

**THE EFFECTIVENESS OF ATTACHMENT INJURY RESOLUTION PROTOCOL (AIRP) IN
REDUCING MARITAL DISTRESS AND IMPROVING MARITAL SATISFACTION IN THE
AREAS OF COMMUNICATION, COMMITMENT, AND TRUST IN HIGH-CONFLICT
COUPLES AFFECTED BY INFIDELITY**

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ABSTRACT

A quasi-experimental pilot study of fourteen heterosexual couples, twenty-eight participants, was conducted to assess whether Attachment Injury Resolution Protocol (AIRP) was effective in reducing marital distress and improving marital satisfaction in the areas of communication, commitment, and trust post infidelity for high-conflict couples. This study was important due to the fact that roughly thirty percent of couples engaged in marital infidelity (Norona et al., 2018). Fourteen heterosexual couples volunteered and were chosen from the clinician's private mental-health practice to participate in a quasi-experimental pilot study. Four self-report assessments were implemented, including the Kansas Marital Conflict Scale (KMCS), Interpersonal Communication Skills Inventory, Commitment-Investment Model Scale, and Trust in Close Relationship Scale. All assessments were administered pre- and post-intervention; four dependent variables included marital distress, marital communication, marital commitment, and trust. An independent t-test was conducted for each variable. Results for this pilot study concluded that Attachment Injury Resolution Protocol (AIRP) is an effective form of treatment, but further research is needed. Also, Attachment Injury Resolution Protocol (AIRP) does not effectively improve marital communication for high-conflict couples than Phase II of EFT without AIRP. Recommendations for future research would include a study on a larger population, more diverse ethnicities, and additional domains for testing, including sexual satisfaction and forgiveness.

Keywords: Attachment Injury Resolution Protocol (AIRP), Emotion-Focused Therapy, attachment, trauma, infidelity

Dedication

I would like to dedicate this work to my parents, Francis and Bert, who have encouraged and supported me throughout this process. I would also like to dedicate this work to my fellow colleagues and close friends who have pushed me and supported me during this endeavor.

Finally, I would like to thank the Almighty God for His unfailing love and mercy, who provided these gifts and talents to complete this study.

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CHAPTER ONE: INTRODUCTION

Overview

Trauma caused by infidelity can significantly affect an individual and a couple (Fincham & May, 2017). These effects may include dissociation, PTSD, interpersonal issues, lack of communication and commitment (Negash & Morgan, 2016). According to Henry et al. (2011), recent research has indicated that exposure to trauma, directly or indirectly, can significantly impact a spouse/partner, children, and first responders to those affected by trauma. Traumatic events are “highly stressful experiences that require individuals to take immediate action (i.e., fight or flight) to survive and leave lasting significant memories that are also distressing” (Figley & Barnes, 2005, p. 379). This study will address the effects of infidelity trauma and Attachment Injury Resolution Protocol (AIRP) on marital satisfaction and marital distress and its effects on marital communication, marital commitment, and trust.

Background

In summarizing findings from previous research, “authors estimated that between 30–60 % of men and 20–50 % of women had been involved in some form of marital infidelity” (Norona et al., 2018, p. 85). Additional research “provided even higher estimates based on the research, with estimates ranging from 33–75 % of men to 26–70 % of women have been involved in an extramarital relationship” (Jeanfreau et al., 2014, p. 328). In a recent study on “college-attending dating couples, more than half of participants reported having an emotional connection or being physically intimate with someone other than their romantic dating partner in the prior two years” (Norona et al., 2018, p. 85). “Surveys indicate 40–75% of married college students report that they have engaged in hooking up," this is usually defined as “range of physically intimate

behaviors (from kissing to sexual intercourse) that occur outside of the context of a relationship” (Shimberg et al., 2016, p. 354).

Today, the “lack of clarity around dating relationships may make infidelity more acceptable than in the past, when clear rules existed for such relationships” (Toplu-Demirtaş & Fincham, 2018, p. 253). “Two factors appear to lessen the degree of disapproval and encourage a more permissive attitude toward dating infidelity: biological sex and infidelity history” (Toplu-Demirtaş & Fincham, 2018, p. 252). “Compared to their female counterparts, male college students consistently hold more favorable attitudes toward infidelity” (Toplu-Demirtaş & Fincham, 2018, p. 252). Further, growing evidence shows that “attitudes toward infidelity and intentions are positively and strongly associated with each other in dating samples” (Toplu-Demirtaş & Fincham, 2018, p. 253).

History of Counseling High- Conflict Couples

According to many researchers, there have been several phases of counseling for high-conflict couples (Gurman & Fraenkel, 2002). High-conflict couples are defined as couples who have a "high degree of distrust, anger, and hostility towards their marital partner" (Cohen & Levite, 2012, p. 389). Cohen and Levite (2012) identify four potential indicators of high-conflict couples, including a) pattern of increased negativity than positivity during conflict; b) unable to maintain Gottman's 5:1 positive to negative interaction ratio to maintain marital happiness; c) display “Gottman's 'Four Horsemen of the Apocalypse' including criticism, contempt, defensiveness and stonewalling;” d) engage in "high-conflict" behaviors for a minimum of six months (p. 389).

These evolving patterns in theory and practice are reviewed as having progressed through four distinctive phases:

Phase I—Atheoretical Marriage Counseling Formation (1930–1963; marriage counseling was practiced by service-oriented professionals (e.g., obstetricians, gynecologists, family life educators, clergy) who today would not be considered "mental health experts"; Phase II—Psychoanalytic Experimentation (1931–1966); marriage counseling had no specific theory or technique, grafted onto itself a loosely held-together array of ideas of psychotherapy; Phase III—Family Therapy Incorporation (1963–1985; formed mostly of psychiatrists and distanced themselves from exploring new models of understanding and treating psychological disturbance; and Phase IV—Refinement, Extension, Diversification, and Integration (1986–present; marriage and family counseling reached its "golden age" in which marriage counseling and therapy became functionally invisible. (Gurman & Fraenkel, 2002, p. 216)

History has shown that couples counseling has become more extensive and practical with increased research and data (Gurman & Fraenkel, 2002). As a result, counseling for high-conflict couples is increasingly sought after due to increased knowledge and effectiveness (Gurman & Fraenkel, 2002).

In extreme high-conflict couples, couples' mediation is recommended instead of standard "clinical" counseling. Mediators can help contain family crises by “adapting the model and methods to fit different levels and patterns of conflict” (Parkinson, 2005, p. 72). A mediator would need to “understand the intensity of irrational feelings and reactions” and be able to maintain and control their own strong emotions (Parkinson, 2005, p. 72). For mediation, an “understanding of family systems theory (theory of human behavior that defines the family unit as a complex social system in which members interact to influence each other's behavior” is beneficial in “considering the functions of conflict and varying needs of the couple” (O’Gorman,

2012, p. 15). If couples' mediation is unsuccessful, additional clinical counseling or possible separation may be recommended (Parkinson, 2005).

History of Trauma in Family System

The Diagnostic and Statistical Manual of Mental Disorders (DSM- 5) defines *trauma* as "exposure to actual or threatened death, serious injury, or sexual violence" experienced directly or vicariously by the individual (or by loved ones) and causing significant distress in the cognitive, emotional or behavioral functioning (Pai et al., 2017). The trauma may cause enduring psychological, interpersonal, behavioral, or occupational challenges on the individual and family unit (Pai et al., 2017). According to Nelson and Wampler (2000), "partners with a history of trauma within the family system reported significantly lower marital satisfaction, higher individual stress symptoms, and lower family cohesion than couples with no history of abuse" (p. 177).

Traumatic events are catastrophic events that "require individuals to take immediate action (fight or flight) to survive and leave lasting significant impressions that are also distressing" (Figley & Barnes, 2005, p. 57). Systemic trauma, "or secondary traumatic stress, is how families and other intimate systems respond and minimize the effects of traumatic events on family members, i.e., witnessing a house fire or hearing a family member's traumatic incident" (Figley & Barnes, 2005, p. 57). Whether the perceived threat is experienced directly (or indirectly) by the victim, the family system may feel long-lasting emotional, mental, and physical wounds (Figley & Barnes, 2005). The family system is greatly affected by crisis events (war, natural disasters, abuse, estrangement; Figley & Barnes, 2005). The experiences of the traumatized individual who were directly affected by the trauma may have long-lasting effects on family dynamics and relationships.

According to Henry et al. (2011), recent research has indicated that exposure to trauma, directly or indirectly, can significantly impact spouse/partner, children, and first responders to those affected by trauma. A qualitative interview analysis of 17 individuals with a history of trauma exposure, one or both partners, indicated several interpersonal issues caused by trauma, including a) interpersonal relational roles, b) boundary issues, c) intimacy issues, d) triggers, and e) coping mechanisms (Henry et al., 2011). Secondary traumatization “may include compassion fatigue, vicarious traumatization, burnout, or trauma transmission” (Goff et al., 2006, p. 452).

Several researchers describe the couple and family systems approach to trauma primarily involves

1. secondary traumatic stress theory (i.e., the emotional duress incurred by hearing another's firsthand trauma, Goff et al., 2006);
2. adult attachment theory (the “assumption that romantic partners will develop an affectional bond and serve as the primary attachment figure for the other partner” (Halchuk et al., 2010, p. 37);
3. the relational approach to trauma treatment (i.e., building healthy attachment and connection integrated with appropriate trauma intervention, Halchuk et al., 2010).

Since the primary protective factor in trauma recovery is the family (or attachment figure itself), the destruction and functional damaging of this protective factor can enable different pathology to develop or create greater difficulty for healing for the victim (Klaric et al., 2013). Secondary traumatization (within the family system) “involves a transfer of nightmares, intrusive thoughts, flashbacks, and other Posttraumatic Stress Disorder symptoms” (Klaric et al., 2013, p. 35). In the broader sense, secondary traumatization “refers to any distress transfer (from a trauma

victim) to their immediate surroundings (including people and environment)” (p. 35). This may include a broad spectrum of distress manifestations (Klaric et al., 2013); if the secondary traumatization is not addressed, it is potentially transferable to subsequent generations (Klaric et al., 2013).

History of Infidelity

National surveys show that between 1991 and 2006, there has been an increase in rates of infidelity in all age groups (Fincham & May, 2017).

The most dramatic rise has been in the oldest cohort of men (ages 65–90). A two to three-fold increase is likely attributable to the new forms of treatments for erectile dysfunction that have become easily accessible. Low rates of condom use with secondary partners lead to immediate risk of exposure to sexually transmitted infections. Thus, infidelity is a great source for public health concerns. Numerous individual characteristics have been associated with infidelity, including personality variables such as neuroticism, prior history of infidelity, and number of sex partners before marriage. Some indicators of infidelity may include a permissive attitude toward sex more generally and a greater willingness to have casual sex and engage in sex without closeness, commitment, or love (Fincham & May, 2017, p. 72).

Conceptual and Theoretical Background

Attachment theory in psychology originates with the seminal work of John Bowlby in the late 1930s (McLeod, 2009). Bowlby defined “*attachment* as a lasting psychological connectedness between human beings” (McLeod, 2009, p.11). Attachment theory is under “an evolutionary context, in that the caregiver [attachment figure] provides safety and security for the infant” (McLeod, 2009, p. 11). Attachment theory is “adaptive in the sense that it enhances the

infant's chance of survival and moving to the next phase of life” (McLeod, 2009, p. 11). More importantly, all individuals seek proximity with their caregiver [attachment figure] when under stress or threatened (McLeod, 2009). Researchers have identified three phases of infant attachment, “including a) stranger anxiety - response to the arrival of a stranger; b) separation anxiety (distress level when separated from a caregiver; degree of comfort needed on return); c) social referencing (the degree that child uses the caregiver as a reference point to check how they should respond to new stimuli (secure base)” (McLeod, 2009, p. 8). Theorists believe two main theories help form the foundation of Attachment theory, including a) behaviorist theory of attachment (attachment is a learned set of behaviors to attach to a caregiver; McLeod, 2009). Second, b) evolutionary theory of attachment (pre-programmed to form attachments with others before entering the world, but change/evolves to survive; McLeod, 2009).

The application of “attachment theory to adult love relationships is a building block and a constant with significant revolution that has seen adult love relationships” (Johnson, 2019, p. 170). There has been a general trend of infidelity, less commitment, increased marital distress, and poor communication within relationships (Johnson, 2019). Bowlby suggests there is no such thing as “overdependency or true independence; there is only adequate or ineffective dependence in an adult relationship” (Johnson, 2019, p. 170). Bowlby also emphasizes that “having no attachment strategy is dysfunctional in itself” (seeking extreme avoidance or isolation) with often rigid boundaries that are often globalized (Johnson, 2019, p.170). “Proximity to an attachment figure [significant other] tames fear and offers self-soothing options to feelings of helplessness and meaninglessness” (Johnson, 2019, p. 171). The picture of “secure attachment that emerges from the childhood research [and applied to adulthood] shows securely attached individuals are able to adequately regulate their distress on separation from an attachment figure” [significant

other; Johnson, 2019, p.171); able to send clear, assertive signals to communicate their needs and emotions when together (Johnson, 2019); and able to meta-communicate (non-verbal cues that direct meaning), and change the direction of negative interactions and reengage after distress (Johnson, 2019). In clinical terms, as the relationships “become safe and more secure in the therapy process,” partners can disclose more information, redirect the negative conversation, “reflect on their experience, and create integrated, coherent narratives with [significant others]” (Johnson, 2019, p. 172).

Emotion-Focused Therapy

Attachment theory forms the foundation of Emotion-Focused Therapy (Johnson, 2019). Therefore, the attachment system remains active over the entire life span (Mikulincer & Shaver, 2012). Adults can become emotionally attached to various close relationship partners (Mikulincer & Shaver, 2012). Bowlby also viewed “attachment security as an essential foundation for developing various skills and competencies” (Mikulincer & Shaver, 2012, p. 266). The researcher also indicated “several adaptive benefits of activation and functioning of the attachment system: First, successful bids for proximity and support that restore a person's sense of security [from significant other] reaffirm the value of closeness and strengthen affectional bonds with relationship partners” (Mikulincer & Shaver, 2012, p. 266). “Second, successful bids for proximity and emotional support play a significant role in educating a person on down-regulating negative emotions (anger, anxiety, and sadness) when significant others are not reliably available and supportive” (Mikulincer & Shaver, 2012, p. 266). If a sense of security is not attained, “negative internal working models may be formed (e.g., worries about the relationship; decrease in self-esteem)” (Mikulincer & Shaver, 2012, p. 266).

Problem Statement

A contributing factor to this difficulty of treating couples effected by infidelity is the “notable lack of research on extradyadic involvement and infidelity among diverse couples” (Parker & Campbell, 2017, p. 173). Research gaps include the lack of “research addressing infidelity and appropriate treatment of the individual and couples, clinically approved interventions for recovery, and healthy reattachment of the victim to the betrayer” (Haney & Hardie, 2014, p. 402). Research gaps include few studies on the effects of 'males' or 'females' resulting from infidelity (Haney & Hardie, 2014), and a lack of testing of the effectiveness of rebuilding attachment post-infidelity, the effects on marital distress and satisfaction, and a more specifically, marital trust, forgiveness, and commitment (Toplu-Demirtaş & Fincham, 2018). Further gaps in research include the effects of repairing attachment injury on sexual satisfaction, mental health diagnosis, and communication (Toplu-Demirtaş & Fincham, 2018).

Very little research has been conducted on high-conflict couples affected by infidelity (Haney & Hardie, 2014). More so, the training that clinicians have received is often non-extensive or inadequate for the appropriate reestablishment of attachment after an attachment 'rupture' (Haney & Hardie, 2014). Clinicians who do not receive adequate training can reinforce the trauma, fail to provide a 'safe place' for the couple to process the infidelity, and cause secondary traumatization (Toplu-Demirtaş & Fincham, 2018). “Victims of infidelity report an array of negative emotions, including hurt and anger,” as well as increased “levels of self-doubt, depression, and anxiety” (Weiser & Weigel, 2017, p. 141). Today, the “lack of clear rules and expectations for dating relationships may make infidelity more acceptable than in the past” (Toplu-Demirtaş & Fincham, 2018, p. 253). The problem is that many clinicians do not feel equipped to effectively reduce marital distress and improve marital satisfaction post-infidelity for

high-conflict couples. The problem is that there is a significant lack of research in attachment injury resolution, and its positive effects on marital satisfaction and marital distress, more specifically marital commitment, marital communication, and trust for high-conflict couples affected by infidelity.

Purpose Statement

The purpose of this study is to examine whether the Attachment Injury Resolution Protocol (AIRP) effectively reduces marital distress and improves marital satisfaction in the areas of communication, commitment, and trust post-infidelity for high-conflict couples. An attachment injury caused by infidelity is characterized by "perceived abandonment, betrayal, or breach of trust is a critical moment of need for support expected of attachment figures [significant other]" (Makinen & Johnson, 2006, p. 1055). Infidelity is "one of the most traumatic and disorienting experiences an individual can undergo, and it can cause both emotional and cognitive traumatization" (Haney & Hardie, 2014, p. 402). Marital distress is identified as having a positive direct correlation between an individual's distress (anxiety, depression, alcohol use) and a couple's distress and family systems distress (Lebow et al., 2012). Marital commitment can be "interpreted as the function of satisfaction, investment, and perceived alternatives with a marriage" (Hou et al., 2018, p. 371). Attachment Injury Resolution Protocol (AIRP) has been shown to moderately reduce distress and improve marital satisfaction by resolving attachment injury in 8-10 sessions (Makinen & Johnson, 2006). AIRP will be implemented on 16 couples in a private practice setting with high-conflict couples affected by infidelity.

Significance of Study

The study of Attachment Injury Resolution Protocol (AIRP) and its effectiveness in reducing marital distress and improving marital satisfaction in communication, commitment, and

trust post-infidelity for high-conflict couples will add value in various research areas. This research will add significant value in infidelity trauma, trauma history, attachment theory, the effectiveness of family systems, and the resolution of attachment injury and attachment injury repair. This research will impact the field of psychology, sociology, social work, and marriage and family counseling (Haney & Hardie, 2014). Further research will also impact the field of traumatology (Greenman & Johnson, 2013). Traumatology can significantly affect attachment theory in the conceptualization and treatment of PTSD (Greenman & Johnson, 2013).

The findings from this study will add to psychology, social work, and marriage and family counseling, helping rebuild "attachment" after trauma injury, preventing cyclical or generation trauma, and aid in "holding together" families instead of separation. The findings will also add to the field of traumatology, help resolve individual trauma, and help prevent further trauma to the family system. The most recent research has linked empirical evidence between interpersonal relationships and post-traumatic stress due to trauma caused by infidelity (Greenman & Johnson, 2013). This study will also affect the areas of forgiveness, attachment resolution to address relationship traumas, and attachment-based resolutions (Greenman & Johnson, 2013). The results of this study may also be used for treating others affected by infidelity, used in a community mental health or private practice setting, males or females, those affected by family trauma, and those with attachment issues (Greenman & Johnson, 2013).

Research Questions

RQ1: Is Attachment Injury Resolution Protocol (AIRP) effective for clinically improving marital communication for high-conflict couples affected by infidelity?

RQ2: Is Attachment Injury Resolution Protocol (AIRP) effective for clinically improving marital commitment for high-conflict couples affected by infidelity?

RQ3: Is Attachment Injury Resolution Protocol (AIRP) effective for clinically improving marital trust for high-conflict couples affected by infidelity?

RQ4: Is Attachment Injury Resolution Protocol (AIRP) effective for clinically reducing marital distress for high-conflict couples affected by infidelity?

Definitions

Attachment Injury (AI)- An injury characterized by "perceived abandonment, betrayal, or breach of trust is a critical moment of need for support expected of attachment figures [significant other]" (Makinen & Johnson, 2006, p. 1055).

Attachment Injury Resolution Protocol- An 8-step protocol to rebuild trust and resolve an attachment injury caused by an attachment figure [significant other] (Makinen & Johnson, 2006).

Emotion-Focused Therapy (EFT)- Is a relatively brief couples' treatment focused on forming secure attachment bonds during times of stress and uncertainty, help regulate their emotions, and help rebuild trust and communication throughout the counseling process (Ramisch et al., 2013).

Infidelity- Any behavior that "results in the loss of the partner's confidence in the relationship, or the breaking of an agreement, between the couple due to extradyadic involvement (emotional, physical, or financial) by a member of the relationship" (Silvia et al., 2017, p. 725).

Infidelity Trauma: trauma inflicted on the individual [or relationship] due to an extradyadic involvement by one or both members of the relationship (Fincham & May, 2017).

High-Conflict Couple- This is defined as couples with a "high degree of distrust, anger, and hostility towards their marital partner" (Cohen & Levite, 2012, p. 389).

Couples Satisfaction Index- A 32-item self-report scale designed to measure one's satisfaction in a relationship (Funk & Rogge, 2007).

Interpersonal Communication Skills Inventory- A 40-item self-report scale designed to measure “four critical areas of a couple's communication, including sending explicit messages, listening, giving and receiving feedback, and handling emotional interactions” (Lazo, 2019, p. 18).

Marital Distress- A positive direct correlation between an individual's distress (anxiety, depression, alcohol use) and a couple's distress and family systems distress (Lebow et al., 2012).

Marital Satisfaction- Several indicators of relationship satisfaction include sexual intimacy, mutuality, quality of communication, humor, shared interests, commitment, dependability, and constructive conflict resolution skills (Domingue & Mollen, 2009).

Marital Communication - This is a vehicle for fostering intimacy and trust in relationships and a core component of marital satisfaction (Domingue & Mollen, 2009).

Marital Commitment- This is a function of relationship satisfaction, perceived quality of alternatives to the relationship, and experiences held within the relationship (Fincham & May, 2017).

Marital Trust- is a foundational element of a relationship that enables safety, security, and commitment to grow in a relationship (Josephs, 2020).

Commitment Investment Model Scale- This is a 29-item self-report scale that measures four constructs of the investment model, including commitment level and three bases of dependence, including satisfaction level, quality of alternatives, and investment size (Rusbult et al., 1998).

Summary

In summary, there is a significant lack of research in attachment injury resolution, and its effects on marital satisfaction and marital distress, more specifically marital commitment, marital communication, and trust for high-conflict couples affected by infidelity. The purpose of this study is to examine whether the Attachment Injury Resolution Protocol (AIRP) effectively

reduces marital distress and improves marital satisfaction in the areas of communication, commitment, and trust post-infidelity for high-conflict couples and prevents possible separation.

CHAPTER TWO: LITERATURE REVIEW

Overview

Trauma-based difficulties within a family system are “among the top three reasons an individual or couple would seek counseling services” (Sauerheber & Disque, 2016, p. 215). “Despite extensive resources related to explanations and treatment considerations, clinicians still report discomfort and lack of preparedness when helping couples work through trauma, specifically extramarital affairs or infidelity” (Sauerheber & Disque, 2016, p. 228). Most therapists report “feeling unprepared, uneducated, and lack clinical skill” when addressing trauma within a family (Olmstead et al., 2009, p. 134). “Acceptance and validation of the betrayed partner's pain is an essential bedrock of treatment” (Olmstead et al., 2009, p. 49). However, the needs of the betrayed spouse are often not seen in the therapeutic process. A contributing factor to this difficulty of treating couples effected by infidelity is the “notable lack of research on extradyadic involvement and infidelity among diverse couples” (Parker & Campbell, 2017, p.177).

Throughout chapter two, a brief description of the conceptual and theoretical framework, related literature, gaps in research will be discussed. This chapter expands upon attachment theory and trauma theory, causes of infidelity, and the possible effects on marital distress, marital commitment, marital communication and trust, high-conflict couples counseling, and Emotion-Focused Therapy. Gaps in literature were identified and expanded throughout the chapter.

Conceptual or Theoretical Framework

Attachment Theory

Attachment theory in psychology “originates with the seminal work of John Bowlby in the late 1930s” (McLeod, 2009, p. 2). Bowlby defined *attachment* as a “lasting psychological

connectedness between human beings; interpersonal attachment in the form of a behavioral attachment system” (McLeod, 2009, p. 10). Building on Bowlby's concept of working models, “Ainsworth et al. were the first to develop a model defining different attachment styles for children and adult relationships” (Yip et al., 2018, p. 186). These include anxious attachment, avoidant attachment, and secure attachment (Yip et al., 2018). Attachment theory “asserts that secure attachment in adult romantic relationships are characterized by mutuality, comfort with closeness and intimacy, and reciprocal caregiving” (Domingue & Mollen, 2009, p. 682).

Adult attachment theory assumes that romantic partners will develop an affectional bond and serve as the primary attachment figure for the other (Halchuk et al., 2010). Attachment theory has also been referred to as a trauma theory (Makinen & Johnson, 2006). Following traumatic abandonment, “the injured partner may exhibit symptoms of post-traumatic stress disorder” (Makinen & Johnson, 2006, p. 1059). Many attachment theorists suggest that the attachment figure [significant other] is both the source and solution to the attachment pain (Makinen & Johnson, 2006). Those affected by infidelity will also report a reduction in marital trust, hesitancy towards forgiveness, and difficulty with commitment (Josephs, 2020).

Attachment theory also suggests that a therapist may help couples improve their communication skills or gain insight into past and present relationships. Second, isolation, separation, or disconnection from an attachment figure is inherently traumatizing. Third, from an attachment perspective, the patterns of distress in couple relationships are finite and predictable and reflect the process of separation distress (Johnson, 2019, p. 172).

Conceptually, Emotion-Focused Therapy (EFT) therapists work with couples to “move from insecure attachment to secure attachment” through the communication of attachment-

related emotions, needs, and fears (Domingue & Mollen, 2009, p. 682). EFT watches for emotional responses that generate others, positive or negative, which usually leads to engaging or withdrawing behaviors (Domingue & Mollen, 2009). Mindfulness of the couple's communication patterns is imperative to discontinuing negative interactions and promoting positive attachment (Domingue & Mollen, 2009). "Susan Johnson, the founder of EFT, asserted 'it is the absence of disclosing and responsive interactions that begins the process of relationship distress. Individual attachment needs are then left unsatisfied, and it is this deprivation and distance that eventually lead to conflict and marital distress'" (Domingue & Mollen, 2009, p. 679).

Trauma Theory

Trauma theory was initially developed in Western civilization in the 1980s through the cross-fertilization between psychology and the humanities (Atkinson et al., 2010).

The founding fathers of trauma theory include several theorists: a) Jean-Martin Charcot, a French physician who worked with traumatized "hysteria" women in the Salpetriere hospital; b) Pierre Janet, a student of Charcot, continued to study dissociative phenomena and the effects of traumatic experiences on personality development and behavior; c) Freud and Breuer adopted Charcot ideas and termed traumatic dissociation "hypnotic hysteria" and highlighted its relationship to a traumatic antecedent; d) Abram Kardiner and Herbert Spiegel termed the coin "shell shock" and continued to provide "crisis interventions" to veterans returning from World War I and World War II. (Brandell & Ringel, 2019, p. 75)

According to research, *historical trauma* is defined "as the subjective experiencing and remembering of events in an individual's mind or the life of a community" (Atkinson et al., 2010,

p. 139). Four different assumptions lay the foundation for historical trauma theory: “a) mass trauma can be intentionally and deliberately inflicted upon a target group or population (Sotero, 2016); b) trauma is not limited to a single catastrophic event but may continue over an extended period or generation (Sotero, 2016); c) traumatic events can reverberate throughout the population or family system, creating a universal experience or ‘systemic effect’ of trauma (Sotero, 2016); d) the magnitude of the trauma experience can have secondary and tertiary effects on the family system or population, resulting in a cascade of physical, psychological, social and economic repercussions that persists across generations” (Sotero, 2016, p. 99).

In 1980, Post-Traumatic Stress Disorder (PTSD) was “formally accepted by the American Psychiatric Association as a diagnosis describing the severe and long-term effects of exposure to traumatic stressors like combat, sexual assault, child abuse, motor vehicle accidents or natural disasters” (Sotero, 2016, p. 95). Authors also indicate that “individuals diagnosed with PTSD have increased odds of behavioral health risks, social dysfunction, interpersonal relationship issues, attachment issues, and difficulty mastering life skills and role performance” (Sotero, 2016, p. 98). Trauma as the “result of deliberate intent, caused by a loved one or attachment figures, produces a profound sense of dismay and alienation” (Sotero, 2016, p. 97). Extreme trauma may lead to subsequent impairments in the capacity for parenting, connection, and relationships (Sotero, 2016). Atkinson et al. (2010) suggested that “historical trauma becomes embedded in the family system of people” and is passed on by the “exact ‘mechanisms’ by which culture and family ritualized are generally transmitted, and therefore becomes ‘normalized’ within that family system and culture” (p. 97). Research indicates that as many as “one-third of child victims of physical (including sexual) and psychological abuse grow up to experience parental difficulties” or become abusive of their children (Atkinson et al., 2010, p.

136). The model of historical trauma provides a link between the intergenerational transmission of trauma and individual trauma (Atkinson et al., 2010).

The trans-generation effects of trauma can have significant effects on a family unit. The “trans-generational effects of trauma occur via various mechanisms, including the impact on the attachment relationship with caregivers, parenting and family functioning; the association with parental physical and mental illness; disconnection and alienation from extended family, culture, and society” (Atkinson et al., 2010, p. 138).

These effects are exacerbated by exposure to continuing high levels of stress and trauma, including multiple bereavements and other losses, the process of vicarious traumatization where children witness the lasting effect of the original trauma which a parent or other family members have experienced. Even where children are protected from the traumatic stories of their ancestors, the effects of past traumas still impact children in the form of ill health, family dysfunction, unhealthy attachment styles, community violence, psychological morbidity, and early mortality (Atkinson et al., 2010, p. 138).

Atkinson et al. (2010) define trauma as two-fold a) “psychological as an emotional state of discomfort and stress resulting from exposure to a traumatic event (i.e., sexual assault, physical assault, infidelity, loss of loved one), which shattered the survivor's sense of invulnerability to harm” (p.139). Secondly, “behaviorally, as a set of conscious and unconscious actions and behaviors associated with dealing with the stresses of catastrophe' and the inability to cope with highly traumatic events resulting in psychological and physiological effects” (Atkinson et al., 2010, p. 139). Unresolved trauma can have significant effects on the individual (victim), the family system (loved ones of the victim), the community, and the larger population (Atkinson et al., 2010). Childhood trauma and adult trauma is one of today's “single

most important public health challenges” and one that could be decreased by appropriate prevention and intervention (Atkinson et al., 2010, p. 139).

Research indicates “decreased satisfaction with the primary relationship is consistently related to infidelity, with some evidence of bidirectional effects” (Nelson & Wampler, 2000, p. 172). According to Nelson and Wampler (2000), partners with a history of trauma with the family system reported “significantly lower marital satisfaction, higher individual stress symptoms, and lower family cohesion than couples with no history of abuse” (p. 140). Addressing individual and family trauma with infidelity is essential in performing couples counseling (Atkinson et al., 2010).

Attachment Injury Caused by Infidelity Trauma

Attachment Injury (AI) is defined as an injury characterized by "perceived abandonment, betrayal, or breach of trust is a critical moment of need for support expected of attachment figures [significant other]" (Makinen & Johnson, 2006, p. 1055). According to Darab et al. (2020), four common themes of attachment injury caused by sexual betrayal include “a) sexual relationships, b) emotional effects, c) cognitive effects, and d) behavioral effects” (p. 385). Darab et al. (2020) also indicate that attachment injury caused by infidelity can have significant ramifications, including a) damaging the cultural foundation of mutual trust within partners, b) exacerbating negative communication and attachment cycles, and c) eroding commitment and trust that ground the relationship. Secondary effects of attachment injury caused by infidelity included reduced marital satisfaction, marital commitment, and marital trust (Johnson, 2005).

Attachment theory emphasizes the importance for human beings to make and maintain affectional bonds with significant others; “a secure attachment bond is an affectionate, powerful, reciprocal relationship in which partners mutually derive and provide closeness, comfort, and

security" to each other (Makinen & Johnson, 2006, p. 1055). These bonds are based on a "profound psychological and physiological interdependence" and, therefore, impact psychological well-being (Makinen & Johnson, 2006). A rupture to this attachment, or an attachment injury, can cause a "loss of self," disorganized attachment, and mental health issues (Makinen & Johnson, 2006, p. 1055). Following traumatic abandonment, the injured partner may "exhibit symptoms characteristic of post-traumatic stress disorder" and report decreased levels of trust, reduced commitment, interdependence, and reduced marital satisfaction (Johnson, 2019, p. 172).

Marital Trust

After infidelity, a couple often seeks counseling in hopes of restoring trust, emotional intimacy, reattachment to their partner, and sexual reconciliation (Josephs, 2020). Schade and Sandberg (2012) reported marital infidelity as 'devastating' to marital attachment and marital trust; if a loved one cannot turn to their partner in a time of need, trust is challenging to rebuild (Schade & Sandberg, 2012). Dehghani et al. (2020) reported a direct negative correlation between attachment injury [caused by infidelity] and trust within a relationship. Dehghani et al. (2020), reported that the percentage obtained from the "overall increase of trust among the injured women during the AIRP therapy was 38.76%, and follow-up was 48.58%"; indicating a positive direct correlation between attachment injury resolution and marital trust (Dehghani et al., 2020, p. 285).

According to Warach and Josephs (2021), several findings suggest that infidelity-based attachment trauma amongst couples often manifests itself in reduced marital trust and disorganized attachment behavior, therefore leaving the partner confused, with a presentation of PTSD symptoms, and reduction in communication. According to Dalglish et al. (2015),

individuals in relationships characterized by greater levels of marital trust “will have more positive, well-integrated, and well-balanced internal working models that help them resolve relationship difficulties” (p. 277). Conversely, couples with lower levels of “trust have more rigid and defensive patterns during marital distress” (Zuccarini et al., 2013, p. 155).

Marital trust will be measured the Trust in Close Relationships Scale. *The Trust in Close Relationship Scale* is a “seventeen-item self-report scale designed to measure levels of trust in one's relationship partner; each item is answered based on a 7-point Likert-type scale ranging from 1 (strongly disagree) to 7 (strongly agree)” (Rempel et al., 1985, p. 95). The “scale can be divided up into subscales include a) predictability, b) dependability, c) faith” (Rempel et al., 1985, p.95). The Trust in Close Relationships has been used in several studies including Reis and Shaver (2018), Hoff and Bashir (2015), and Balliet and Van Lange (2013). This scale demonstrated high interval validity (Reis & Shaver, 2018) and strong reliability (Balliet & Van Lange, 2013). This assessment was chosen over other trust assessments since it was used in previous EFT studies (Johnson, 2005).

Marital Distress

According to Lebow et al. (2012), research has shown a direct correlation between individual distress and couples distress. Therefore, a positive direct correlation has been shown between an individual's distress (anxiety, depression, alcohol use) and a couple's distress and family systems distress (Lebow et al., 2012). Adversely, a direct correlation between a couple's distress (increased arguing, martial tension, and strong negative emotions) and an individual's diagnosis of DSM-5 mental-health disorder (i.e. anxiety, depression) has also been shown (Lebow et al., 2012). The strongest associations obtained were “bipolar disorder, alcohol use

disorders, and generalized anxiety disorder” (Lebow et al., 2012, p. 147). Previous research has “linked insecure attachment to relationship distress” (Dalgleish et al., 2015, p. 277).

Marital distress leads to more unsatisfactory treatment outcomes in treating problems “such as depression, anxiety, and substance use disorders” (Lebow et al., 2012, p. 150). Therefore, one can conclude that measuring a couple's distress may indicate an individual's distress and vice versa. Infidelity is reliably associated with “poorer mental health, particularly depression/anxiety and PTSD and relationship dissolution/divorce” (Fincham & May, 2017, p. 72). “Problematic drinking, alcohol dependence, and illicit drug use” are related to infidelity (Fincham & May, 2017, p. 73). According to Askari and Mohd (2012), a relationship between mental health problem (i.e. depression and anxiety) and marital satisfaction and marital distress exists; “the more anxious or depressed a spouse was, the more dissatisfied with marriage the spouse will be” (p. 99). Concluding, the better managed an individual distress is, will have a positive correlation to the couple’s distress (Askari & Mohd, 2012)

Marital Distress will be measured by the Kansas Marital Conflict Scale (KMCS). *The Kansas Marital Conflict Scale (KMCS)* is a 27-item self-report, Likert scale, designed to measure 'marital interactions' and conflict that distressed and non-distressed couples attempt to resolve (Eggeman et al., 1985). The Kansas Marital Conflict Scale was used in several studies including Jehn and Bendersky (2003), Ahmadi et al. (2019), and Hildenbrand and Alderfer (2019). This assessment was chosen over assessments due to high test-retest validity and strong reliability (Ahmadi et a. (2019).

Marital Satisfaction

According to Domingue and Mollen (2009), several indicators of relationship satisfaction for hetero-sexual couples include “sexual intimacy, mutuality, quality of communication, humor,

shared interests, commitment, dependability, and constructive conflict resolution skills. Couples' communication, especially its interactive processes, has been examined extensively as a predictor of relationship satisfaction" (Lock & Levi, 2017, p. 395). According to Dalglish et al. (2015), "attachment security is characterized by low attachment anxiety (a positive view of self) and low attachment avoidance (a positive view of others)" (p. 279). Securely attached couples are more likely to have "higher levels of trust, marital commitment, and marital satisfaction" (Dalglish et al., 2015, p. 278). Individuals with "high attachment avoidance tend to deactivate their attachment needs by inhibiting proximity seeking and trying to handle stress alone" (Dalglish et al., 2015, p. 279).

Emotion-Focused therapy aims to create more secure bonding events through the exploration and expression of "emotional needs and wants to be associated with the loss of connection and create increased marital satisfaction, accessibility, and responsiveness between partners" (Domingue & Mollen, 2009, p. 682). Several positive predictors of marital satisfaction outcome have been examined in one EFT study, including the "quality of the romantic attachment relationship, emotional self-disclosure, and relationship trust" (Dalglish et al., 2015, p. 278). Couples affected by infidelity will directly affect marital satisfaction, including marital communication and commitment and may require extensive reattachment [to attachment figure] to repair marital satisfaction and commitment (Fincham & May, 2017).

Marital Communication

According to Domingue and Mollen (2009), marital communication is "seen as a vehicle for fostering intimacy and trust in relationships due to partners feeling understood and attached" (p. 679). Unhealthily attached adults are more likely to "cling, make demands, stonewall, or withdraw because they believe their partner will reject them" (Domingue & Mollen, 2009, p.

682). Couples' communication has been examined extensively as a [positive or negative] predictor of relationship satisfaction (Domingue & Mollen, 2009). Dr. John Gottman found that negative affect reciprocity “(the increased probability that a person's emotions will be negative, i.e., anger, sadness) is the most consistent negatively correlated predictor of relationship satisfaction” (Gottman & Silver, 1999, p. 72). Dr. John Gottman found that stable, satisfied couples exhibit fewer components of “criticism, defensiveness, and stonewalling than unsatisfied, unhappy couples; however, contempt was found to be non-existent in stable, satisfied couples” (Gottman & Silver, 1999, p. 73).

According to Domingue and Mollen (2009), satisfied couples also engage in more effective communication repair attempts (e.g., smiling, expressing appreciation to soften complaints, expressing commitment) “when the conflict discussion begins to turn negative, thus preventing further negative reciprocity and de-escalating the conflict and creating a less negative, more positive emotional climate” (p. 682). Positive sentiment override “which leads one partner to interpret the other partner's negative behaviors as neutral instead of negative” allows the couple to 'move' through their problems instead of shutting down (Domingue & Mollen, 2009, p. 683). Communication and conflict resolution skills has a positive influence on marital satisfaction (Domingue & Mollen, 2009).

According to Hou et al. (2018), a study including 400 Chinese couples found that healthy communication and marital commitment had a positive correlation to marital satisfaction. More specifically, wives indicated a stronger correlation between marital commitment to marital satisfaction than marital communication and marital satisfaction (Hou et al., 2018).

A study conducted by Haris and Kumar (2018) with 50 married couples, reported healthy interpersonal communications directly predicted increased marital satisfaction for marital life.

In a recent study conducted by Askari and Mohd (2012), one hundred and eight participants comprised of 54 married couples assessed the effects of healthy communication and conflict resolution skills on marital satisfaction; “results indicated that healthy communication and conflict resolution skills had significant positive effects on the marital satisfaction and mental health scores” (Askari & Mohd, 2012, p. 99).

Marital communication will be measured by the Interpersonal Communication Skills Inventory. *The Interpersonal Communication Skills Inventory* is a 40-item self-report scale designed to measure four key areas of the couple's communication, including sending clear messages, listening, giving and receiving feedback, and handling emotional interactions (Pfeiffer & Jones, 1974). This inventory aims to identify communication strengths and potential areas for development; couples will check a "usually, sometimes, or seldom" Likert scale response (Lazo, 2019). The Interpersonal Communication Skills Inventory scored high in internal consistency validity and strong reliability (Pfeiffer & Jones, 1974).

Marital Commitment

Marital commitment can be interpreted as the “function of satisfaction, investment, and perceived alternatives” with a marriage (Hou et al., 2018, p. 370). Put simply, greater marital commitment can be “predicted by greater satisfaction, greater investment, and lesser perceived alternatives” (Hou et al., 2018, p. 371). Admittedly, the investment model of commitment suggests a “close connection between satisfaction and commitment and even further depicts that satisfaction can predict commitment” (Hou et al., 2018, p. 371). The effects that commitment determinates and promotes marital satisfaction can also be inferred from social exchange theory. Recent research linked the Big Five Model (BFM) and Five-Factor Model (FFM) domains of “neuroticism, conscientiousness, extraversion, agreeableness, and openness” to romantic

satisfaction with married couples (O'Meara & South, 2019, p. 1210). According to McCray (2015), infidelity may have a direct effect on marital trust, and marital commitment, and negatively affect marital satisfaction. As a result, marital distress and marital communication may negatively be affected by infidelity (McCray, 2015).

In this specific model, commitment is central to relationship satisfaction and “comprises both an experienced attachment and a motivation to continue the relationship” (Fincham & May, 2017, p. 72). Commitment, in turn, is a “function of relationship satisfaction, perceived quality of alternatives to the relationship, and both tangible” (e.g., shared possession) and intangible (e.g., shared experiences), and experiences within the relationship (Fincham & May, 2017, p. 72). The commitment model predicts many pro-relationship behaviors and has been effective in predicting infidelity and marital satisfaction (Fincham & May, 2017).

Marital Commitment will be measured by the Commitment Investment Model Scale. *The Commitment Investment Model Scale* is a 29-item self-report scale that measures four constructs of the investment model, including “commitment level, and three bases of dependence, including satisfaction level, quality of alternatives, and investment size” (Rusbult et al., 1998, p. 358). This assessment was used in several studies including Gordon et al. (2012), Finkel et al. (2013), and Feeney and Collins (2015). This assessment demonstrated high internal reliability (Feeney & Collins, 2015) and high validity (Finkel et al., 2013). This assessment was chosen over alternative assessment due to its high internal reliability and consistency (Feeney & Collins, 2015).

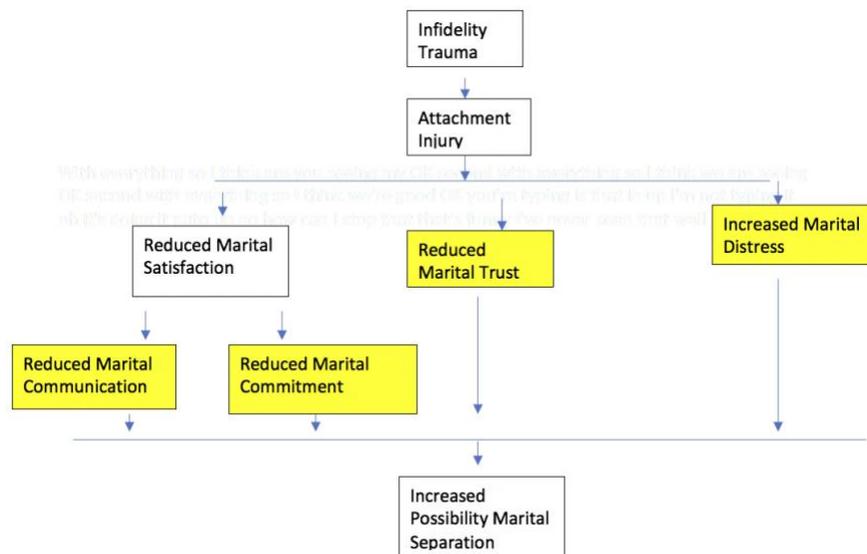
Marital Separation

As shown in figure 1, infidelity trauma causes an attachment injury, which causes a decrease in marital satisfaction, decreases marital trust, and increases marital distress. Reduced

marital satisfaction is directly affected by decreased marital communication and decreased marital commitment. All dependent variables, including reduced marital communication, reduced marital commitment, reduced marital trust, and increased marital distress, may indicate an increased possibility of marital separation. Haris and Kumar (2018), reported poor communication may lead decreased marital satisfaction and increased divorce rates. Askari and Mohd (2012) reported that “poor communication, finance, infidelity, substance abuse, unresolved mental health issues, and inadequate conflict resolution skills are the most common reasons for separation and divorce” (p. 99).

Figure 1

Effects of Trauma Caused by Infidelity



Note. Yellow shaded boxes indicate dependent variables.

Attachment Injury Resolution Protocol

Attachment Injury Resolution Protocol is an eight-step protocol to rebuild trust and resolve an attachment injury caused by an attachment figure [significant other] (Makinen &

Johnson, 2006). Attachment injuries are defined by Makinen and Johnson (2006) "as characterized by perceived abandonment, betrayal, or breach of trust is a critical moment of need for support expected of attachment figures [significant other]" (p. 1055). Infidelity can be considered an "attachment injury," an intense trauma or violation of trust that brings the nature of the whole relationship into question" (Schade & Sandberg, 2012, p. 437). If the attachment injury is not addressed immediately, it may increase distress, distrust, and emotional sensitivity over time. Often, the attachment injury can cause the injured partner to "repeatedly recall the event with a great deal of emotion, similar to a traumatic flashback, with the potential to overwhelm the offending spouse," thus leading to potential PTSD symptoms for the couple and the injured partner (Burgess Moser et al., 2016, p. 235). Attachment theory has also been referred to as a theory of trauma. "When people are without physical or emotional support, they are most vulnerable and have difficulty regulating their emotions" (Brubacher, 2018, p. 25).

Related Literature

Research gaps include the "lack of extensive research addressing infidelity and appropriate treatment of the individual and couples, clinically approved interventions for recovery, and healthy reattachment of the victim to the betrayer" (Haney & Hardie, 2014, p. 402). By too quickly trying to 'fix' the marriage or assuming that the betrayed spouse contributed to the unfaithful partner's infidelity, "the therapeutic process can inadvertently re-traumatize an already emotionally fragile client while not addressing his or her emotional needs" (Haney & Hardie, 2014, p. 410). This study addresses "therapeutic considerations for working with the betrayed partner and provides practical guidelines" for addressing a betrayed client's psychological and emotional needs (Haney & Hardie, 2014, p. 410).

Attachment-Based Interventions

Attachment theory is a primary component to addressing infidelity within high-conflict couples and assumes a “reciprocal relationship between parents and children that shape our internal world and our relational world” (Diamond et al., 2016a, p. 145). “If parents are sensitive and available to their children's emotional needs, children internalize a belief that people are generally trustworthy and that they are worthy of being loved” (Diamond et al., 2016a, p. 145). This reciprocal cycle of “interpersonal interaction and internal feelings and perceptions make up the fabric of family and individual development” (Diamond et al., 2016a, p. 145).

Attachment-based family therapy capitalizes on the innate, biological, and existential desire for meaningful and secure relationships (Diamond et al., 2016b).

Attachment-Based Theory, like emotion-focused couples therapy, work to uncover what experiences and relational processes (e.g., harsh criticism) have damaged trust in family relationships and couples. ABFT explicitly targets the improvement of attachment security as the primary mechanism of change (Diamond et al., 2016b). Broadly speaking, Relationship Self-Regulation (RSR) is defined as the ability of partners in an intimate relationship both to monitor and work on sustaining their relationship and affect relationship satisfaction and reduce tension amongst high-conflict couples. (Diamond et al., 2016b, p. 2)

Attachment-Based Family Therapy (ABFT) was introduced into Belgium in 2009 and “found to be highly effective with couples’ therapy” (Santens et al., 2016, p. 242). Little research has been done to test whether ABFT is effective for treating individuals affected by infidelity. The ABFT therapist seeks to understand how a client’s attachment experiences “shape his/her beliefs and expectations of self and others and how that story or explanation impacts behavior in

the future” (Scott et al., n.d., p. 155). Power can be operationalized in many ways. In romantic relationships, “power could be studied as a dyadic variable by looking at the degree of influence that romantic partners have over each other” (Lammers & Maner, 2016, p. 55).

Attachment Styles

Two attachment styles have been directly correlated to possible reasons of infidelity. “Attachment avoidance and attachment anxiety are two types of insecure personality dimensions also associated with infidelity; high insecurity is associated with more conflict and more negativity in relationships, which are precursors to infidelity” (Selterman et al., 2019, p. 274). Avoidance is associated with wanting “greater independence/autonomy as a motivator for infidelity”, while attachment anxiety is associated with wanting “greater intimacy and emotional fulfillment as a motivator for infidelity” (Selterman et al., 2019, p. 274). Recent authors based their work on Bowlby, by positing that these infant attachment styles form the basis for the formation of romantic attachments in adult life (Tie & Poulsen, 2013). Securely attached individuals believe “that the significant people in their lives will be there for them in times of distress, and trust that those people will continue to support them and not abandon them; people in securely attached relationships trust, accept and support their partners” (Tie & Poulsen, 2013, p. 558). Anxiously attached individuals display specific characteristics such as the need to be always with their partner, fall in love easily, and experience great panic upon separation (Tie & Poulsen, 2013).

On the contrary, individuals with avoidant attachments styles “avoid emotional closeness with partners and dislike when the partner attempts to make such contact; individuals with an avoidant attachment style also tend to exhibit jealousy and experience intense sexual attraction,” which may lead to infidelity or conflict within couples (Tie & Poulsen, 2013, p. 559). Anxiety

relates to the degree of anxiety and vigilance concerning rejection and abandonment; “avoidance relates to the degree of discomfort with closeness and the dependence or a reluctance to be intimate with others” (Greenberg & Goldman, 2008, p. 72). Therefore, avoidant attached individuals could be an indicator for those who engage in infidelity (Greenberg & Goldman, 2008).

Infidelity Within High-Conflict Couples

The definition of infidelity “is complex, and there is no single set of criteria that is universally agreed upon” (Silvia et al., 2017, p. 720). Due to the vagueness of the definition, it may make it more difficult for the betrayed partner to grieve and heal from the trauma. *Infidelity* can be defined as a “behavior that results in the loss of the partner's confidence in the relationship or breaking an agreement between the couple” (Silvia et al., 2017, p. 720). Victims of infidelity report an array of negative emotions, “including hurt and anger, as well as increased levels of self-doubt, depression, and anxiety” (Weiser & Weigel, 2017, p. 935). In the United States, “infidelity is particularly viewed as unacceptable for romantic relationships” (Weiser & Weigel, 2017, p. 935). Researchers found that lack of “satisfaction, better alternatives, and personal disposition were the reasons most often provided for why individuals would be likely to cheat” (Weiser & Weigel, 2017, p. 936). The scope of infidelity extends beyond the marital realm, with “persons in cohabiting and dating relationships reporting higher rates of infidelity than married persons” (Fincham & May, 2017, p. 71).

Two factors lessen the degree of disapproval of infidelity and encourage a more “permissive attitude toward dating infidelity: biological sex and infidelity history” (Toplu-Demirtaş & Fincham, 2018, p. 253). Further, there is growing evidence showing that “attitudes toward infidelity and intentions toward infidelity are positively and strongly associated with each

other in dating samples” (Toplu-Demirtaş & Fincham, 2018, p. 253). It was hypothesized that males and dating college students who reported (past/current) infidelity would have “more permissive attitudes toward infidelity and show greater intention of engaging in dating infidelity” (Toplu-Demirtaş & Fincham, 2018, p. 253). Infidelity can have significant effects on a relationship, “including loss of partner, violence, or other reparations sought by the betrayed partner” (Selterman et al., 2019, p. 253).

Effects of Infidelity

Several effects of infidelity include “interpersonal conflict, family disruption, violence, psychological distress” (Negash & Morgan, 2016, p. 200). An estimated “11-21 % of individuals with children commit infidelity” (Negash & Morgan, 2016, p. 200).

One area of prominent concern is when one or both partners have engaged in acts of infidelity. Research that does exist points to specific factors associated with the healing of a relationship after the significant betrayal of infidelity. These factors include relationship satisfaction, a deliberate and committed decision to stay together, forgiveness, and trust. The authors believe the betrayed partner's capacity to trust again largely depends on a variety of factors. One, being the betraying partner must be perceived as trustworthy; and second, the betraying partner is able to make behavioral changes. (Sauerheber & Disque, 2016, p. 215)

Infidelity has also been “causally linked to domestic violence” (Fincham & May, 2017, p. 72). According to Warach and Josephs (2021), several findings suggest that infidelity-based attachment trauma amongst couples often manifestations itself in a disorganized attachment behavior, therefore leaving the partner confused, uncertain, and distant. As a result, the main

goal of Emotion- Focused Therapy is to rebuild a secure attachment style among the couple (Warach & Josephs, 2021).

Types of Infidelity

A variety of infidelity may occur within a committed relationship. Researcher in the field of traumatology often distinguish between two forms of “infidelity: sexual and emotional” (Ellis & Kleinplatz, 2018, p. 44). “A person may interpret infidelity as evidence that he or she is undesirable or unworthy of love” (Ellis & Kleinplatz, 2018, p.44). Others may attribute the cause of infidelity to “situational factors beyond anyone's immediate control (e.g., believing that they are incompatible with their partners)” (Ellis & Kleinplatz, 2018, p. 44). Either form of infidelity (sexual or emotional) can be traumatic for the significant partner.

Infidelity can be a traumatic and terrifying experience an individual or couple may experience; it can create psychology and emotional effects including “complex grief, making it a particularly challenging form of crisis” (Haney & Hardie, 2014, p. 402). Individuals have been known to develop PTSD as a result of infidelity. One of the most robust findings concerning infidelity literature is that “men are more likely to engage in extramarital sex than women” (Munsch & Yorks, 2018, p. 582). Consequently, men's evolved desire for variety suggests they should be more inclined than women to take advantage of opportunities for “extradyadic sex, whereas women's evolved desire for long-term mating suggests they should be less inclined to take advantage of opportunities for extradyadic sex” (Munsch & Yorks, 2018, p. 402).

Internet Infidelity.

Some of the issues associated with problematic Internet usage (which may lead to infidelity), “include greater degrees of uninhibited behavior, addiction, secrecy of online activities, misrepresentation of time spent online, impairment of daily duties, interference of

online behavior with the relationship, and altered levels of sexual intimacy with a partner” (Cravens et al., 2013, p. 75). “Treatment of infidelity may include: (a) the seven issues that increase a couple's vulnerability to Internet infidelity, (b) self-of-the-therapist issues, and (c) divisive issues in treatment” (Clayton, 2014, p. 75).

The digital revolution has dramatically impacted the formation and effects on the family. Many users face information explosion through “Facebook feeds that contain every activity that their virtual friends have engaged in” (Eichenberg et al., 2017, p. 250). “Virtual flirtatious behaviors elicit physical and sexual reactions” that are stronger than in a regular face-to-face interaction (Abbasi & Alghamdi, 2017, p. 3). The lack of verbal and nonverbal cues leaves individuals with ground for difficulties in interpretation of “what is intended and what is typed on a screen” (Birditt et al., 2017, p. 324). There is no doubt that infidelity damages relational trust, commitment and connection within a relationship (Hertlein et al., 2010).

High-Conflict Couples

As opposed to dealing with generalized "high-conflict couples," this study will focus specifically on high-conflict couples affected by infidelity. Cohen and Levite (2012) defined "high-conflict couples" as couples who have a "high degree of distrust, anger, and hostility towards their marital partner" (p. 389). Cohen and Levite (2012) identify four potential indicators of high-conflict couples, including a) pattern of increased negativity than positivity during conflict; b) unable to maintain Gottman's 5:1 positive to negative interaction ratio to maintain marital happiness; c) display Gottman's 'Four Horsemen of the Apocalypse' including criticism, contempt, defensiveness, and stonewalling; d) engage in "high-conflict" behaviors for a minimum of six months. Authors indicated that "infidelity, in the context of a dyadic

relationship, represents a partner's violation of norms regulating the level of emotional or physical intimacy with people outside the relationship" (Reich & Kalantar, 2018, p. 25).

Gottman and Silver (1999) have "identified four dysfunctional forms of communication, which he calls the four horsemen of the apocalypse: criticism, contempt, defensiveness, and stonewalling. Couples with high distress will often exhibit all four types of dysfunctional communication in successive order" (Gottman & Silver, 1999, p. 72). Criticism takes a specific behavior's complaint one step further by adding in blame and character assassination (Gottman & Silver, 1999). Contempt, "characterized by sarcasm and cynicism, demeans the spouse, conveys disgust, and leads to more conflict than reconciliation" (Gottman & Silver, 1999, p. 73). Gottman "believes defensiveness is a form of blaming one's spouse and denying one's own role in the conflict" (Gottman & Silver, 1999, p. 73). Stonewalling serves as an "out" when the conflict becomes too overwhelming (or one or both partner becomes emotionally "flooded" by the other); stonewalling often further frustrates the partner and increases the overall tension in the relationship (Gottman & Silver, 1999).

Morgante et al. (2011) identifies six interventions to improve success and treatment when working with high-conflict couples, including a) manage counter-transference (an emotion or reaction to a particular subject's thought, actions, or behaviors (Morgante et al., 2011); b) providing a safe place the couple (the therapist needs to be consistent, steady, self-assured, warm but authoritative, and creates reasonably high expectations of the couple; c) use of effect time-outs (creating a pause in the negative interaction for the couple to regain space and insight to the problem; Morgante et al., 2011); d) sustain intimacy until good-faith is established; e) increase conflict-resolution skills (use of 4 C's [Cues, commit, cooldown, comeback]; f) build healthy,

more-positive methods for the couple to bond and attach (including healthy self-care, positive affirmations, and mental encouragement) (Winley et al., 2016).

Infidelity has negative consequences on the involved people and causes problems in the marital relationship (Reich & Kalantar, 2018).

Relational infidelity, affairs, or extradyadic involvement (EDI) is frequently cited as one of the most detrimental experiences to a romantic relationship, damaging the security and trust between partners. Various estimates indicate infidelity occurs in 60–75% of relationships and is cited as the leading cause for divorce. While both attachment anxiety and avoidance predict a greater likelihood of EDI, one consideration within the current literature is the co-occurring levels of attachment anxiety and avoidance that determine a person's style. (Parker & Campbell, 2017, p. 174)

Family & Couples Therapy

The main techniques used in Brief Strategic Family Therapy (BSFT) “were engaging with families, identifying maladaptive interactions and family strengths, and restructuring maladaptive family interactions” (Carr, 2016, p. 468). Where parents cannot be engaged in treatment, a one-person adaptation of BSFT has been developed. “BSFT involves 12-30 sessions over three to six months, with treatment duration and intensity being determined by problem severity” (Carr, 2016, p. 468). Brief Strategic Family Therapy has shown effectiveness with improving interpersonal communications and positive family dynamics (Carr, 2016).

Attachment-Based Family Therapy

Attachment-based family therapy (ABFT) “is a manualized, brief (12–16 week) family-based intervention model for treating depressed and anxious family members. The approach is rooted in structural family therapy,” multidimensional family therapy, and emotion-focused

therapy (Feder & Diamond, 2016, p. 84). “ABFT has been shown to be highly effective for high-conflict couples and distress couples” (Feder & Diamond, 2016, p. 85). Attachment-based family therapy could be used for high-conflict couples affected by infidelity.

Emotion-Focused Therapy

Emotion-focused therapy, developed by Johnson and Greenberg, is a “relatively brief treatment, usually lasting 12-20 therapy sessions” (Ramisch et al., 2013, p. 378). The goal is for therapists to help couples “develop a secure attachment bond to turn toward each other during times of stress and uncertainty and help regulate their emotions in the process” (Coppola, 2020, p. 589). A meta-analysis of EFT studies conducted by Johnson et al. (1999) “concluded that approximately 90% of treated couples rated themselves better than controls and 70% to 73% of couples continued to show improvement at follow-up” (p. 75). “EFT is one of the few interventions for couples that sustains change over time” (Ramisch et al., 2013, p. 377). Overall, there is a “strong consensus in the literature that EFT is one of the most effective, if not the most effective treatment for couples, and effective for treating couples affected by infidelity” (Wiebe & Johnson, 2016, p. 392). One of the reasons EFT is effective, is the couple's ability to experience high emotional connection in key sessions and the “shaping of new interactions where partners are able to clearly express attachment fears and needs and be emotionally responsive to the other's needs” (Lebow et al., 2012, p. 147).

The three stages of EFT are very important for improving attachment for high-conflict couples.

EFT consists of three stages divided into nine steps; each stage has its own specific set of therapeutic goals. EFT consists of three stages: de-escalation of the couple's negative cycle (Stage I), restructuring of problematic interactions (Stage II), and

consolidation/integration (Stage III). EFT clinicians follow a set of nine prescribed steps (four in Stage I, three in Stage II, and two in Stage III). EFT focuses on helping partners share these emotions with each other to fortify their attachment behaviors, with the goal to create and strengthen secure attachment bonds between couples so they can share their feelings and face uncertainty and life-threatening situations. (Greenman & Johnson, 2012, p. 567)

For secure attachment bonds to form, the couple must sustain engagement around the difficult thoughts and emotions that arise from infidelity that often drive problematic interactional cycles in relationships and form positive, healthy interactions instead (Timm & Hertlein, 2020).

Attachment Injury Resolution Protocol

Attachment Injury Resolution Protocol (AIRP) has been shown to moderately reduce distress by resolving attachment injury in 8-10 sessions (Makinen & Johnson, 2006). EFT focuses on changing attachment behaviors to improve distressed relationships, attachment, and healthy communication (Halchuk et al., 2010). The goal of EFT is to help couples access underlying emotions, reduce negative interaction, and “foster positive interactions that promote accessibility and trust between the partners” (Halchuk et al., 2010, p. 36). Healing the attachment injury involves emotionally “processing the deep hurt, pain, trauma related to the rupture of an attachment, restoring emotional accessibility and responsiveness to these emotional expressions,” and rebuilding trust, which is crucial for the relationship to survive (Makinen & Johnson, 2006, p.). The attachment injury comes “alive again when the injured partner is invited to risk emotionally engaging with his/her attachment figure with the goal of creating a new, positive emotional space and experience” (Makinen & Johnson, 2006, p. 1059). Therefore, this is the optimal time for therapeutic interventions of AIRP and the resolution process to be

implemented: to help rebuild trust and resolve attachment injury among the couple (Makinen & Johnson, 2006).

AIRP phases

Attachment Injury Marker

1. In a highly emotional manner, the injured partner describes the incident in which he or she experienced a violation of trust that damaged his or her belief in the relationship. The incident is alive and present rather than a calm recollection.
2. Offending partner discounts, denies, validates, or acknowledges the incident and his or her partner's pain and moves into a defensive stance (Makinen & Johnson, 2006, p. 1056).

Differentiation of Affect

3. Injured partner stays in touch with the injury and begins to articulate its impact and attachment significance.
4. Offending partner begins to hear and understand the significance of the injurious event (Makinen & Johnson, 2006, p. 1056).

Reengagement

5. Injured partner tentatively moves toward a more integrated articulation of the injury and allows the other to witness his or her vulnerability by expressing grief and fear concerning the specific loss of the attachment bond.
6. The offending partner becomes more emotionally engaged, acknowledges responsibility for his or her part, and expresses empathy, regret, and remorse (Makinen & Johnson, 2006, p. 1056).

Forgiveness and Reconciliation

7. Injured partner then risks asking for comfort and caring that was unavailable at the time of the injury.

8. Offending partner responds in a caring manner that acts as an antidote to the traumatic experience (Makinen & Johnson, 2006, p. 1056).

Effectiveness of EFT

At the end of the 1990s, a “meta-analysis found a 70–73% recovery rate for relationship distress (86% significant improvement over controls) and an effect size of 1.3”; results have shown to be effective and stable following a four-year follow-up (Lebow et al., 2012, p. 147). According to Burgess et al. (2016), as the result of EFT, couples' attachment behavior significantly “increased toward security”, and the individual's “attachment anxiety and avoidance behaviors significantly decreased with relationship satisfaction” (p. 233). The study results indicated that couples' marital satisfaction continued to increase throughout EFT treatment; “the majority of couples made clinically significant improvements in marital satisfaction from pre- to posttherapy” (Dalglish et al., 2015, p. 277).

There is substantial empirical support for EFT for couple distress (Greenman & Johnson, 2012). According to Greenman and Johnson (2012), “70 - 73% of couples” who receive EFT reported reduced levels of relationship distress, and “86 - 90% of distressed couples who participate in EFT report significant increases in relationship satisfaction”; results appear to be stable over time (Greenman & Johnson, 2012, p. 566). According to Greenman and Johnson (2012), researchers detected a “notable reduction in the trauma symptoms of women who had been subjected to intrafamilial abuse during childhood and who participated in 20 sessions of EFT for couples” (p. 567).

Effectiveness of AIRP

According to Zuccarini (2010), “outcomes for EFT as an intervention for general relationship distress and AIRP have been successfully tested” (p. 5). Audiotapes of “18 EFT couple cases were used to study the client change process, the validity of AIRP. Study findings suggest couple clients who utilized AIRP engaged deeply with their internal experience were more deliberate and controlled in their processing and more affiliative in their interpersonal responses in comparison with couples who did not receive AIRP” (Zuccarini, 2010, p. 10). The study also reported successful attachment injury resolution and attachment repair (Zuccarini, 2010).

According to Chapman and Caldwell (2012), attachment injury as a result of an affair can change the relationship permanently with or without the consent of the injured partner and there may or may not be a recommitment to the marriage. This study reported increased ability for couples to create secure connections with others that offer restitutive emotional experiences of purposefulness, connection, and belonging through AIRP. Trans-identified (TI) couples reported increased attachment resolution, communication, and emotional awareness with AIRP.

According to Halchuk et al. (2010), a study of 12 participants was done to determine if the significant improvement in marital distress of resolved couples at post-treatment would be observable three years after AIRP. With respect to the attachment injury resolution model, it was reported that after a 3-year follow-up, AIRP was effective in showing decreased marital distress, reduced attachment injury, decreased avoidant and anxious attachment (Halchuk et al., 2010).

Summary

As stated previously, many clinicians find themselves unequipped and struggle to aid couples after an affair, or cause more damage, with incorrect treatment interventions. Several

articles outline the strengths and weaknesses of attachment-based therapy, causes and reasons for infidelity and the trauma effects that occur due to infidelity. As a result of further review, extensive gaps in literature were identified in the areas of effective attachment-based trauma interventions for high-conflict couples, suffering from infidelity. Very few resources were able to articulate any treatment for infidelity couples or the effectiveness of attachment-based trauma for treatment. Due to these gaps in the literature this study will aim to explore if the Attachment Injury Resolution Protocol (AIRP) is an effective strategy in reducing marital distress and improving marital satisfaction in the areas of communication, commitment, and trust post infidelity for high-conflict couples.

CHAPTER THREE: METHODS

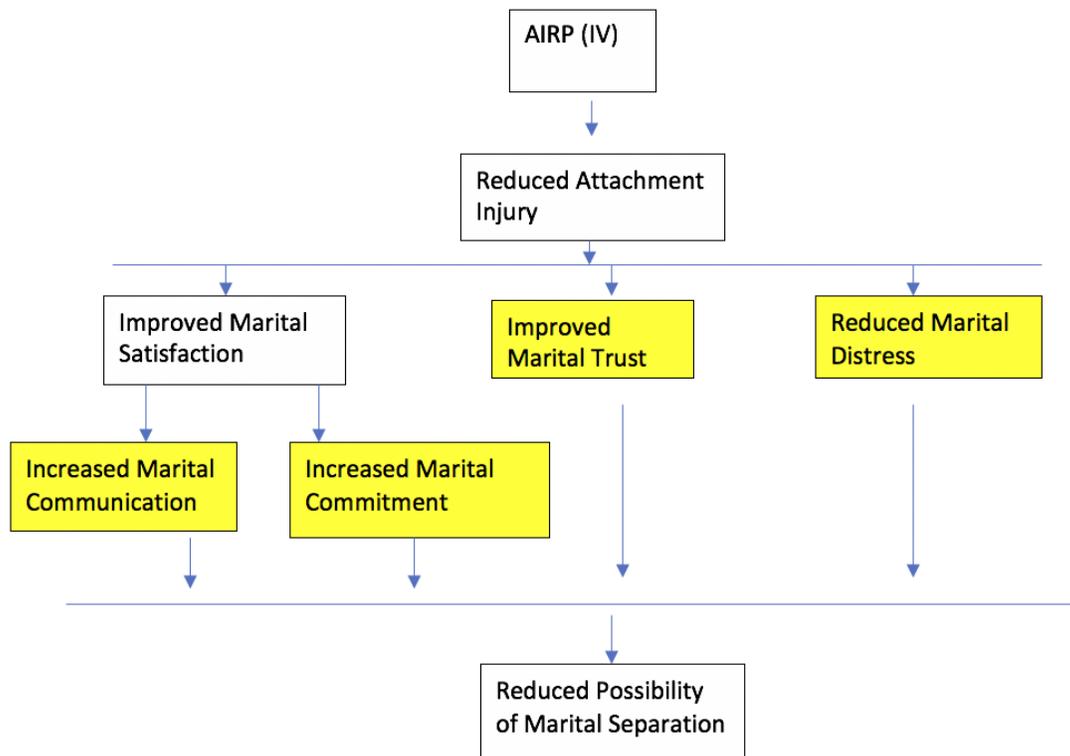
Overview

This chapter addresses the methodology of whether Attachment Injury Resolution Protocol (AIRP) effectively reduces marital distress and improves marital satisfaction in the areas of communication, commitment, and trust post-infidelity for high-conflict couples. Chapter three includes a detailed description of the research design, research questions, hypotheses, participants and settings, instrumentation, procedure, and data analysis. The chapter concludes with a generalized summary and recommendations for future research.

Figure 2 shows the proposed effects of the Attachment Intervention Resolution Protocol (AIRP) on reducing attachment injury, resulting in improved marital satisfaction, improved marital trust, and reduced marital distress. Improved marital satisfaction is directly affected by increased marital communication and increased marital commitment. All dependent variables, including improved marital communication, improved marital commitment, increased marital trust, and reduced marital distress, may directly affect marital separation.

Figure 2

Effects of AIRP Intervention



Note: Yellow shaded boxes indicate dependent variables.

Design

The study will utilize the Attachment Injury Resolution Protocol that has been designed and implemented for high-conflict couples affected by infidelity. This design will include a quasi-experimental pilot study of fourteen hetero-sexual couples. The Attachment Injury Resolution Protocol was implemented with 14 couples, 28 participants (N of 28) affected by infidelity. The independent variable included the AIRP intervention; the dependent variables include marital distress, marital communication, marital commitment, and trust.

Research Questions

Research Questions. The following research question will guide this study: "Is Attachment Injury Resolution Protocol (AIRP) more effective in reducing marital distress and improving marital satisfaction in the areas of communication, commitment, and trust post infidelity for high-conflict couples than Phase II of EFT without AIRP?"

Sub Research Question

RQ1: Is Attachment Injury Resolution Protocol (AIRP) effective for clinically improving marital communication for high-conflict couples affected by infidelity?

RQ2: Is Attachment Injury Resolution Protocol (AIRP) effective for clinically improving marital commitment for high-conflict couples affected by infidelity?

RQ3: Is Attachment Injury Resolution Protocol (AIRP) effective for clinically improving marital trust for high-conflict couples affected by infidelity?

RQ4: Is Attachment Injury Resolution Protocol (AIRP) effective for clinically reducing marital distress for high-conflict couples affected by infidelity?

Hypotheses

The alternate hypotheses for this study are:

Ha1. Attachment Injury Resolution Protocol (AIRP) will significantly improve marital communication for high-conflict couples affected by infidelity.

Ha2. Attachment Injury Resolution Protocol (AIRP) will significantly improve marital commitment for high-conflict couples affected by infidelity.

Ha3. Attachment Injury Resolution Protocol (AIRP) will significantly improve marital trust for high-conflict couples affected by infidelity.

Ha4. Attachment Injury Resolution Protocol (AIRP) will significantly reduce marital distress for high-conflict couples affected by infidelity.

Participants and Setting

Participants in the study will be couples who are currently engaging in marital counseling due to trauma or infidelity. This study will not include Intimate Partner Violence (IPV) or any marital counseling partners is contraindicated. All fourteen couples, twenty-eight participants, will have completed Phase I of Emotion-Focused Therapy (resolving negative interactions) and focusing only on AIRP of Phase II (restructuring of problematic interactions). Attachment Injury Resolution Protocol will be given to couples who have consented to receive treatment. A minimum of seven couples affected by infidelity will be administered the AIRP protocol, and seven couples will remain in the control group. An inclusion criterion for high-conflict couples will include:

1. a pattern of increased negativity, rather than positivity, during conflict;
2. inability to maintain Gottman's 5:1 positive to negative interaction ratio to maintain marital happiness;
3. displays one of Gottman's 'Four Horsemen of the Apocalypse' (criticism, contempt, defensiveness or stonewalling);
4. engages in "high-conflict" behaviors for a minimum of six months (Cohen and Levite (2012)).

An initial verbal screening will be given to assess the couple's compatibility. The therapeutic process “can inadvertently re-traumatize an already emotionally fragile client, while not addressing his or her emotional needs” (Haney & Hardie, 2014, p. 402). Therefore, consistent and appropriate implementation of the protocol is imperative. Convenience sampling

would be used for the research design as participants would be current clients of the therapist. Participation would be voluntary, and clients will not be compensated for their participation. Participants will have their “assessment fee” waived for partaking in the research. Upon completion of the intervention, couples will have the option of having their graded assessment integrated into their ongoing treatment plan. As a result, no charge will be included for the grading and report, and clients will not receive a discounted amount for services. The Attachment Injury Resolution Protocol (AIRP) couples will be implemented in an out-patient mental health setting or community-based facility, depending on the outreach and accessibility of the couple. Couples will consent to participate in an attachment-based trauma protocol.

Ethical Considerations

Several ethical dynamics were considered for this research study. The researcher is aware that she is wearing two “hats” during the procedural process; one clinical and the second, researcher. The researcher will let the participants know of this dual role and will avoid undue bias using an “automated system” to generate who will be in the control and experimental group for random sampling, rather than picking names out of a hat to avoid researcher bias; and reminding the participants of the clinician’s dual role and encouraging the participants to voice concern if they feel the roles were ever to be overlapping each other.

These include

1. voluntary participation (free will in participating in the study, discontinuation of the participant’s involvement in the study may occur at any time per request of the participant, and no negative repercussions will be implemented if participant denies study participation);

2. beneficence is “the obligation of the researcher to act for the benefit of the client, supported by a number of moral rules to protect, defending the right of others and preventing harm; help persons with disabilities, and rescuing persons in danger” (Varkey, 2021, p. 18); the researcher will implement beneficence by ensuring benefits outweigh the risk, and minimal harm, if any, will be incurred by the participant;
3. confidentiality (protecting any confidential or identifying information and releasing only upon consent of the participant),
4. storage of data (secure storage of password encrypted data, and locked cabinets of hard copy documents);
5. destruction of data after the required time (data will be destroyed after three year unless otherwise requested by the participant);
6. consent forms (an accurate and clear study description will include the number of visits, expected time commitment, and any eligibility criteria that will fully align with the proposed research plan. Information will be clear and understandable and free from technical or scientific jargon. Information will be balanced and free of misleading emphasis that makes the study excessively attractive and anticipated benefits should not be overstated.)
7. conflict of interest (researcher will avoid researcher bias, the researcher will use statistical analysis instead of subjective interpretation to calculate the results);
8. no pressure to participate (the study will be voluntary and potential participants will be given adequate time and ability to decipher request, undue inducement will be avoided);
9. permission to use research data (will only be granted by consent of participants with the consent form (Varkey, 2021).

Instrumentation

The following procedures will be measured pre- and post-treatment to validate the results. Marital satisfaction and marital distress will be measured by four dependent variables: marital communication, marital commitment, marital trust, and couple's distress. The Kansas Marital Conflict Scale (KMCS), Interpersonal Communication Skills Inventory, Commitment-Investment Model Scale, and Trust in Close Relationship Scale will be given to each participant. The Kansas Marital Conflict Scale will measure marital distress. *The Kansas Marital Conflict Scale* (KMCS) is a 27-item self-report, Likert scale, designed to measure 'marital interactions' and conflict that distressed and non-distressed couples attempt to resolve (Eggeman et al., 1985). The Kansas Marital Conflict Scale has excellent internal reliability and validity (Eggeman et al., 1985). *Interpersonal Communication Skills Inventory* is a 40-item self-report scale designed to measure four key areas of the couple's communication, including sending clear messages, listening, giving and receiving feedback, and handling emotional interactions (Pfeiffer & Jones, 1974). This inventory aims to identify communication strengths and potential areas for development (Lazo, 2019). Couples will check a "usually, sometimes, or seldom" Likert scale response. The Interpersonal Communication Skills Inventory scored high in internal consistency validity and strong reliability (Pfeiffer & Jones, 1974). *Commitment Investment Model Scale* is a 29-item self-report scale that measures four constructs of the investment model, including commitment level, and three bases of dependence, including satisfaction level, quality of alternatives, and investment size (Rusbult et al., 1998). Only questions related to the subdomain of commitment will be included in this study. *The Trust in Close Relationship Scale* is a seventeen-item self-report scale designed to measure levels of trust in one's relationship partner. Each item is answered based on a 7-point Likert-type scale ranging from 1 (strongly disagree) to

7 (strongly agree). The scale can be divided up into subscales, including a) predictability, b) dependability, c) faith (Rempel et al., 1985). The Trust in Close Relationship Scale was administered to 47-couples and demonstrated high internal validity and reliability (Rempel et al., 1985). These assessments will be given pre-and post-treatment.

Variables

The independent variable in this pilot study is Phase II of Emotion-Focused Therapy, Attachment Injury Resolution Protocol (AIRP). The therapist created a series of eight AIRP interventions which will be implemented throughout the eight sessions. There are four dependent variables in this study, including marital distress (measured by Kansas Marital Conflict Scale (KMCS), marital communication (measured by Interpersonal Communication Skills Inventory), marital commitment (measured by Commitment- Investment Model Scale), and trust (measured by Trust in Close Relationship Scale); and one independent variable, the Attachment Injury Resolution Protocol (AIRP). A contributing factor to the difficulty of assessing marital satisfaction and “distress is the notable lack of research on extradyadic involvement among diverse couples to develop an effective treatment approach” (Parker & Campbell, 2017, p. 174).

Procedure

Pre-intervention

An Attachment-Injury Resolution Protocol for High- Conflict couples affected by infidelity was compiled and administered to 14 couples in an out-patient mental health setting. An application to the IRB was submitted for approval. The protocol was implemented over a 8-week treatment (total of 8 eight sessions). Fourteen couples, 28 participants, were chosen from the clinician's private mental health practice, and the AIRP treatment, pilot study, self-report assessments were administered by the same clinician. The clinician has specifically been trained

in Emotion-Focused Therapy and has roughly ten years of clinical experience. Each couple completed a voluntary consent form. A brief informal interview was conducted with each couple, confirming they met the criteria of "high-conflict" and were affected by infidelity. Participants were on a voluntary basis and were not compensated for their participation. Eight couples were not included in the treatment and considered the "control" group. Each couple was administered four self-report quantitative scales pre- and post-intervention, including the Interpersonal Communication Skills Inventory, Commitment-Investment Model Scale, Trust Inventory, and Kansas Marital Conflict Scale (See appendix A-D). The primary focus of interventions was Phase II of Emotion-Focused Therapy (restructuring problematic interactions) and included specific interventions from Attachment Injury Resolution Model (AIRP); after completing Phase I of EFT (resolving negative interactions). To offset the possibility of couples dropping out of the research study, the clinician has sent recruitment material to sixteen plus couples. In the rare event that participants decide to drop out, their data will not be used in the data analysis. Participants are reinforced the voluntary nature of the study and that there will be no negative repercussion for couples who discontinue their participation. Data collection and analysis will continue with the remaining participants and data from the participants who have completed the intervention and the four assessments (pre and post) will be used in the data analysis.

Intervention for Experimental Group

Specific phases and interventions of AIRP included:

Attachment Injury Marker

1. In a highly emotional manner, the injured partner describes the incident in which he or she experienced a violation of trust that damaged his or her belief in the relationship. The incident is alive and present rather than a calm recollection.

2. Offending partner discounts, denies, validates, or acknowledges the incident and his or her partner's pain and moves into a defensive stance (Makinen & Johnson, 2006, p. 1056).

Differentiation of Affect

3. Injured partner stays in touch with the injury and begins to articulate its impact and attachment significance.

4. Offending partner begins to hear and understand the significance of the injurious event (Makinen & Johnson, 2006, p.1056).

Reengagement

5. Injured partner tentatively moves toward a more integrated articulation of the injury and allows the other to witness his or her vulnerability by expressing grief and fear concerning the specific loss of the attachment bond.

6. The offending partner becomes more emotionally engaged, acknowledges responsibility for his or her part, and expresses empathy, regret, and remorse (Makinen & Johnson, 2006, p. 1056).

Forgiveness and Reconciliation

7. Injured partner then risks asking for comfort and caring that was unavailable at the time of the injury.

8. Offending partner responds in a caring manner that acts as an antidote to the traumatic experience (Makinen & Johnson, 2006, p. 1056).

Once the attachment injury in the relationship is resolved, the therapist can more readily “facilitate a cycle of positive interaction, reinforcing the comfort, reassurance, and nurturing that define a secure attachment bond” (Schade & Sandberg, 2012, p. 444).

Intervention for Control Group

Emotion-Focused Therapy (EFT) is an experiential, systemic therapy (Greenman & Johnson, 2012). The primary goal of Emotion-Focused Therapy is to reduce negative interaction patterns and establish a more secure emotional connection (Greenman & Johnson, 2012). This is achieved primarily in Phase II of EFT by encouraging partners to recognize and react appropriately to each other's needs for emotional connection while maintaining a healthy emotional connection (Greenman & Johnson, 2012). Each partner becomes a safety cue for the other, and provides a "safe place" for the partner to process and explore emotions (Greenman & Johnson, 2012).

During Phase II of EFT, the emotions and needs of the partner and the 'injured partner' are addressed to reestablish healthy emotional attachment (Greenman & Johnson, 2012). Specific interventions for EFT of Phase II (restructuring of problematic interactions) not including AIRP, lasting eight sessions, included:

Step 5: Delve into and identify disowned needs and aspects of self that have been hidden for each partner [both partners].

Step 6: Promote acceptance of these tender and hidden parts, aspects of self, and new ways of relating [both partners].

Step 7: Facilitate the expression of needs and wants and restructure the interaction to create true emotional engagement [both partners; Greenman & Johnson, 2012). Upon completion of EFT Phase II, couples would normally progress to Phase III. Post-intervention collection tools were implemented upon completion of Phase II of EFT.

Post Intervention

Results and data analysis were conducted by the clinician alone. Several data collection tools were readministered to the control and experimental group, including the Interpersonal Communication Skills Inventory, Commitment-Investment Model Scale, Trust in Close Relationship Scale, and Kansas Marital Conflict Scale.

Data Analysis

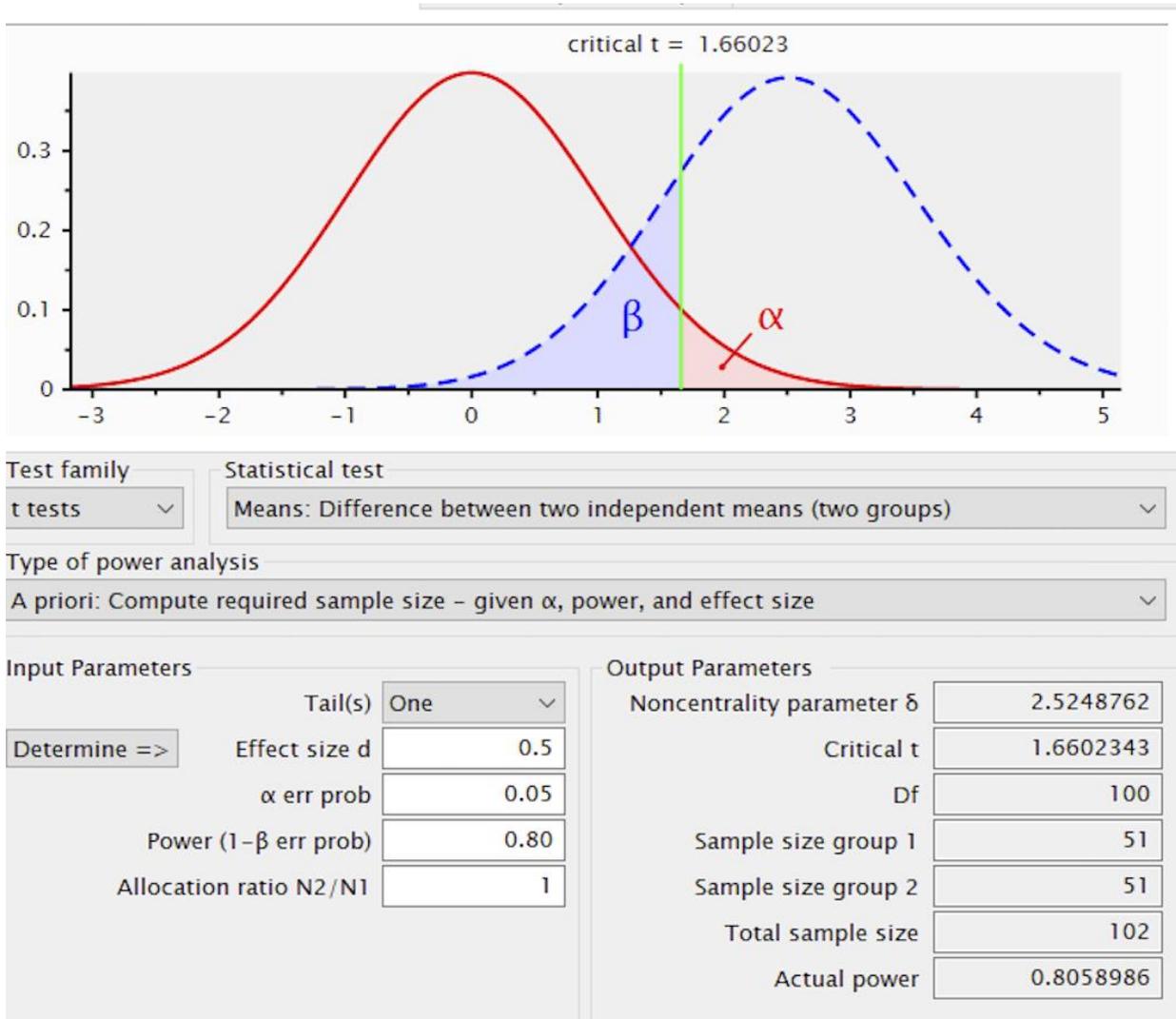
An independent *t*-test was conducted for all four research questions and hypotheses. According to Warner (2013), an independent *t*-test is used to measure the difference in means between two independent groups (control group and the experimental group) for one of the dependent variables [marital distress, marital communication, marital commitment, trust] to test whether population means are significantly different. The independent *t*-test is a parametric test (Warner, 2013). An *independent t-test* is defined as "a statistic that can be used to test many different hypotheses about scores on a quantitative variable, i.e., whether the means on a quantitative variable *Y* differs between groups" (Warner, 2013, p. 1121).

According to Warner (2013), three assumptions exist for an independent *t*-test to be conducted. First, the scores of the *Y* outcome variable must be quantitative and normally distributed; second, the variance of the *Y* scores should be equal or homogeneous across the two populations that correspond to the sample; third, independent observations both between and within groups. Each *t*-test met these assumptions. Also, in this study, one can assume an alpha level of probability .05, tested with SPSS (IBM Corp, 2019), and adequacy of sample size (large enough sample to display a normal bell curve tested, with G*Power (See Figure 3)(Faul et al., 2009). *Cohen's d* was used to determine the effect size of .50 (medium effect size; IBM) (IBM Corp, 2019). The homogeneity of variance (standard deviations of samples are approximately

equal) was tested with SPSS (IBM Corp, 2019; Warner, 2013) and the alpha (significance level of 0.05) was chosen via the clinician. SPSS was used to calculate and produce results (IBM Corp, 2019).

Figure 3

*G*Power Graph*



Note: This graph indicates that although the sample size should be at least 102 for statistically significant results, this study is a pilot study due to the small sample size and did not produce statistically significant results.

Summary

In summary, there is a significant lack of research in the area of attachment injury resolution, and its effects on marital satisfaction and marital distress, more specifically marital commitment, marital communication, and trust for high-conflict couples affected by infidelity. Chapter 3 addresses the methodology of the quasi-experimental pilot study, including four research questions (with congruent hypotheses), participants and setting (fourteen heterogeneous couples, twenty-eight participants, from private practice setting); instrumentation (The Kansas Marital Conflict Scale (KMCS), Interpersonal Communication Skills Inventory, Commitment-Investment Model Scale, and Trust in Close Relationship Scale); four dependent variables (marital distress, marital communication, marital commitment, and trust); procedures (an experimental group using AIRP; control group using Phase II of EFT without AIRP), and data analysis (computation of four independent *t*-test). This chapter attempts to the question as to whether Attachment Injury Resolution Protocol (AIRP) is more effective in reducing marital distress and improving marital satisfaction in the areas of communication, commitment, and trust post-infidelity for high-conflict couples than Phase II of EFT without AIRP?

CHAPTER FOUR: FINDINGS

Overview

This chapter addresses the findings of whether Attachment Injury Resolution Protocol (AIRP) effectively reduces marital distress and improves marital satisfaction in the areas of communication, commitment, and trust post-infidelity for high-conflict couples than Phase II of EFT without AIRP? Chapter four includes a detailed assessment of descriptive statistics for each experimental and control group, including mean, median, standard deviation, and standard error mean; and the corresponding statistical test results, including alternative hypothesis analysis, alpha level, effect size, and whether the alternate hypothesis was supported. Charts and data screening are presented for each alternative hypothesis. The chapter concludes with a generalized summary and a reinstatement of the problem and purpose of the study.

Descriptive Statistics

Figure 4 described several group statistics calculated via SPSS (IBM Corp, 2019) for pre- to post-change scores for marital commitment, marital trust, marital communication, and couples' distress for experimental and control groups. Both experimental and control groups had $N = 14$, respectively. This chart provides a broad overview of general statistics, which were used to compute the independent t -test for this study; this includes mean (M), standard deviation (SD), and standard error mean (SEM). Statistics for pre to post change in marital commitment for experimental group ($M = 5.43$, $SD = 1.65$, $SEM = .44$) and control group ($M = 4.14$, $SD = 1.56$, $SEM = .42$). Statistics for pre- to post-change in marital trust for the experimental group ($M = 4.93$, $SD = 1.38$, $SEM = .37$) and control group ($M = 3.50$; $SD = 1.22$; $SEM = .33$). Statistics for pre to post change marital distress for experimental group ($M = 6.58$, $SD = 1.28$, $SEM = .34$) and control group ($M = 4.85$, $SD = 1.10$, $SEM = .29$). Statistics for pre to post change in marital

communication for the experimental group ($M = 6.07$, $SD = 1.77$, $SEM = .47$) and control group ($M = 5.71$, $SD = 1.49$, $SEM = .40$). Frequencies for these groups were not calculated, because they were deemed not relevant. Group statistics for pre to post change in scores for marital commitment, marital trust, marital communication, and couples' distress for experimental and control groups were used to calculate independent t-tests for this study.

Figure 4

Descriptive Statistics Chart

Group Statistics					
	Experimental vs. Control Group	N	Mean	Std. Deviation	Std. Error Mean
Pre to Post Change in Marital Commitment Scores	Experimental Group	14	5.4286	1.65084	.44121
	Control Group	14	4.1429	1.56191	.41744
Pre to Post Change in Trust Scores	Experimental Group	14	4.9286	1.38477	.37009
	Control Group	14	3.5000	1.22474	.32733
Pre to Post Change in Marital Distress Scores	Experimental Group	14	6.5714	1.28388	.34313
	Control Group	14	4.8571	1.09945	.29384
Pre to Post Change in Marital Communication Scores	Experimental Group	14	6.0714	1.77436	.47422
	Control Group	14	5.7143	1.48989	.39819

Note: This chart includes the number of participants, mean, standard deviation, and standard deviation error mean for pre to post change in scores for marital distress, commitment, communication, and marital trust.

Results

Hypotheses

Independent sample *t*-tests, calculated via SPSS (IBM Corp, 2019), were used to analyze the pre-test to post-test protocol for marital communication, marital commitment, marital trust, and couple's distress for the experimental and control group. Marital satisfaction and marital

distress were measured by four dependent variables: marital communication, marital commitment, marital trust, and couple's distress. Respectfully, the following assessments were used to measure each dependent variable change [marital communication, marital commitment, marital trust, and couple's distress]: Interpersonal Communication Skills Inventory, Commitment-Investment Model Scale, and Trust in Close Relationship Scale, The Kansas Marital Conflict Scale (KMCS). For each assessment, a difference score subtracting the pre-test score from the post-test score was computed; these were summed to obtain a total difference score. The summed difference was then used to compute the independent t-tests. Data screening was performed for each test. Each hypothesis has a corresponding research question that is answered below. Difference scores were compared between the control and intervention groups, and calculated results are explained below.

Hypothesis One

RQ1: Is Attachment Injury Resolution Protocol (AIRP) effective for clinically improving marital communication for high-conflict couples affected by infidelity?

Ha1. Attachment Injury Resolution Protocol (AIRP) will significantly improve marital communication for high-conflict couples affected by infidelity.

Figure 5 shows there was no significant improvement in marital communication, measured by the Interpersonal Communication Skills Inventory pre/post-test scores in the experimental group who received the AIRP compared to the control group who did not receive the AIRP. An independent samples t-test was conducted to compare the pre to post change in scores for marital communication for the experimental (N=14) and control groups (N=14). Preliminary data screening indicated no outlier scores through a boxplot (Figure 6). This test did not meet the normal assumption of normal distribution (Figure 7) due to a small sample size. To

further rule out additional outliers, a boxplot was conducted to compare the pre- to post-change in scores for marital communication (Figure 8); no outliers exist; therefore, it can be concluded that the data is normally distributed. The Levene test assessed the assumption of homogeneity of variance, $F = 1.26, p = .27$; this indicated no significant violation of the equal variance assumptions; therefore, the pooled variances version of the t test was used. Equal variances assumed, there were no significant differences ($t(26) = .58, p = .60$) in the scores with means score for experimental group ($M = 6.07, SD = 1.78$) was higher than the control group ($M = 5.71, SD = 1.49$). The alpha size was .05; Cohen’s d was .22, a small effect size (exhibited in Figure 6; IBM Corp). Hence H_{a1} was not supported, and the null hypothesis was accepted. There was no statistically significant improvement in the overall marital communication as measured by the Interpersonal Communication Skills Inventory pre- to post-test change in the intervention group who received the AIRP compared to the control group who did not receive the AIRP.

Figure 5

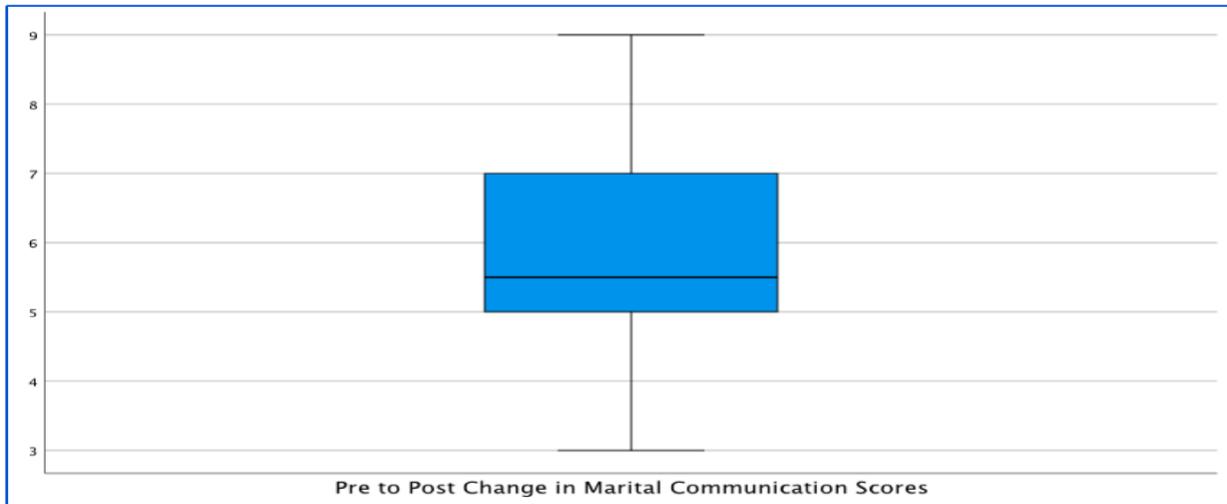
Independent Samples T-Test and Sample Effect Size for Pre-to-Post Intervention on Marital Communication

Independent Samples Test									
		Levene's Test for Equality of Variances				t-test for Equality of Means			
		F	Sig.	t	df	Significance		Mean Difference	Std. Error Difference
						One-Sided p	Two-Sided p		
Pre to Post Change in Marital Communication Scores	Equal variances assumed	1.255	.273	.577	26	.285	.569	.35714	.61922
	Equal variances not assumed			.577	25.245	.285	.569	.35714	.61922

Independent Samples Effect Sizes					
		Standardizer ^a	Point Estimate	95% Confidence Interval	
				Lower	Upper
Pre to Post Change in Marital Communication Scores	Cohen's d	1.63831	.218	-.527	.959
	Hedges' correction	1.68754	.212	-.512	.931
	Glass's delta	1.48989	.240	-.511	.982

Figure 6

Box Plot for Pre-to-Post Intervention on Marital Communication



Note: No circles or asterisks on either end of the boxplot indicate no outliers are present (IBM Corp, 2019).

Figure 7

Bell Curve for Pre-to-Post Intervention on Marital Communication

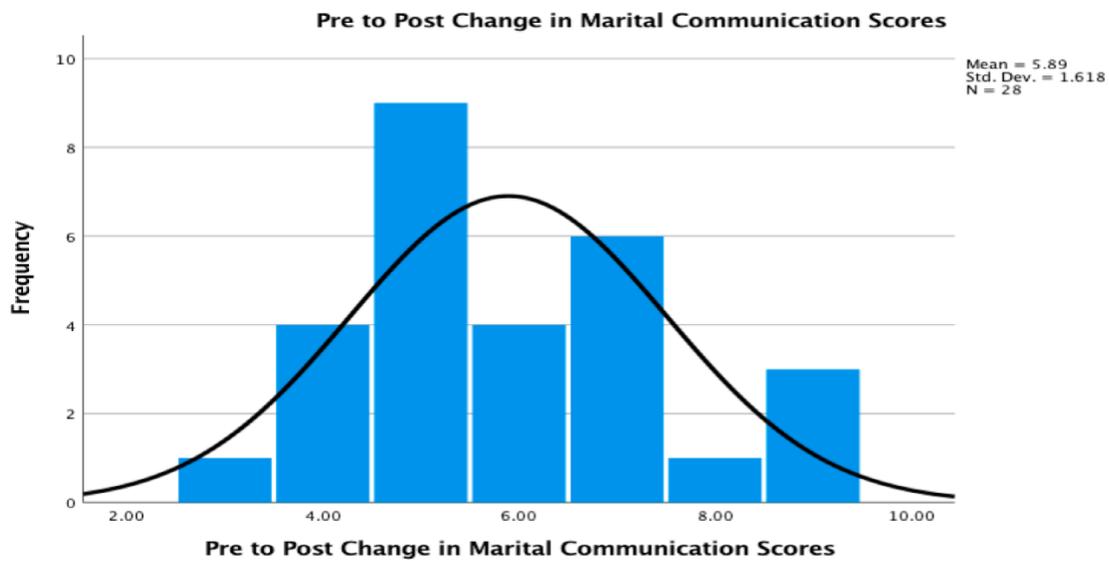
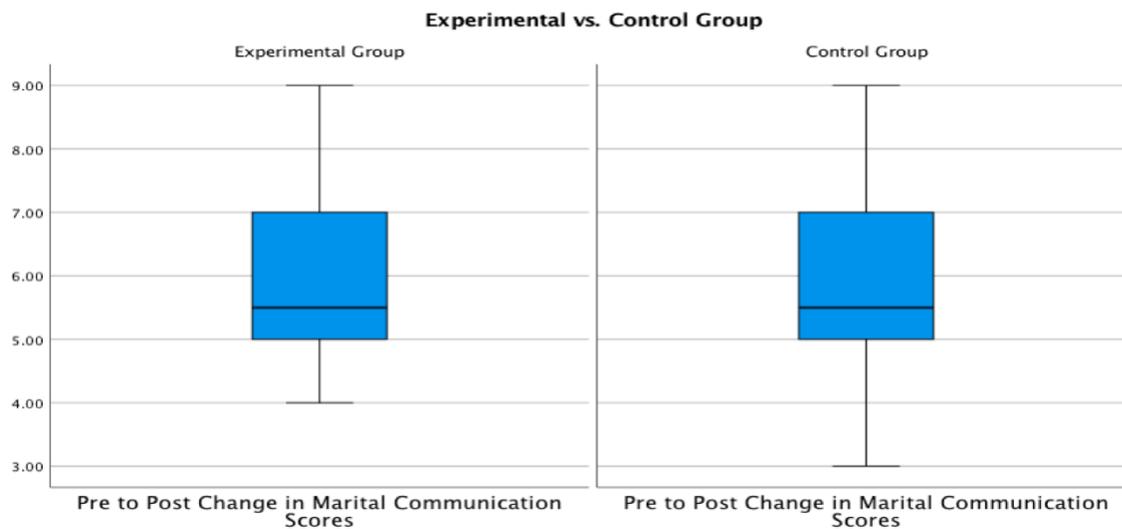


Figure 8

Normal Distribution Box Plot Pre-to-Post Intervention on Marital Communication



Hypothesis Two

RQ2: Is Attachment Injury Resolution Protocol (AIRP) effective for clinically improving marital commitment for high-conflict couples affected by infidelity?

Ha2. Attachment Injury Resolution Protocol (AIRP) will significantly improve marital commitment for high-conflict couples affected by infidelity.

Figure 9 indicated a significant improvement in marital commitment, measured by the Commitment-Investment Model Scale, pre/post-test scores in the experimental group who received the AIRP compared to the control group who did not receive the AIRP. An independent samples *t*-test was conducted to compare the pre- to post-change scores for marital commitment for the experimental (N=14) and control groups (N=14). Preliminary data screening indicated no outlier scores (Figure 10). This test did not meet the normal assumption of normal distribution (Figure 11) due to a small sample size. To further rule out additional outliers, a boxplot was conducted to compare the pre to post change in scores for marital commitment (Figure 12; no

outliers exist; therefore, it can be concluded that the data is normally distributed. The Levene test assessed the assumption of homogeneity of variance, $F = .228, p = .596$; this indicated no significant violation of the equal variance assumptions; therefore, the pooled variances version of the t -test was used. Equal variances assumed, there were significant differences ($t(26) = 2.12, p = .044$) in the scores with means score for experimental group ($M=5.43, SD=1.65$) was higher than the control group ($M=4.15, SD= 1.56$). The alpha size was .05; Cohen’s d was .80, a medium effect size (exhibited in Figure 9; IBM Corp). Hence H_{a2} was supported, and the null hypothesis was rejected. There was a statistically significant improvement in the overall marital commitment, as measured by the Commitment-Investment Model Scale, pre- to post-test change in the intervention group who received the AIRP compared to the control group who did not receive the AIRP.

Figure 9

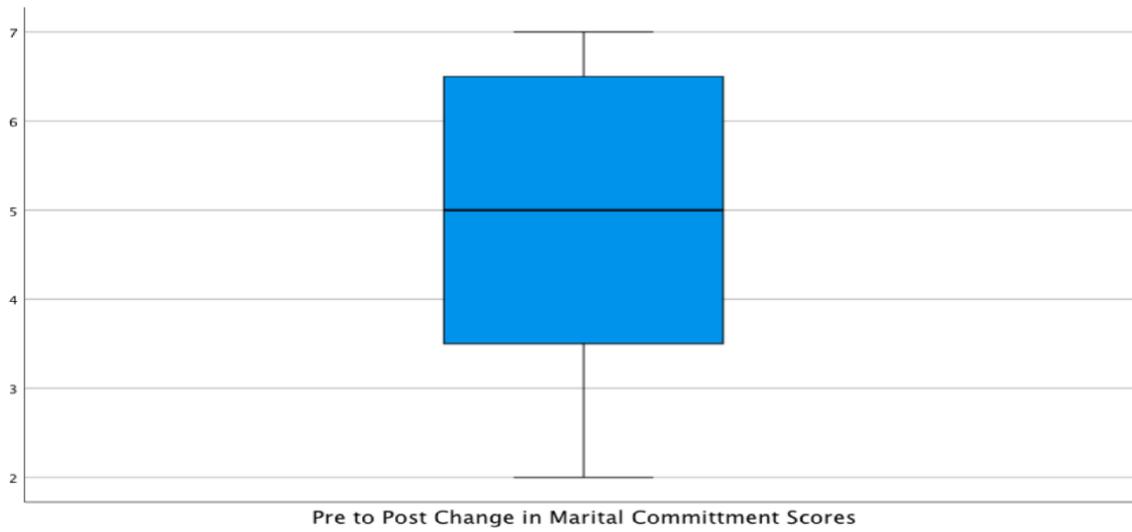
Independent Samples T-Test and Sample Effect Sizes for Pre-to-Post Intervention on Marital Commitment

Independent Samples Test									
		Levene's Test for Equality of Variances				t-test for Equality of Means			
		F	Sig.	t	df	Significance		Mean Difference	Std. Error Difference
						One-Sided p	Two-Sided p		
Pre to Post Change in Marital Commitment Scores	Equal variances assumed	.288	.596	2.117	26	.022	.044	1.28571	.60739
	Equal variances not assumed			2.117	25.921	.022	.044	1.28571	.60739

Independent Samples Effect Sizes					
		Standardizer ^a	Point Estimate	95% Confidence Interval	
				Lower	Upper
Pre to Post Change in Marital Commitment Scores	Cohen's d	1.60699	.800	.021	1.565
	Hedges' correction	1.65528	.777	.021	1.519
	Glass's delta	1.56191	.823	.006	1.614

Figure 10

Box Plot for Pre-to-Post Intervention on Marital Commitment



Note: No circles or asterisks on either end of the boxplot indicate no outliers are present (IBM Corp, 2019)

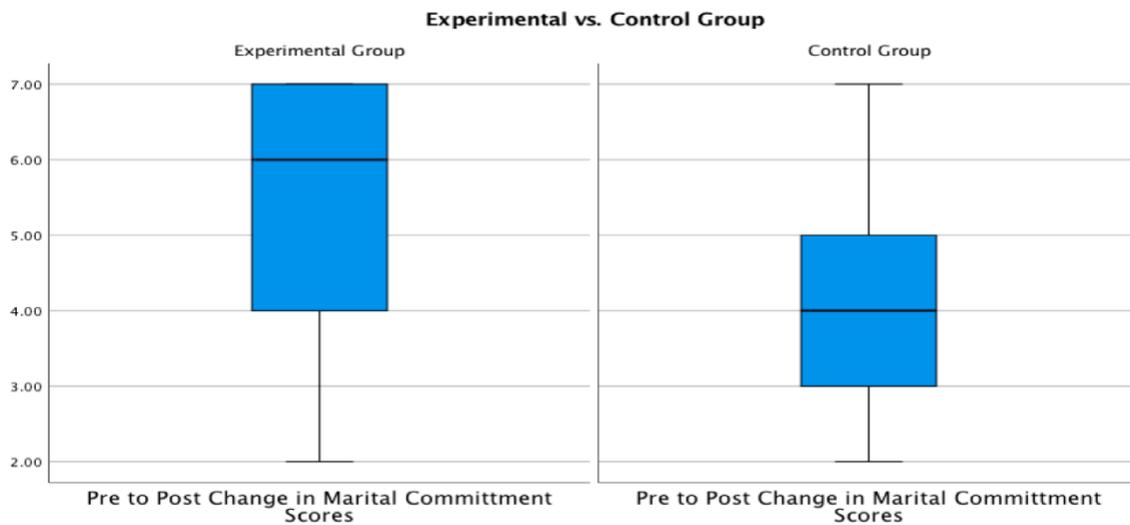
Figure 11

Bell Curve for Pre-to-Post Intervention on Marital Commitment



Figure 12

Normal Distribution Box Plot Pre-to-Post Intervention on Marital Commitment



Hypothesis Three

RQ3: Is Attachment Injury Resolution Protocol (AIRP) effective for clinically improving marital trust for high-conflict couples affected by infidelity?

Ha3. Attachment Injury Resolution Protocol (AIRP) will significantly improve marital trust for high-conflict couples affected by infidelity.

Figure 13 indicates a significant improvement in marital trust, measured by the Trust in Close Relationship Scale, pre/post-test scores in the intervention group who received the AIRP compared to the control group who did not receive the AIRP. An independent samples *t*-test was conducted to compare the pre- to post-change in scores for marital trust for the experimental (N=14) and control groups (N=14). Preliminary data screening indicated no outlier scores (Figure 14). This *t*-test did meet the assumption of normal distribution (Figure 15). The Levene test assessed the assumption of homogeneity of variance, $F = .12$, $p = .74$; this indicated no significant violation of the equal variance assumptions; therefore, the pooled variances version of the *t*-test was used. Equal variances assumed, there were significant differences ($t(26) = 2.89$, $p = .09$) in the scores with means score for experimental group ($M = 4.93$, $SD = 1.38$) was higher than the control group ($M = 3.50$, $SD = 1.22$). The alpha size was .05; Cohen's *d* was 1.10, a large effect size (Figure 13; IBM Corp). Hence, Ha3 was supported, and the null hypothesis was rejected. There was a statistically significant improvement in the overall marital trust, as measured by the Trust in Close Relationship Scale pre- to post-test change in the intervention group who received the AIRP compared to the control group who did not receive the AIRP.

Figure 13

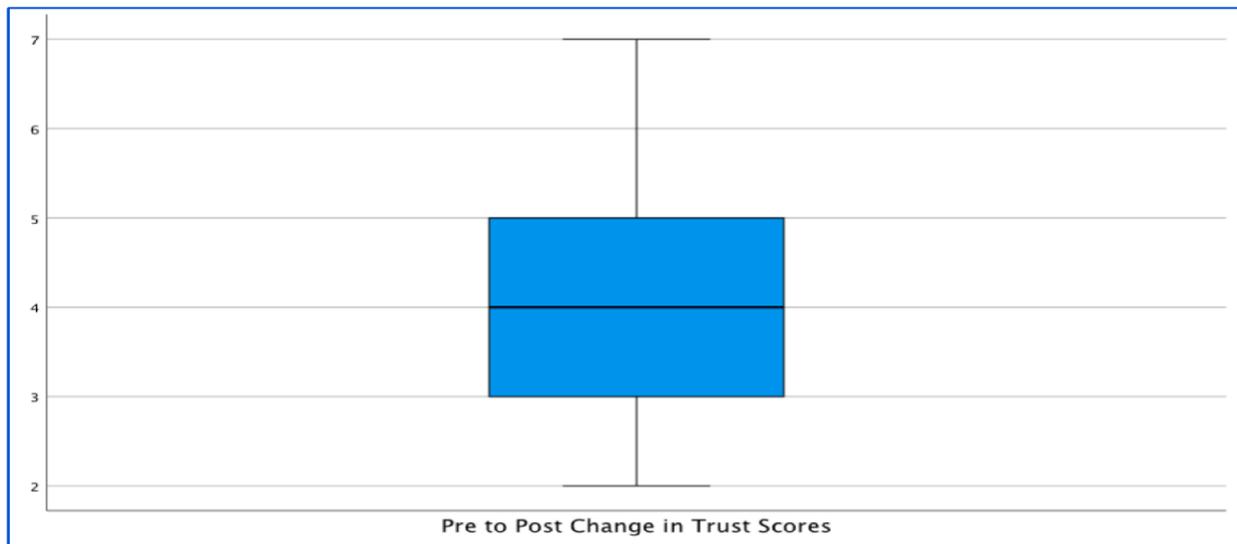
Independent Samples T-Test and Sample Effect Sizes for Pre-to-Post Intervention on Marital Trust

		Levene's Test for Equality of Variances		t-test for Equality of Means					
		F	Sig.	t	df	Significance		Mean Difference	Std. Error Difference
Pre to Post Change in Trust Scores	Equal variances assumed	.112	.741	2.891	26	.004	.008	1.42857	.49408
	Equal variances not assumed			2.891	25.618	.004	.008	1.42857	.49408

		Independent Samples Effect Sizes			
		Standardizer ^a	Point Estimate	95% Confidence Interval	
Pre to Post Change in Trust Scores	Cohen's d	1.30721	1.093	.286	1.881
	Hedges' correction	1.34649	1.061	.278	1.826
	Glass's delta	1.22474	1.166	.287	2.014

Figure 14

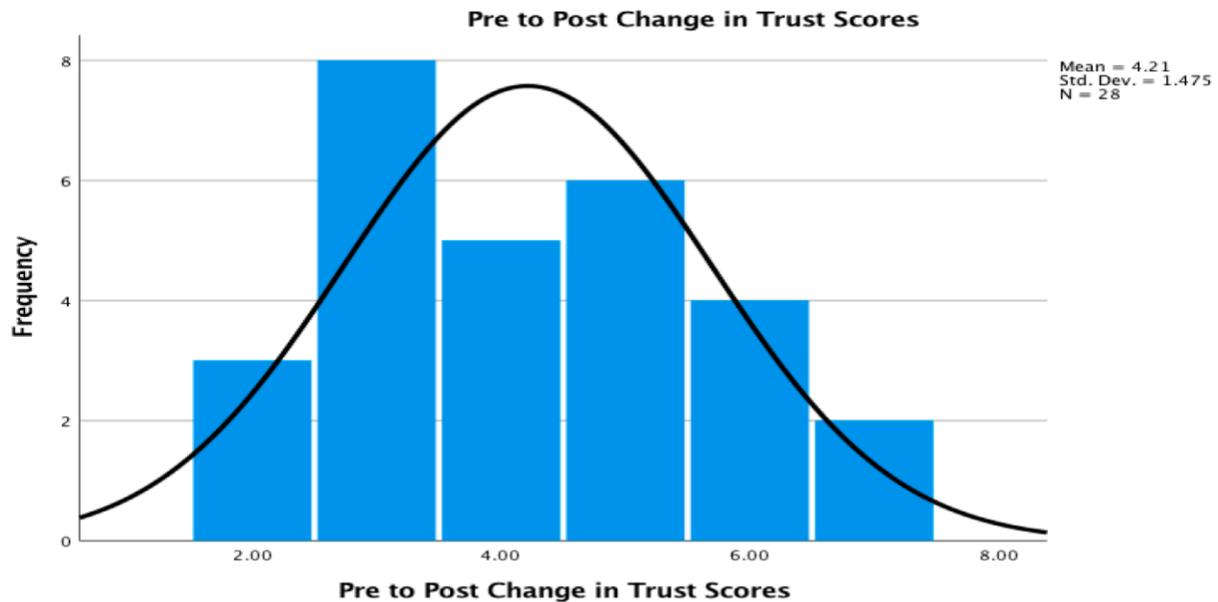
Box plot for Pre-to-Post Intervention on Marital Trust



Note: No circles or asterisks on either end of the boxplot indicate no outliers are present (IBM Corp, 2019)

Figure 15

Bell Curve for Pre-to-Post Intervention on Marital Trust



Hypothesis Four

RQ4: Is Attachment Injury Resolution Protocol (AIRP) effective for clinically reducing marital distress for high-conflict couples affected by infidelity?

Ha4. Attachment Injury Resolution Protocol (AIRP) will significantly reduce marital distress for high-conflict couples affected by infidelity.

Figure 16 indicates a significant reduction in marital distress, measured by the Kansas Marital Conflict Scale (KMCS), pre/post-test scores in the experimental group who received the AIRP as compared to the control group who did not receive the AIRP. An independent samples *t*-test was conducted to compare the pre- to post-change scores for marital distress for the experimental (N=14) and control groups (N=14). Preliminary data screening indicated no outlier scores (Figure 17). This *t*-test did not meet the assumption of normal distribution (Figure 18).

The Levene test assessed the assumption of homogeneity of variance, $F = .59, p = .45$; thus, indicated no significant violation of the equal variance assumptions; therefore, the pooled variances version of the t -test was used. Equal variances assumed, there were significant differences ($t(26) = 3.80, p = .001$) in the scores with means score for experimental group ($M = 6.57, SD = 1.28$) was higher than the control group ($M = 4.86, SD = 1.10$). The alpha size was .05; Cohen’s d was 1.14, large effect size (Figure 16). Hence H_{a4} was supported, and the null hypothesis was rejected. There was a statistically significant improvement in the reduction of overall marital distress, as measured by the Kansas Marital Conflict Scale (KMCS) pre- to post-test change in the intervention group who received the AIRP compared to the control group who did not receive the AIRP.

Figure 16

Independent Samples T-Test and Sample Effect Sizes for Pre-to-Post Intervention on Marital Distress

		Independent Samples Test							
		Levene's Test for Equality of Variances				t-test for Equality of Means			
		F	Sig.	t	df	Significance		Mean Difference	Std. Error Difference
Pre to Post Change in Marital Distress Scores	Equal variances assumed	.580	.453	3.795	26	<.001	<.001	1.71429	.45175
	Equal variances not assumed			3.795	25.399	<.001	<.001	1.71429	.45175

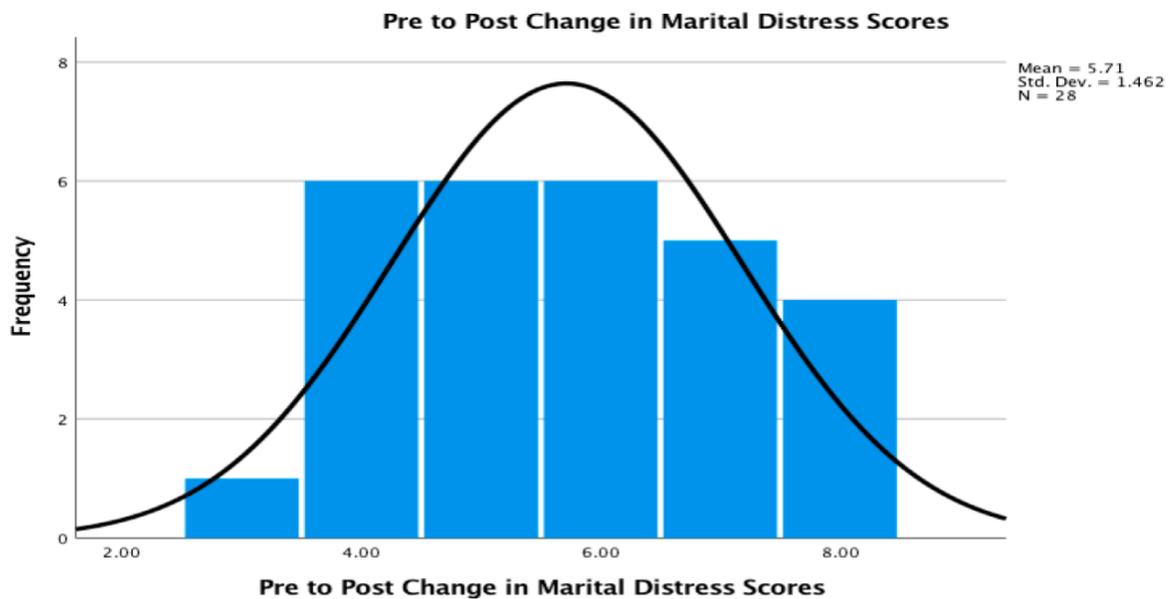
		Independent Samples Effect Sizes			
		Standardizer ^a	Point Estimate	95% Confidence Interval	
Pre to Post Change in Marital Distress Scores	Cohen's d	1.19523	1.434	.587	2.260
	Hedges' correction	1.23115	1.392	.570	2.194
	Glass's delta	1.09945	1.559	.592	2.490

Figure 17

Boxplot for Pre-to-Post Intervention on Marital Distress



Note: No circles or asterisks on either end of the boxplot indicate no outliers are present (IBM Corp, 2019)

Figure 18*Bell Curve for Pre-to-Post Intervention on Marital Communication*

Each independent *t*-test met the three assumptions of an independent *t* test including the scores of the Y outcome variable must be quantitative and approximately normally distributed; second, the variance of the Y scores should be equal or homogeneous across the two populations that correspond to the sample; third, independent observations both between and within groups. Each *t*-test met these assumptions. The first assumption was met for all *t*-tests. The assumption of homogeneity of variance was assessed by the Levene test, thus indicated no significant violation of the equal variance assumptions; therefore, the pooled variances version of the *t*-test was used for each test. The criteria for independent observations both between and within groups was met by each participant being assigned to only one group, and the scores between groups 1 and 2 were not paired. It can be concluded that the assumptions for each *t*-test for the pre-to-post-test change in the scores for marital trust, communication, commitment, and marital distress were met.

Summary

The problem is that there is a significant lack of research in attachment injury resolution, and its positive effects on marital satisfaction and marital distress, more specifically marital commitment, marital communication, and trust for high-conflict couples affected by infidelity. The purpose of this study is to examine whether the Attachment Injury Resolution Protocol (AIRP) effectively reduces marital distress and improves marital satisfaction in the areas of communication, commitment, and trust post-infidelity for high-conflict couples than Phase II of EFT without AIRP? The results indicate that Ha2, Ha3, Ha4 were accepted, and the corresponding null hypothesis was rejected. Thus, suggesting that Attachment Injury Resolution Protocol (AIRP) is more effective for clinically improving marital commitment, marital trust, and reducing marital distress for high-conflict couples affected by infidelity than Phase II of EFT without AIRP. Results indicated that Ha1 was not supported, and the null hypothesis was accepted. Therefore, indicating that Attachment Injury Resolution Protocol (AIRP) is not more effective for clinically improving marital communication for high-conflict couples affected by infidelity than Phase II of EFT without AIRP. A discussion of the findings is presented in chapter five.

CHAPTER FIVE: CONCLUSIONS

Overview

This chapter provides a conclusion to whether Attachment Injury Resolution Protocol (AIRP) effectively reduces marital distress and improves marital satisfaction in the areas of communication, commitment, and trust post-infidelity for high-conflict couples than Phase II of EFT without AIRP? Chapter five includes an analysis of each research question discussed considering the results, literature, other studies, and theory. The discussion examines whether the results support or contradict current studies and research. Implications of the study are provided, and the results of this study impact the field of marriage and family counseling and traumatology. Limitations causing threats to internal and external validity and recommendations to future research are discussed. The chapter concludes with a generalized summary and a reinstatement of the problem and purpose of the study.

Discussion

The purpose of this study was to examine whether the Attachment Injury Resolution Protocol (AIRP) effectively reduces marital distress and improves marital satisfaction in the areas of communication, commitment, and trust post-infidelity for high-conflict couples than Phase II of EFT without AIRP? Participants included fourteen couples, twenty-eight participants (N of 28), and control group (M= 14), and an experimental group (M = 14). Each participant was administered pre- and post-assessments of the Kansas Marital Conflict Scale (KMCS), Interpersonal Communication Skills Inventory, Commitment-Investment Model Scale, and Trust in Close Relationship Scale. The pre- to post-change scores were calculated to create four independent t-tests. A difference score subtracting the pre-test score from the post-test score was computed. The summed difference was then used to calculate the independent *t*-tests.

Therefore, it can be concluded that the Attachment Injury Resolution Protocol (AIRP) effectively reduces marital distress and improves marital satisfaction in the areas of commitment and trust post-infidelity for high-conflict couples than Phase II of EFT without AIRP. As a result, data for this study supported RSQ2, RSQ3, and RSQ4, and the null hypothesis was rejected. Also, data did not support RQ1, and the null hypothesis was accepted.

RQ1: Is Attachment Injury Resolution Protocol (AIRP) effective for clinically improving marital communication for high-conflict couples affected by infidelity?

RQ2: Is Attachment Injury Resolution Protocol (AIRP) effective for clinically improving marital commitment for high-conflict couples affected by infidelity?

RQ3: Is Attachment Injury Resolution Protocol (AIRP) effective for clinically improving marital trust for high-conflict couples affected by infidelity?

RQ4: Is Attachment Injury Resolution Protocol (AIRP) effective for clinically reducing marital distress for high-conflict couples affected by infidelity?

The study results supported current research that AIRP reduced marital distress post-infidelity for high-conflict couples. According to Zuccarini (2010), outcomes for EFT as an intervention for general relationship distress and AIRP have been successfully tested. Audiotapes of 18 EFT couple cases were used to study the client change process and the validity of AIRP. The study reported successful attachment injury resolution and attachment repair and reduction of marital distress (Zuccarini, 2010). Study findings suggest couple clients who utilized AIRP engaged deeply with their internal experience were more deliberate and controlled in their processing and more affiliative in their interpersonal responses than couples who did not receive AIRP (Zuccarini, 2010). This study supports the body of research that AIRP is effectively reduces marital distress post-infidelity for high-conflict couples.

The results of this study supported current research that AIRP improves marital satisfaction in the areas of commitment and trust post-infidelity for high-conflict couples. According to Chapman and Caldwell (2012), attachment injury as a result of an affair can change the relationship permanently with or without the consent of the injured partner and there may or may not be a recommitment to the marriage. Trans-identified (TI) couples reported increased attachment resolution, communication, and emotional awareness with AIRP. According to Halchuk et al. (2010), a study of 12 participants was done to determine if the significant improvement in marital distress of resolved couples at post-treatment would be observable three years after AIRP. This study reported increased ability for couples to create secure connections with others that offer restitutive emotional experiences of purposefulness, connection, and belonging through AIRP. With respect to the attachment injury resolution model, it was reported that after a three-year follow-up, AIRP was effective in showing decreased marital distress, reduced attachment injury, improved marital trust, decreased avoidant and anxious attachment (Halchuk et al., 2010). This study supports the body of research that AIRP effectively improves marital commitment and trust post-infidelity for high-conflict couples.

The results of this study did not support current research that AIRP improves marital communication post-infidelity for high-conflict couples. This may have occurred since the Interpersonal Communication Skills Inventory assessed for sending clear messages, listening, giving, and getting feedback, instead of AIRP focusing primarily on “creating a safe place” and each partner feeling validated and heard. In a recent study conducted by Schade and Sandberg (2012), one hundred and eight participants comprised of 54 married couples assessed the effects of healthy communication and conflict resolution skills on marital satisfaction and reported EFT to improve marital communication. Schade and Sandberg (2012) also reported couples having

improved marital communication, emotional expression, and articulation of needs due to EFT. Domingue and Mollen (2009) reported EFT is effective in improving communication and connection. This study supports the body of research that AIRP effectively improves marital communication post-infidelity for high-conflict couples.

The results of this pilot study positively impact the field of traumatology, marriage and family and psychology. It will positively impact the clinical importance of implementing AIRP for attachment resolution in areas of marital satisfaction and marital distress. This research would have positively impacted the field of psychology, sociology, social work, and marriage and family counseling (Haney & Hardie, 2014). As a result of this pilot study, it can be inferred that AIRP had a positive outcome for the experimental group only. This procedure should be replicated with a larger sample size. It would be encouraged for this study to be completed again with a larger sample size to test statistical significance.

Implications

This study does bring to light the negative impact of the trauma of infidelity and its effects on marital satisfaction and marital distress. As discussed in the previous section (Figure 3), the trauma of infidelity may cause an increase in attachment injury and therefore cause a reduction in marital satisfaction and an increase in marital distress. As a result, the reduction of attachment injury can improve marital satisfaction and reduce marital distress. In summarizing findings from previous research, “authors estimated that between 30–60 % of men and 20–50 % of women had been involved in some form of marital infidelity” (Norona et al., 2018, p. 86). “Additional research provided even higher estimates based on the research, with estimates ranging from 33–75 % of men to 26–70 % of women have been involved in an extramarital

relationship” (Jeanfreau et al., 2014, p. 330). Many clinicians still do not feel equipped to effectively reduce marital distress and improve marital satisfaction post-infidelity for high-conflict couples (Toplu-Demirtaş & Fincham, 2018). The authors believe the betrayed partner's capacity to trust again largely depends on various factors (Sauerheber & Disque, 2016). Researchers believe infidelity can cause a disorganized attachment, destruction in the family system, and lack of trust and commitment among partners (Sauerheber & Disque, 2016). As shown above, AIRP effectively reduces marital distress and improves marital satisfaction in the areas of communication, commitment, and trust post-infidelity for high-conflict couples. It can be concluded that AIRP will help mitigate the harmful effects of trauma caused by infidelity.

This study does bring to light the importance of attachment injury resolution and the effects of broken attachment among a couple. Attachment Injury Resolution Protocol (AIRP) has been shown to moderately reduce distress and improve marital satisfaction by resolving attachment injury in 8-10 sessions (Makinen & Johnson, 2006). EFT and AIRP focus on changing attachment behaviors to reduce distressed relationships, commitment, trust, and healthy communication (Halchuk et al., 2010). The goal of AIRP and EFT is to help couples access underlying emotions, reduce negative interaction, and foster positive interactions that promote accessibility and trust between the partners (Halchuk et al., 2010). As indicated by AIRP effectively reducing marital distress and improving marital satisfaction in the areas of marital commitment and trust post-infidelity for high-conflict couples through the Attachment Injury Resolution Protocol; it can be concluded that attachment injury resolution is a component to improving marital distress and marital satisfaction post-infidelity for high-conflict couples. This study does bring to light the importance of attachment injury resolution to improve marital satisfaction and reduce marital distress.

Christian Implication

Since this study was conducted purely clinically, a discussion of Christian interpretation of this study may be necessary. A component of this study was assessing whether Attachment Injury Resolution Protocol (AIRP) effectively reduces marital distress and improves marital satisfaction in the areas of communication, commitment, and trust post-infidelity for high-conflict couples. A primary component of the Attachment Injury Resolution Protocol is attachment injury resolution and rebuilding healthy attachment. Many attachment theorists suggest that the attachment figure [significant other] is both the source and solution to the attachment pain (Makinen & Johnson, 2006). A Christian worldview would reinforce that healthy attachment is needed and even necessary for the family system to thrive. “Therefore, a man shall leave his father and mother and hold fast to his wife, and the two shall become one flesh” (NABRE, Ephesian 5:31). Healthy attachment and ‘coming together and man and wife’ are essential for Christian living. “For husbands, this means love your wives, just as Christ loved the church. He gave up his life for her that he might sanctify her” (NABRE, Ephesians 5:26). Healthy attachment is a strong component of Christian living.

Limitations

Threats to internal validity may include testing (the pre-test used to establish a baseline affects the results of the post-test), participant selection (participants in the control and experimental group differ substantially and can thus not be compared), or attribution (throughout a longer study, participants may drop out) (Lakens & Albers, 2017). These potential threats were navigated by offering the pre- and post-test once, as opposed to multiple times; participants in the control and experimental group were evenly numbered and randomly selected for the control

and research group to avoid researcher bias; the procedure was kept to eight fifty-minute sessions to avoid testing fatigue and potential attribution.

Threats to external validity may include sampling bias (the sample is not representative of the population), testing effect (the administration of a pre-or post-test affects the outcomes), and situation effect (factors like the setting, time of day, location, researchers' characteristics, etc. limit the generalizability of the findings) (Lakens & Albers, 2017). These potential threats to external validity were navigated by selecting participants with a history of infidelity regardless of demographics; the same seasoned clinician administered the study and pre- and post-assessments implemented the same to avoid testing effect; the study was conducted in a private practice setting with a variety of individuals to prevent situation effect.

Additional limitations to the study include a smaller sample size, a Christian-based setting, and potential time restraints (8-week protocol instead of 12-week protocol), and current clients "feeling obligated" to participate in the research study. These limitations were navigated by offering non-Christian assessment and a non-Christian AIRP protocol without any Christian spirituality integration. Even though the study was conducted in a Christian setting, all interventions and assessments were purely clinically based. The potential time restraint was navigated by confirming that all eight weeks of study could fit into eight weeks instead of 12 weeks. Keeping all interventions within the protocols the same, the study was conducted over eight weeks instead of 12 weeks. The potential "obligation" of current clients to participate in the study was navigated by the researcher reinforcing the voluntary nature of the study and no negative repercussions for not participating in the study.

The number of individuals evaluated is one of the most important components in any research study. Previous research suggested that AIRP can positively effect attachment

resolution (Jeanfreau et al., 2014). This number of participants does categorize the study as small. A smaller sample size reduces the power of the research and increases the margin of error (Lakens & Albers, 2017). Also, a smaller sample size may cause inflated effect size, lower statistical power, and low reproducibility (Lakens & Albers, 2017). As shown in G*Power Graph (Figure 3) (Faul et al., 2009), 102 participants were required to produce clinically significant results. Therefore, the findings of this study cannot be generalized to the public at large since the sample size was too small. The difference between the scores of the groups only indicated improvement within the study itself.

When a study has a higher sample size, the likelihood of encountering Type-I and Type-II errors is reduced, if other parts of your study are carefully constructed and problems avoided. Larger sample size allows the researcher to increase the significance level of the findings since the confidence of the results is likely to increase with a higher sample size (Schreffler & Huecker, 2021). Therefore, if the researcher rejects your null hypothesis, then the sample size needs to be at least equal to the sample size needed for the statistical significance chosen and expected effects. Therefore, the lack of an adequate sample size caused lower statistical power and generalizability (Schreffler & Huecker, 2021). Reproducing this study with a larger sample size would reduce these errors.

Recommendations for Future Research

Recommendations for future research may include implementing the study with a broader population and ethnicities, including Asian, European, African, or Chinese. Ethnicities demographics were not included in this study but would be recommended for future research. Specific studies have been conducted with males/females and college-age studies, but very few studies have been conducted with a select demographic or ethnicity. Most studies conducted on

infidelity are tested on a specific gender or age, as follows. “Surveys indicate 40–75% of married college students report that they have engaged in "hooking up," a term that has been used to refer to a range of physically intimate behaviors (from kissing to sexual intercourse) that occur outside of the context of a relationship” (Shimberg et al., 2016, p. 355). This study conducted with more diverse ethnicities would be recommended.

Infidelity can have several effects on a couple, including lack of sexual satisfaction, difficulty forgiving after an affair, and mental issues among the partners. Infidelity causes several consequences, including interpersonal conflict, psychological distress, increase in anxiety or depression (Negash & Morgan, 2016). Additional research on the effects of infidelity on the partner’s mental is recommended. “An estimated 11-21 % of individuals with children commit infidelity, and 75 % of individuals report a decrease in sexual satisfaction after infidelity” (Negash & Morgan, 2016, p. 199). Little research has been conducted on AIRP affecting sexual satisfaction. Forgiveness has received even less attention with the treatment of infidelity (Olmstead et al., 2009). It is reported that roughly 70 % of couples have difficulty forgiving their significant other after infidelity (Olmstead et al., 2009). Additional domains for testing the positive effects of AIRP may include sexual satisfaction, forgiveness after an affair, and reduction of mental health issues of the partner.

Another recommendation for future research would include conducting this study with a larger population, a minimum of 102 participants. This could be done by recruiting more participants, extending the time for the study to be conducted (over several months instead of the researcher’s time restraint of eight weeks) would allow more couples to participate in the study, and networking with other clinicians to conduct the research. The results of this study would be

generalizable and create an accurate effect size and higher statistical power (Schreffler & Huecker, 2021). Statistical significance would allow the researcher to generalize the results and implement a protocol to help the field of psychology, marriage and family, and traumatology. These recommendations would aid the body of research and help advance the field of marriage and family, social work, and traumatology. Additional domain for research would include whether AIRP had a greater impact on second or third marriages as opposed to first time marriages. In this study, ten couples were engaged in their first marriage, and four couples were participating in their third or fourth marriage.

Summary

The problem is that there is a significant lack of research in attachment injury resolution, and its positive effects on marital satisfaction and marital distress, more specifically marital commitment, marital communication, and trust for high-conflict couples affected by infidelity. The purpose of this study is to examine whether the Attachment Injury Resolution Protocol (AIRP) effectively reduces marital distress and improves marital satisfaction in the areas of communication, commitment, and trust post-infidelity for high-conflict couples than Phase II of EFT without AIRP? Even though the findings of this study initially indicated AIRP effectively reduced marital distress and improved marital satisfaction in the areas of commitment and trust post-infidelity for high-conflict couples than Phase II of EFT without AIRP, the findings cannot be generalized to the public at large since the sample size was too small. The difference between the scores of the groups only indicated improvement within the study itself. Therefore, it can be concluded in this pilot study that Attachment Injury Resolution Protocol (AIRP) is an effective form of treatment, but further research is needed. Also, Attachment Injury Resolution Protocol (AIRP) does not effectively improve marital communication for high-conflict couples than Phase

II of EFT without AIRP. The results of this study did not find a significant change when the experimental group was compared to the control group using pre-test and post-test measures since the sample size of 102 participants was not met. Therefore, it is recommended that this study be reproduced with a larger sample size.

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Appendix A: The Commitment- Investment Model Scale

Removed to comply with copyright.

https://fetzer.org/sites/default/files/images/stories/pdf/selfmeasures/Self_Measures_for_General_Relationship_Satisfaction_INVESTMENT_MODEL.pdf

Appendix B: Kansas Marital Conflict Scale (KMCS)

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<https://scales.arabpsychology.com/s/kansas-marital-conflict-scale-kmcs/>

Appendix C: Trust in Close Relationship Scale

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https://fetzer.org/sites/default/files/images/stories/pdf/selfmeasures/Self_Measures_for_Trust_T

RUST_IN_CLOSE_RELATIONSHIPS.pdf

Appendix D: Interpersonal Communication Skills Inventory

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[https://numerons.files.wordpress.com/2012/04/11-interpersonal-communication-skills-
inventory.pdf](https://numerons.files.wordpress.com/2012/04/11-interpersonal-communication-skills-inventory.pdf)

Appendix E: IRB Approval Letter

LIBERTY UNIVERSITY

INSTITUTIONAL REVIEW BOARD

January 5, 2022

Sarah Cordonnier
Pamela Moore

Re: IRB Exemption - IRB-FY21-22-161 The Effectiveness of Attachment Injury Resolution Protocol (AIRP) in Reducing Marital Distress and Improving Marital Satisfaction in the Areas of Communication, Commitment and Trust in High- Conflict Couples Affected by Infidelity.

Dear Sarah Cordonnier, Pamela Moore,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:104(d):

Category 2.(ii). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording).

Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation.

Your stamped consent form(s) and final versions of your study documents can be found under the Attachments tab within the Submission Details section of your study on Cayuse IRB. Your stamped consent form(s) should be copied and used to gain the consent of your research participants. If you plan to provide your consent information electronically, the contents of the attached consent document(s) should be made available without alteration.

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at irb@liberty.edu

Sincerely,

Administrative Chair of Institutional Research
Research Ethics Office

Appendix F: Recruitment Email or Letter

Recruitment Template: Email and Letter

[Date]

[Recipient]
[Title]
[Address 1]

Hello [potential participant],

As a doctoral student in the School of Community Care and Counseling at Liberty University, I am conducting research as part of the requirements for a Doctor in Education degree. The purpose of my research is to assess whether Attachment Injury Resolution Protocol (AIRP) with Phase II of EFT is more effective in reducing marital distress and improving marital satisfaction in the areas of communication, commitment, and trust, post-infidelity for high-conflict couples than Phase II of Emotion-Focused Therapy (EFT) without AIRP. If you meet my participant criteria and are interested, I would like to invite you to join my study.

Participants must be 18 years of age or older, be currently engaged in marital counseling due to the trauma of infidelity, have completed Phase I of Emotion-Focused Therapy (resolving negative interactions), and meet the criteria for a high-conflict couple. Both spouses must be willing to participate. Those criteria include a pattern of increased negativity, rather than positivity, during conflict; the inability to maintain Gottman's 5:1 positive-to-negative interaction ratio in order to maintain marital happiness; displays of one of Gottman's 'Four Horsemen of the Apocalypse' (criticism, contempt, defensiveness or stonewalling); engagement in "high-conflict" behaviors for a minimum of six months.

Participants, if willing, will be asked to participate in either Phase II of Emotion-Focused Therapy (EFT), or Attachment Injury Resolution Protocol (AIRP) including Phase II of EFT. It should take approximately 8 sessions (8.5 hours) to complete the programs listed. Each participant will be asked to complete four assessments at the time of the first and last session. These include The Kansas Marital Conflict Scale (KMCS), Interpersonal Communication Skills Inventory, Commitment-Investment Module Scale, and Trust in Close Relationships Scale. The assessments will take 35 minutes to complete. Names and other identifying information will be requested as part of this study, but the information will remain confidential.

To participate, contact me at 555-555-1212 or [email address] or sign and return the attached consent form.

A consent document will be included in the second page of this email [or letter]. The consent document contains additional information about my research. If you choose to participate, you will need to sign the consent document and return it to me via mail or email (address listed on consent form) within five days receipt of this letter.

Participants who choose to participate, will have their four assessments graded and integrated into their ongoing treatment plan with no additional charge (usually \$50/assessment). Participants will receive free assessment and integration into their ongoing treatment plan for any assessments completed.

Thank you for your time.

Sincerely,

Sarah Cordonnier, LPCC
Researcher
[email address]

Appendix G: Consent Letter

General Consent for Participation

Title of the Project: The Effectiveness of Attachment Injury Resolution Protocol (AIRP) in Reducing Marital Distress and Improving Marital Satisfaction in the Areas of Communication, Commitment and Trust in High-Conflict Couples Affected by Infidelity

Principal Investigator: Sarah Cordonnier, LPCC-S, Doctoral Student, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you and your spouse must be 18 years of age or older, be currently engaged in marital counseling due to the trauma of infidelity, have completed Phase I of Emotion-Focused Therapy (EFT) (resolving negative interactions), and meet the criteria for a high-conflict couple. Both spouses must be willing to participate. Those criteria include a pattern of increased negativity, rather than positivity, during conflict; the inability to maintain Gottman's 5:1 positive-to-negative interaction ratio in order to maintain marital happiness; displays of one of Gottman's 'Four Horsemen of the Apocalypse' (criticism, contempt, defensiveness or stonewalling); engagement in "high-conflict" behaviors for a minimum of six months. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?

The purpose of the study is to assess whether Attachment Injury Resolution Protocol (AIRP) with Phase II of EFT is more effective in reducing marital distress and improving marital satisfaction in the areas of communication, commitment, and trust post-infidelity for high-conflict couples than Phase II of EFT without AIRP.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you and your spouse to do the following things:

1. Engage in either eight sessions of Phase II of Emotion-Focused Therapy (control group), or Phase II of EFT and Attachment Injury Resolution Protocol (AIRP) (experimental group). You will be randomly assigned to either the control or experimental group. It should take approximately 8 sessions (8.5 hours) to complete the programs listed.
2. Complete four assessments at the time of the first and last session. These include The Kansas Marital Conflict Scale (KMCS), Interpersonal Communication Skills Inventory, Commitment-Investment Model Scale, and Trust in Close Relationship Scale. The assessments will take 35 minutes to complete.

How could you or others benefit from this study?

Benefits for participants completing Phase II of EFT and AIRP may include improved communication, improved marital commitment, improved marital trust, and reduced marital distress. Benefits for participants completing only Phase II of EFT may include improved communication, improved commitment, and improved marital trust.

Benefits to society include adding to the field of research in the areas of psychology, traumatology, and marriage and family counseling. Research from this study may help future clinicians effectively treat infidelity and attachment injury resolution with couples.

What risks might you experience from being in this study?

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life and normal therapy. If you are placed in the control group and do not find Phase II of EFT to be as effective as anticipated, you and your spouse will be offered AIRP treatment after completion of Phase II of EFT.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be kept confidential through the use of codes. The therapeutic interventions will be conducted in a location where others will not easily overhear the conversation.
- Data will be stored on a password-locked computer and in a double-locked cabinet. The data may be used in future clinical presentation. After three years, all electronic records will be deleted, and all physical records will be shredded.

How will you be compensated for being part of the study?

Participants will be compensated for participating in this study. Couples will be offered a ‘free’ grading of the assessments and integration of the results into their ongoing treatment plan. The usual cost is \$50 per assessment, but this fee will be waived for couples participating in the study. Participants will be offered the free grading and integration for each assessment they complete.

Does the researcher have any conflicts of interest?

The researcher serves as a Licensed Professional Clinical Counselor at [private practice’s name]. The researcher has no financial interest in the outcome of this study. This disclosure is made so that you can decide if this relationship will affect your willingness to participate in this study. No action will be taken against an individual based on his or her decision to participate or not participate in this study.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with your clinician, Sarah Cordonnier, LPCC-S or Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Sarah Cordonnier, and you may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at 555-555-1212 [email address]. You may also contact the researcher's faculty sponsor, Dr. Pamela Moore, at [email address].

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

Printed Subject Name

Signature & Date