parent, leads to the experience of attachment security (Costello, 2013; Fosha, 2000).

This study explored whether ABFT, a therapy characterized by the use of in vivo dialogues, was more effective in facilitating the productive processing of primary adaptive emotions and attachment needs than individual EFT, characterized by the use of imaginal dialogues. We hypothesized that ABFT would facilitate more productive emotional processing, as actually speaking directly to one's parent is more likely to arouse emotions and associated unmet attachment needs than simply imagining a conversation with one's parent. Coming face-to-face with the injuring parent elicits episodic memories of past traumatic events and interactions, and their associated emotion schemes. Such in vivo exposure is preferable to imaginal exposure, as it more closely represents the circumstances of the traumatic events and, consequently, more readily evokes the emotion network (McNally, 2007; Wolitzky-Taylor, Horowitz, Powers, & Telch, 2008). For that reason, speaking directly to the injuring parent is likely to be more evocative than speaking to an imagined representation of the parent.

In addition, in this aroused state, parents' actual caring, attuned, empathic responses may have more impact on young adults' experience in the attachment relationship than imagined parental responses. While it is one thing to *imagine* one's parents expressing empathy, love, and a desire to understand, it may be quite another thing to hear these words uttered genuinely and convincingly by the parent him/herself. As the old adage goes, "seeing is

believing." These new, more positive experiences of feeling cared for and safe are likely to compete with, weaken, and transform previous negative or traumatic relational schemas (Foa et al., 2006; Greenberg, 2012). Indeed, prior research on ABFT has shown that observer-rated decreases in parental psychological control and increases in parental psychological autonomy-granting over the course of the therapy predicted pre- to posttreatment increases in adolescents' perceived parental care and decreases in perceived attachment-related anxiety and avoidance (Shpigel, Diamond, & Diamond, 2012).

A second and related question is whether amount of in-session productive emotional processing is predictive of treatment outcome. The primary outcome of interest in this study was resolution of unresolved anger toward the target parent. In addition, we were interested in whether treatment led to changes in young adult's experience in their relationship with their parent (i.e., attachment anxiety and avoidance) and their levels of psychological symptoms. Prior research has shown that amount of emotional processing predicts treatment outcome across a range of treatment approaches, including EFT (Greenberg, 2012), behavioral therapy (Foa et al., 2006), and dynamic therapy (Diener & Hilsenroth, 2009). This is the first study, however, to examine the link between productive emotional processing and treatment outcome in family therapy in general, and ABFT in particular. Because productive emotional processing is a purported essential element in the change process in both treatments, we hypothesized that it would predict treatment outcome across both treatments. Also, because we expected that ABFT would lead to greater amounts of productive emotional processing, we predicted that ABFT would evidence greater reductions in unresolved anger, attachment avoidance and anxiety, and psychological symptoms than would EFT.

Method

Procedure

Thirty-two young adults suffering from unresolved anger toward a parent received 10 weeks of either EFT or ABFT. There were 16 participants in each treatment group. Before beginning treatment, all 32 participants completed self-report questionnaires assessing their levels of: unresolved anger toward their target parent; state anger, attachment anxiety and avoidance in relation to their target parent; and psychological symptoms. These measures were again completed at midtreatment and immediately posttreatment.

Recruitment. Participants were recruited through advertisements posted in two cities in Israel: one in the South and one in the center of the country. The advertisements offered free, brief therapy for individuals who "experience high levels of anger toward their parent." The ads went on to specify that the "anger must be frequently aroused, have persisted for at least 12 months, and currently interfere with the quality of their relationship with their parent."

Those responding to the advertisement were first screened over the phone to ensure that they met the above mentioned criteria. In addition, participants were told that in order to participate, their parent would have to agree to attend some treatment sessions. Of the 55 individuals screened, 22 (40%) chose not to come in for a follow-up evaluation. Five of those 22 reported that it was because

their parents lived out of the country, three reported that it was because their parents lived too far away to attend sessions, seven did not want their parent involved in the therapy, and the remaining seven gave no reason.

The 33 young adults who met inclusion criteria, and agreed to include their parent in the treatment, were invited to the clinic for an initial evaluation. All of their parents (i.e., the parent who was the target of their anger) agreed to participate. During this evaluation, the young adult underwent an abbreviated structured interview (SCID-IV) to rule out bipolar disorder, psychotic disorders, substance disorders, and/or suicidal ideation. Only one potential participant was ruled out because she reported high levels of depressive symptoms and suicidal ideation, along with a history of psychiatric treatment. She was referred to the university counseling center for treatment. Target parents were also invited to the clinic for an initial brief assessment in order to rule out bipolar disorder, psychotic disorders, substance disorders, and/or suicidal ideation that would make them poor candidates for brief, intense therapy. None of the parents who came for assessment were ruled out, and all completed the necessary consent forms.

Treatment assignment. After participants and their parents completed consent forms, they were assigned to one of the two treatment conditions. Treatment assignment was made according to geographic location. Those who lived near the clinic in the South received ABFT because that was where the trained ABFT therapists were housed. For the same reason, those who lived near the clinic in central Israel received EFT because that was where the trained EFT therapists were housed. Before giving their consent, participants were told that participation in the study required their agreeing to be assigned to one of the two treatments. They were *not* aware of which treatment they would receive before agreeing to participate. None of the young adults withdrew from the study after learning of their treatment assignment. The study was approved by Ben-Gurion University's Human Subjects Review Board.

Participants

Clients included 32 young adults reporting unresolved anger toward at least one of their parents, and their respective parents who were the object of their anger. In order to be included in the study, participants had to indicate that their anger: (a) was of significant intensity; (b) had persisted for at least a year; and (c) currently bothered them, and negatively impacted upon the quality of their relationship with their target parent.

On average, clients were 25.6 years old ($SD = 2.9$). Twenty-two were women and the remaining 14 were men. All were of Israeli Jewish background, most of them secular. Twenty-six were undergraduate students, two were M.A. students, one was a doctoral-level student, and three had completed their education and were working full time. Twenty of the clients reported that their anger was primarily directed toward their mother and 12 reported that their anger was primarily directed toward their father.

Treatments

Attachment-based family therapy. ABFT is a manualized, 10–16 week empirically supported treatment originally designed for treating depressed and suicidal adolescents. It has proven

efficacious in a number of clinical trials (Diamond et al., 2014). The treatment is rooted in the structural tradition (Minuchin, 1974), attachment theory, developmental research, and recent conceptualizations regarding the role of emotions and expression of attachment needs in psychotherapy (Fosha, 2000; Greenberg, 2012). The treatment delivered in this study was an adaptation of ABFT designed for adults suffering from unresolved anger toward a parent.

The primary goal of the treatment was to help the young adult and parent identify, discuss, and work through past and current family traumas and conflicts that have strained the attachment bond and damaged trust. The treatment was composed of four interrelated tasks. The therapy began with the task of building an alliance with the young adult. Therefore, the first two to three sessions, conducted alone with the young adult, focused on understanding the circumstances/dynamics of the anger, and preparing the young adult to communicate their frustrated attachment needs and primary emotions directly to their parent. The next two to three sessions, conducted alone with the parent, comprised the alliance building with parent task. During this task, the therapist: focused on learning about the parent as a person in their own right; reviewed the parent's own history of being parented; helped the parent to reflect upon both his or her own experience of the relationship rupture as well as on his or her young adult's experience of the relational rupture; and prepared the parent to empathically validate and support his or her young adult. The following four to six sessions were conjoint sessions, including both the young adult and parent. These sessions comprised attachment episodes: direct conversations about the young adult's pain associated with the rupture, unmet attachment needs, and attempts at better attunement. Finally, the last two to three sessions were devoted to consolidating gains: helping the young adult and parent to use their newfound openness, trust, and communication skills to deepen their relationship by sharing their thoughts and feelings about important events in their lives.

Emotion-focused therapy. EFT (Elliott & Greenberg, 2007; Greenberg, 2004; Greenberg, Rice & Elliot, 1993; Greenberg & Watson, 2006) is a manualized, individual, empirically supported brief treatment (typically delivered in 16–24 sessions). EFT is based on client-centered principals (i.e., unconditional positive regard, empathy, and genuineness) and utilizes experiential interventions such as focusing, systematic evocative unfolding, empty-chair dialogues and two-chair dialogues designed to deepen emotional processing. A strong relational bond with the therapist allows the client to feel safe enough and valued enough to productively engage in the task of attending to and exploring their most vulnerable emotions (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2014). Therapist acceptance, congruence, and empathy also contribute to clients' affect regulation by providing interpersonal soothing. Over time, this interpersonal soothing is internalized, contributing to the client's capacity to self-soothe and regulate painful emotions (Greenberg & Watson, 2006). The central goal of treatment is to elicit primary maladaptive emotions, such as shame or fear, and to transform them by recruiting primary adaptive emotions such as sadness at loss and assertive anger. EFT, also known as process-experiential therapy, has proved efficacious in 18 outcome studies with various populations, including depressed, abused, and traumatized individuals (Elliott et al., 2004).

In the context of this study, experiential interventions, including empty-chair dialogues, were used to process unresolved anger. Empty-chair dialogue is a specific intervention designed to modify the affective information processing difficulties associated with unfinished business (Greenberg, Rice, & Elliott, 1993). The client is guided through an imaginary dialogue with the significant other, the purpose of which is to resolve unresolved emotional issues. The empty-chair dialogue facilitates arousal of emotion and restructuring of the relevant self-other schema such that there is greater self-affirmation and a new understanding of the other. Paviio and Greenberg (1995) have demonstrated the efficacy of the empty-chair dialogue in resolving unfinished business.

In this study, the first two to three sessions were devoted to developing a strong therapeutic alliance based on therapeutic presence and empathic attunement. These sessions focused on understanding the narrative underlying the unresolved anger while providing a congruent, empathic, and validating relationship. The next four to five sessions, the working phase, focused on empty-chair enactments, facilitating a movement from secondary anger to primary assertive anger and sadness (Pascual-Leone & Greenberg, 2007). The final sessions were devoted to consolidating gains and further emphasizing new meanings that emerged during the chair dialogues. All of the sessions were conducted individually with the young adult.

Therapists and Therapist Training/Supervision

ABFT therapists included two female master-level social workers and one male clinical psychologist. One therapist treated seven clients, the second therapist treated five clients, and the third therapist treated four clients. The social workers had 12 and 15 years of family therapy experience each. The clinical psychologist, Dr. Gary M. Diamond, one of the codevelopers of ABFT, had over 20 years of clinical experience and had been training and supervising therapists to use ABFT for over a decade. Dr. Diamond trained and live-supervised the other two therapists.

EFT therapists included two male and two female clinical psychologists. Three of the therapists held Ph.D. degrees and the fourth an M.A. degree. One therapist treated six clients, the second treated two clients, the third treated two clients, and the fourth treated six clients. Their years of clinical experience ranged from 13 to 25. Two had over five years of experience specifically working with EFT. The other two received initial training from Dr. Leslie Greenberg, the primary developer of EFT, and ongoing live supervision from Dr. Ben Shahar, a trained and experienced EFT supervisor.

Measures

Anger resolution. Anger resolution was measured using the *Unfinished Business Resolution Scale* (UFB-RS; Singh, 1994). The UFB-RS is a 14-item instrument used by clients to rate the degree to which their unfinished business with another has been resolved. The instrument includes items such as, "I have come to terms with not getting what I want from this person." The UFB consists of three subscales ("Feelings and needs," "Empathy and acceptance," and "Forgiveness"). In addition, a full-scale score can be calculated using 11 items derived from the "Feelings and needs" and "Empathy and acceptance" subscales. Each item is

scored from 1 (*not at all*) to 5 (*very much*). In the current study, the full scale score was used. Scores were reversed such that higher scores indicate greater levels of resolution. In previous studies, the test-retest reliability over one month was between .73 and .81. In our sample, Cronbach's alphas for the various administrations of the scale (i.e., pre-, mid-, and posttreatment) ranged from .74 to .80.

State anger toward parent. The 10-item State Anger subscale of the State-Trait Anger Expression Inventory (STAXI; Spielberger, 1988) was used to measure state anger. Examples of items from this subscale include, "I am feeling angry" and "I feel like screaming at somebody." Each item is rated on a 4-point scale ranging from 0 (*almost never*) to 3 (*almost always*). Participants used the scale to report on their current level of anger toward the target parent. In this sample, Cronbach's alphas for this subscale ranged from .80 to .94.

Psychological symptoms. In order to gauge participants' psychological well-being, we employed the Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983). The BSI is a brief psychological self-report inventory including 53 items, each of which represents a symptom or a complaint (e.g., feeling lonely, worrying). Respondents rated the degree to which they were disturbed by each of the items during the preceding month using a scale of 0 (*not at all*) to 4 (*very much*). The inventory is composed of nine subscales: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. In addition, the global severity index (GSI) reflects the average score across the nine subscales. Greater scores reflect higher levels of psychiatric symptoms and distress. The BSI is one of the most frequently used measures of psychiatric symptoms and has established reliability and validity (Derogatis & Savitz, 1999), including with Israeli samples (Al-Krenawi, Graham, & Kanat-Maymon, 2009). In this sample, Cronbach's alphas for GSI scores ranged from .94 to .96.

Attachment avoidance and anxiety. The Relationship Structures questionnaire (ECR-RS; Fraley, Waller & Brennan, 2000) was used to measure attachment anxiety and avoidance. The ECR-RS is a revised version of the Experiences in Close Relationships Scale (Brennan, Clark, & Shaver, 1998) and contains nine short statements rated on a 5-point scale, ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Examples of items on the attachment avoidance scale include, "It helps to turn to this person in times of need (reverse score)" and "I find it easy to depend on this person (reverse scored)." Examples of items on the attachment anxiety scale include "I'm afraid that this person may abandon me" and "I often worry that this person doesn't really care for me." Participants completed the questionnaire in relation to the target parent only. In previous studies, the measure has been shown to have good reliability and validity (Fraley, Heffernan, Vicary, & Brumbaugh, 2011). In this study, the Cronbach's alpha reliability estimate for the attachment anxiety scale was 0.90 and for the attachment avoidance scale was 0.96.

Productive emotional processing. We used an amended version of the Client Emotional Productivity Scale-Revised (CEPS-R; Greenberg, Auszra, & Herrmann, 2007) in order to measure the amount of emotional processing in each session. Productivity was assessed in the context of young adults' in-session emotional expressions. In accordance with the scale, emotional processing is considered productive when the emotion expressed is: (a) primary;

(b) experienced in the present and in a mindfully aware manner; (c) symbolized; (d) owned by the client who experiences her- or himself as an agent, rather than as a victim of the feeling; (e) not overwhelming; (f) fluid rather than blocked; (g) differentiated; and (h) associated with a therapeutically relevant theme. The scale is applied once the emotion has been judged to be on theme, primary, and adaptive.

For the purposes of this study, each therapy segment comprising an expression of a primary adaptive emotion associated with the young adult–parent relationship was rated for productivity. In the original measure, productivity was rated on a 5-point scale with a score of (–2) reflecting clearly nonproductive processing, (–1) reflecting possibly nonproductive processing, (0) reflecting unclear/off theme, (+1) possibly productive processing, and (+2) clearly productive processing. The measure was subsequently collapsed into a three-point scale in order to improve reliability ($K = .75$) and was shown to predict treatment outcome (Greenberg, Auszra, & Herrmann, 2007). For the purposes of this study, only clear incidents of emotional processing were of interest. Consequently, the category of “unclear, off theme” was collapsed with the category of “clearly nonproductive,” resulting in a dichotomous scale: “clearly productive processing” or “clearly not productive processing”. Categorizing unclear instances as not productive raises the threshold for what is considered productive processing and increases the internal validity of the study. In order to quantify amount of productive emotional processing per case, we calculated the total time (in seconds) of productive emotional processing across the two sessions in each case deemed to include the most amount of emotional processing.

Selecting sessions for coding productive emotional processing. In order to select the two sessions in each case deemed to have the most amount of emotional processing, we first identified all sessions involving in vivo or imaginal dialogues. In ABFT, this meant conjoint sessions composed of attachment episodes. In EFT, this meant sessions that contained at least one empty-chair episode. Next, the therapist from the given case was asked to choose from those sessions the two with the most amount of productive emotional processing, basing their choice on their notes and videotape review of the sessions.

Emotional processing coders and coder training. Seven undergraduate psychology students were trained to code productive emotional processing using the CEPS-R. Coders were 23–25 years old. All were female, second year undergraduate students. Over the course of eight weeks, coders met with the productive

emotional processing trainer (third author) twice a week, with each training session lasting for three hours. During the course of the training, coders read articles about emotional processing, read and discussed the CEPS-R manual, and practiced rating 12 tapes of therapy sessions not included in the study sample. Practice tapes were discussed during group training sessions, with coding ambiguities and discrepancies addressed and resolved. Only after coders consistently reached consensus among themselves, and with the trainer, did they begin to code actual study tapes. Selected sessions were randomly assigned to rotating pairs of coders who then rated them for productive emotional processing. Each rater watched and coded each taped session independently. Coders marked the seconds in which productive processing took place. Only seconds which both raters coded as productive emotional processing (i.e., absolute agreement) were scored as such.

Results

Preliminary Results

Pretreatment between-groups equivalence. In order to evaluate whether the two treatment groups were equivalent pretreatment, we compared them on four demographic variables. There were no between-groups differences regarding age, ($t(22) = -1.23, ns$), gender ($\chi^2(1, N = 32) = 0.55, ns$), education ($\chi^2(2, N = 32) = 3.29, ns$), or living conditions (i.e., living with parents vs. living independently) ($\chi^2(1, N = 32) = 0.51, ns$). We also compared the two groups' initial levels on all five dependent variables. There were no pretreatment between-groups differences on any of the dependent variables, including state anger, ($t(18) = -1.88, ns$), attachment anxiety, ($t(30) = -0.36, ns$), attachment avoidance, ($t(30) = 0.46, ns$), psychological symptoms, ($t(30) = -1.26, ns$), and unfinished business, ($t(30) = 1.67, ns$). Means and standard deviations for all study variables appear in Table 1. Correlations between pretreatment levels of the five dependent variables appear in Table 2.

Thirty-one of the 32 participants completed treatment. Treatment completers attended between nine and 16 sessions. The mean number of sessions in the ABFT group was 10.67 ($SD = 1.72$), and the mean number of sessions in the EFT group was 10.56 ($SD = 1.63$), with no significant differences between the groups on number of sessions completed, ($t(29) = .17, ns$). One case from the ABFT group dropped out of treatment after two sessions. This case was included in all subsequent analyses consistent with an intent-to-treat analytic approach.

Table 1
Means and Standard Deviations for All Study Measures

Group	Age	EP	Time	STAXI-SA	ECR-RS-ANX	ECR-RS-AV	UFB-T	BSI-T
ABFT ($N = 16$)	25.0 (2.0)	10.47 (12.72)	Pre-	18.56 (3.26)	2.06 (1.62)	4.78 (1.77)	2.74 (.55)	.76 (.37)
			Mid-	15.56 (6.69)	1.90 (1.59)	3.92 (1.50)	3.22 (1.14)	.70 (.45)
			Post-	17.75 (2.38)	1.27 (.50)	3.66 (1.69)	3.70 (.65)	.64 (.40)
EFT ($N = 16$)	26.45 (3.67)	43.44 (54.58)	Pre-	23.31 (9.57)	2.29 (1.97)	4.47 (2.12)	2.45 (.44)	.97 (.54)
			Mid-	16.93 (8.71)	2.13 (1.34)	4.43 (1.87)	2.09 (1.06)	.92 (.58)
			Post-	20.37 (5.96)	1.87 (1.23)	4.67 (1.90)	3.21 (.76)	.76 (.49)

Note. ABFT = Attachment-Based Family Therapy; EFT = Emotion-Focused Therapy; EP = Productive emotional processing; Time = Time of measurement (Pre-/Mid-/Posttreatment); STAXI-SA = State-Trait Anger Expression Inventory—State Anger subscale; ECR-RS-ANX = Experience in Close Relationships—Relationship Structures—Anxiety Subscale; ECR-RS-AV = Experience in Close Relationships—Relationship Structures—Avoidance Subscale; UFB-T = Unfinished Business Resolution Scale—Total Scores; BSI = Brief Symptoms Inventory—Total Scores.

Table 2
Bivariate Correlations Among All Dependent Variables
at Pretreatment

	1	2	3	4	5
1. BSI-T					
2. UFB-T	-.05				
3. ECR-RS-ANX	.22	-.11			
4. ECR-RS-AV	.08	.00	-.00		
5. STAXI-SA	.30	.25	.23	.08	

Note. BSI-T = Brief Symptoms Inventory—Total Score; UFB-T = Unfinished Business—Total Score; ECR-RS-ANX = Experience in Close Relationships—Relationship Structures—Anxiety Subscale; ECR-RS-AV = Experience in Close Relationships—Relationship Structures—Avoidance Subscale; STAXI-SA = State-Trait Anger Expression Inventory—State Anger Subscale.
 $p < .001$.

Therapist effects. In order to estimate the amount of variance in outcomes due to therapist, we calculated intraclass correlations (ICC). Therapists' effects were calculated as follows: $ICC = \sigma_{therapist}^2 / (\sigma_{therapist}^2 + \sigma_{patient}^2 + \sigma_{error}^2)$, with $\sigma_{therapist}^2$ representing the variance of therapists' random effect, $\sigma_{patient}^2$ representing the variance of patients' random effect, and σ_{error}^2 representing the variance of the error. Results showed that the estimated variances of the therapists' random effect were nonsignificant for all outcome measures. Specifically, for three of the outcome measures the ICCs for the therapists' effects were null and nonsignificant ($\sigma_{therapist}^2 = 0.00$, $p = .99$, for psychological symptoms, attachment anxiety, and attachment avoidance), and for the two other measures they were nonsignificant ($ICC = 0.02$, $\sigma_{therapist}^2 = 0.01$, $SE = 0.03$, $Z = 0.38$, $p = .35$, for unresolved anger, and $ICC = 0.02$, $\sigma_{therapist}^2 = 0.87$, $SE = 3.73$, $Z = 0.23$, $p = .40$, for state anger), indicating that random effects did not contribute significantly to variance in outcomes.

Main Results

Treatment outcome. In order to examine whether the two treatments led to decreases in unresolved anger, state anger, attachment anxiety and avoidance, and psychological symptoms, we first conducted a repeated-measure MANOVA with treatment serving as one between-subjects independent variable, time (measured at pretreatment, midtreatment, and posttreatment) serving as a repeated independent, within-subject variable, and the five aforementioned variables serving as the dependent measures. Results showed a main effect for time, $F(2, 29) = 7.87$, $p = .002$, $\eta_p^2 = .35$. In addition, there was a significant interaction for time by measure, suggesting that the five measures changed differently over time, $F(8, 23) = 3.49$, $p = .009$, $\eta_p^2 = .55$. Finally, the time by measure by treatment interaction approached significance and evidenced a large effect size, suggesting a trend toward significant differences in changes in measures over time according to treatment, $F(8, 23) = 7.87$, $p = .09$, $\eta_p^2 = .41$.

We followed up with a series of five univariate repeated-measure ANOVAs, examining each of the dependent variables separately. In regards to anger resolution, results showed a main effect for time, $F(2, 60) = 20.34$, $p = .000$, $\eta_p^2 = .40$, with both groups showing a linear decrease in unresolved anger over time,

$F(1, 30) = 28.64$, $p = .000$, $\eta_p^2 = .49$. In addition, there was a main effect for treatment, $F(1, 30) = 9.29$, $p = .005$, $\eta_p^2 = .24$, with ABFT showing a lower mean level of unresolved anger over the course of treatment. There was, however, no treatment by time interaction. In regards to state anger, results showed a main effect for time, $F(2, 60) = 3.42$, $p = .04$, $\eta_p^2 = .10$, with both groups showing a linear decrease in state anger over time, $F(1, 30) = 5.48$, $p = .03$, $\eta_p^2 = .15$. In addition, there was a main effect for treatment, $F(1, 30) = 4.81$, $p = .04$, $\eta_p^2 = .14$, with ABFT showing a lower mean level of state anger over the course of treatment. There was, however, no treatment by time interaction.

In regards to attachment anxiety, results showed a main effect for time, $F(2, 60) = 5.81$, $p = .005$, $\eta_p^2 = .16$, with both groups showing a linear decrease in attachment anxiety over time, $F(1, 30) = 7.06$, $p = .01$, $\eta_p^2 = .19$. There was no main effect for treatment, nor was there a treatment by time interaction. In regards to attachment avoidance, results showed that there was no main effect for time, $F(2, 60) = 2.62$, ns , $\eta_p^2 = .08$. There was, however, a significant treatment by time interaction, showing a greater decrease in attachment avoidance over time in the ABFT versus the EFT group, $F(2, 60) = 6.02$, $p = .01$, $\eta_p^2 = .17$. Post hoc comparisons revealed that, while there was a linear decrease in attachment avoidance over time in the ABFT group, $F(1, 30) = 12.67$, $p = .003$, $\eta_p^2 = .46$, there was no such trend in the EFT group. Finally, in regards to psychological symptoms, results showed a main effect for time, $F(2, 60) = 6.94$, $p = .002$, $\eta_p^2 = .19$. There was no main effect for treatment nor was there a treatment by time interaction.

Productive emotional processing. There were significantly more seconds of productive emotional processing in EFT ($M = 43.44$ s, $SD = 54.58$) than in ABFT ($M = 10.47$ s, $SD = 12.72$), $t(16) = -2.39$, $p = .02$, $d = .84$. In order to examine whether productive emotional processing predicted changes over the course of therapy, we analyzed five multiple regression models. Pre- to posttreatment change in unresolved anger, state anger, attachment anxiety and avoidance, and psychological symptoms each served as the dependent variable for one of the regression analyses. Treatment type, amount of productive emotional processing, and the treatment type by amount of productive emotional processing interaction were entered as predictors. Amount of productive emotional processing predicted pre- to posttreatment changes in psychological symptoms (i.e., BSI scores) across both treatments, $R^2 = 0.20$, $F(2, 28) = 3.52$, $p = .05$, with the Beta for emotional processing being .48, $t(28) = 2.64$, $p = .01$. There was no treatment by productive emotional processing interaction. The models for the other four dependent variables were not significant. Results from the five regression models appear in Table 3. Because none of the interaction terms were significant, they were not included in the final models.

Discussion

A growing body of research suggests that emotional processing is a central and common change mechanism across various types of therapies (Diener & Hilsenroth, 2009; Foa et al., 2006; Greenberg, 2011). This study examined whether ABFT, characterized by the use of in-session dialogues between young-adults and their parents, was more effective than individual EFT, characterized by the use of imaginal dialogues, in terms of facilitating productive

Table 3
Multiple Regression Analyses Predicting Change in Psychological Symptoms, Attachment Anxiety, Attachment Avoidance, State Anger, and Unresolved Anger From Productive Emotional Processing

Dependent variable	Predictor	R^2	B	f^2	$SE B$	β	t
BSI-T	EP	.20*	.00	.25	.00	.48	2.64*
	Treatment		-.17		.12	-.25	-1.36
ECR-RS-ANX	EP	.06	.01	.06	.01	.23	1.14
	Treatment		.10		.47	.04	.21
ECR-RS-AV	EP	.23*	-.01	.30	.01	-.14	-.77
	Treatment		1.46		.50	.52	2.93*
STAXI-SA	EP	.04	.01	.04	.02	.07	.33
	Treatment		-2.06		1.92	-.21	-1.07
UFB-T	EP	.02	-.00	.02	.00	-.10	-.51
	Treatment		-.08		.35	-.05	-.23

Note. BSI-T = Brief Symptoms Inventory—Total Score; ECR-RS-ANX = Experience in Close Relationships—Relationship Structures—Anxiety Subscale; ECR-RS-AV = Experience in Close Relationships—Relationship Structures—Avoidance Subscale; STAXI-SA = State-Trait Anger Expression Inventory—State Anger Subscale; UFB-T = Unfinished Business—Total Score; EP = Productive Emotional Processing; Treatment = Type of therapy (Attachment-Based Family Therapy or Emotion-Focused Therapy).

* $p < .05$.

emotional processing among a sample of young adults presenting with unresolved anger toward a parent. This study also examined whether amount of productive emotional processing predicted treatment outcome. In contrast to our expectations, we found significantly *more* productive emotional processing in EFT than in ABFT. Results also showed that while both treatments led to significant and equivalent decreases in anger resolution, state anger, attachment anxiety, and psychological symptoms, only ABFT evidenced a trend toward decreases in attachment avoidance. Although amount of productive emotional processing did not explain the unique decrease in attachment avoidance in ABFT, greater amounts of productive emotional processing predicted greater decreases in psychological symptoms (but not other outcome measures) across both treatments.

The finding that greater amounts of productive emotional processing predicted greater decreases in psychological symptoms from pre- to posttreatment, across the two treatment conditions, is consistent with findings from previous research. A number of studies have found that emotional arousal, particularly in conjunction with perceptual processing or meaning making, predicted decreases in psychological symptoms in EFT for depression (Auszra et al., 2013; Greenberg et al., 2007; Missirlian et al., 2005). It is also consistent with findings from behavioral treatments showing that emotional processing predicted symptom reductions across a range of anxiety disorders (Foa et al., 2006). This is the first study, to the best of our knowledge, to provide evidence for the therapeutic role of productive emotional processing in family therapy.

The fact that there were more seconds of productive emotional processing in EFT than in ABFT was surprising. Our clinical

experience suggests that when parents are present in the therapy session, and the young adult is face-to-face with the very object of her or his anger and longing, emotional arousal is high. Indeed, learning theory posits that the salience of the stimulus is an important factor in the arousal of emotions and incorporation of new information (Rescorla & Wagner, 1972). Moreover, empathic, validating parental responses are thought to facilitate deeper processing. Upon further consideration, however, this unexpected finding reminds us that in ABFT, productive emotional processing is not the only, or even the primary, change target. In ABFT, the young adult's productive emotional processing is conceived of as only one element of corrective attachment episodes. Just as important is helping parents to hear, be accurately attuned to, acknowledge and empathically validate their young adult's emotional experience and unmet attachment needs. For that reason, during conjoint ABFT sessions, therapists spend time tracking, inquiring about, and attending to parents' emotional experience, and supporting and guiding them as they become more available for and responsive to their young adults. The fact that therapists' attention and interventions, and client speech-turns, are typically equally divided among family members during ABFT attachment episodes may partially account for between-treatment differences in amount of young adults' productive processing.

Another possibility is that, in some cases, the young adult's productive processing was interrupted due to high levels of anxiety and/or less than optimal parental responses. It is important to remember that disclosing heretofore unspoken emotions and unmet attachment needs directly to one's parents makes one vulnerable. In some cases, the young adult may have feared that their parent would respond in an invalidating or rejecting manner, and that they might be hurt or frustrated once again. In other instances, momentary defensive or even blaming responses by a parent may have shut the young adult down.

In regards to the brief amount of productive emotional processing identified across both treatments, it should be noted that previous research has also shown that only a very small amount of highly productive emotional processing is necessary to achieve change. A recent study of short-term dynamic therapy for clients with adjustment disorders found that one minute of expressed grief distinguished between good and poor outcome cases (Kramer, Pascual-Leone, Despland, & de Roten, 2015). According to the sequential model of emotional processing developed by Pascual-Leone and Greenberg (2007), grief is a vulnerable, primary adaptive emotion that involves advanced levels of meaning making and reflects the highest level of emotional processing. Similarly, in this study, our measurement approach only captured what would be described as high levels of emotional processing. The measure we employed, the productivity scale, requires the simultaneous presence of all elements of productive processing, including arousal, expression, acceptance, agency and differentiation. Clearly, different definitions of what constitutes productive processing, and different measurement approaches and thresholds, will lead to different findings regarding when such processing actually begins and ends, and how much productive processing is present in a given session.

As expected, we found a trend suggesting that ABFT led to greater reductions in attachment avoidance than did EFT. More specifically, results suggested that young adults who participated in ABFT were more likely to report an increase in feeling like it

was helpful to turn to their parent and discuss things with them, and trust and depend on their parent, than were those young adults who participated in EFT. This finding echoes results from previous studies on ABFT which found that the treatment led to decreases in attachment avoidance (Diamond, Reis, Diamond, Siqueland, & Isaacs, 2002; Shpigel, Diamond & Diamond, 2012). In contrast to our prediction, however, decreases in attachment avoidance were not mediated by young adults' levels of productive emotional processing. One possibility is that young adults' experiences of their relationships with their parents changed as much because of their parents' behavior as it did because of their own explicit productive emotional processing. Indeed, our clinical experience suggests that just having a parent show up in the therapy room sometimes signals a greater level of care and openness than what the young adult had experienced previously. We have also witnessed moments when parents were able to empathically conjecture what their young adult was feeling, validate their young adult's experience, and take responsibility for their own part in what their young adult was feeling, even when the young adult was unable to articulate their feelings and needs themselves. In some cases, parents even offered an apology for their past behavior. A deeply felt and credible apology, followed by forgiveness, can have a profound psychological impact (Greenberg, Warwar, & Malcolm, 2010).

The fact that both treatments evidenced reductions in unresolved anger, state anger, attachment anxiety, and psychological symptoms is promising. It is true that both EFT and ABFT already have substantial research bases evidencing their efficacy. For example, EFT has been shown to be quite effective in the treatment of depression (Goldman, Greenberg, & Angus, 2006; Greenberg & Watson, 1998; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003), trauma resulting from early childhood abuse (Paivio, Hall, Holowaty, Jellis, & Tran, 2001; Paivio & Nieuwenhuis, 2001), and unresolved interpersonal injuries from significant others (Greenberg & Foerster, 1996; Greenberg & Malcolm, 2002; Greenberg, Warwar, & Malcolm, 2010; Paivio & Greenberg, 1995). Recent studies indicate that EFT may also be effective with generalized anxiety disorder (Timulak, McElvaney, & O' Brien, 2012) and social anxiety disorder (Shahar, 2014). Likewise, ABFT has been shown to reduce depressive and suicidal symptoms, anxiety symptoms, family conflict, and attachment anxiety and avoidance among depressed and suicidal adolescents (Diamond et al., 2002, 2010, 2012). This is the first study, however, to suggest that both of these treatments may be efficacious in regards to resolving unresolved anger toward an attachment figure.

The finding that the two treatments were equally efficacious on four of the five outcome measures was contrary to our expectations. It is consistent, however, with the contention that equivalence between two bona fide manualized treatments is the norm rather than the exception (Luborsky, Singer, & Luborsky, 1975; Stiles, Shapiro, & Elliott, 1986; Wampold et al., 1997), though others have seriously challenged this contention (Crits-Christoph, 1997; Westmacott, & Hunsley, 2007). Importantly, EFT and ABFT are very similar on many dimensions, including their emphasis on the therapeutic relationship, productive emotional processing, and core relational themes. While this study was designed, in essence, to isolate the hypothesized differential impact of imaginal versus in vivo enactments with parents, it is important to remember that such enactments are only one of many factors likely

impacting the course and outcome of treatment. Perhaps what these two treatments had in common explained more of the variance in treatment outcome than what distinguished between them.

Our confidence in these findings is buoyed by a number of methodological strengths of the study. First, both treatments are manualized, empirically supported, and designed to promote productive emotional processing. Second, therapists were trained and live-supervised by experienced trainers in both treatment conditions. Third, productive emotional processing was assessed using a particularly rigorous measure (i.e., the productivity scale) and rigorous procedure (i.e., only instances of exact agreement were included).

With that said, a number of important limitations warrant mentioning. First, the relatively small number of participants likely precluded the ability to detect small between-groups effects, if they existed. Second, our results require replication in new and larger samples in order to evaluate the robustness of the findings. Third, participants were assigned to treatment condition in a quasi-experimental manner (i.e., based on geographical region). Fourth, the quality and nature of parents' responses in the conjoint treatment, and imagined parental responses in the individual treatment, were not measured. Such responses may have moderated the effect of productive emotional processing on the various outcome measures. Fifth, productive emotional processing was only coded in the context of sessions characterized by the use of imaginal or in vivo enactments. Selecting other sessions, which did not include imaginal or in vivo enactments but, instead, were characterized by the use of other emotion evoking interventions, may have yielded different results. Sixth, the number, length, and quality of imaginal and in vivo enactments in each condition were not directly assessed, variables which could potentially moderate any between-treatment differences. Finally, there was no long-term follow-up.

Despite these limitations, the findings from this study provide further evidence of the important role productive emotional processing plays in the therapeutic change process. This is the first study to examine productive emotional processing in the context of family therapy in general, and ABFT in particular. In terms of practical clinical implications, these findings suggest the potential importance of training therapists to stay with, and sufficiently deepen, clients' awareness and expression of their primary adaptive emotions and unmet attachment needs before moving on to reshaping interpersonal interactions. In terms of future research, it may prove instructive to also capture the quality of parental responses to their young adults' vulnerable disclosures, and the interaction between parental responses and young adults' productive emotional processing.

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