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Attachment-Based Family Therapy and Individual Emotion-Focused Therapy for Unresolved Anger: Qualitative Analysis of Treatment Outcomes and Change Processes

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Twenty-six clients who received 10 sessions of either attachment-based family therapy (ABFT) or individual emotion-focused therapy (EFT) for unresolved anger toward a parent were interviewed 6 months after completing treatment. Interviews were analyzed using the consensual qualitative research approach. Clients in both conditions reported improved relationships with parents, gaining a new perspective of their parent, increased compassion toward parent, less reactivity to anger, feeling cleaned-out, and acquiring new coping strategies. Whereas ABFT clients more often reported improved relationships with parents, EFT clients more often reported feeling cleaned-out. Clients in both groups attributed change to productive emotional processing. Also, clients in both groups attributed change to saying difficult things that had never been said before directly to parents, though more so in ABFT. Whereas ABFT clients noted the importance of their parents participating in treatment and mutual vulnerability, EFT clients noted the importance of remembering previously avoided memories and feelings, and getting their anger of their chest. While some EFT clients reported that therapy had a negative impact on their relationship with their parents and increased their anger, some ABFT clients reported that the positive impact of therapy during the active phase of treatment did not last, though there were no meaningful between-groups differences regarding these negative treatment outcomes and processes. Results are discussed in the context of previous quantitative findings from the same sample, and in the context of prior research on experiential and emotion-focused therapies. Implications for future research are noted.

Keywords: attachment-based family therapy, individual emotion-focused therapy, qualitative analysis, treatment outcome, treatment process

Many young adults present for therapy with unresolved anger toward a parent (Benton, Robertson, Tseng, Newton, & Benton, 2003; Hoffman & Weiss, 1987). Such anger often stems from a perceived lack of parental care, invalidation, criticism, or abuse (Lazarus, 1991). Unresolved anger is activated easily and quickly, and typically results in ongoing conflict and physical distancing (Greenberg & Safran, 1987). When left untreated, such anger can persist for months, or even years, and destroy the very fabric of the relationship.

Two empirically based experiential therapies used to target unresolved anger are attachment-based family therapy (ABFT; Diamond, Diamond, & Levy, 2014) and individual emotion-focused therapy (EFT; Greenberg, 2002, 2011). ABFT is a focused, empirically informed family-based treatment whose primary goal is to help repair ruptures in relationships between young adults and their parents. The model's purported central change mechanism is corrective attachment/identity episodes. Such episodes are in-session conversations between young adults and their parents, during which the young adult shares her/his primary adaptive emotions associated with unmet attachment and identity needs (e.g., the need to be cared for, the need to be validated), and parents are helped to respond in an open, empathic, validating, nondefensive manner. As a result, the young adult feels heard, understood, cared about, and validated in a manner like never before. This leads to a reduction in frustration, isolation, and hurt. Such corrective attachment/identity experiences transform interactional patterns, internal working models (i.e., representations of self and others), and the young adults' experience of their relationships with parents (Diamond et al., 2014). ABFT has shown to be efficacious in a number of previous clinical trials for depressed and suicidal adolescents (Diamond et al., 2014; Diamond, Siqueland & Diamond, 2003; Diamond, Reis, Diamond, Siqueland, & Isaacs,

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2002; Diamond, Shahar, Sabo & Tsvieli, 2016; Diamond et al., 2010).

EFT, in contrast, is an individual therapy combining client-centered principals (e.g., unconditional positive regard, empathy, and genuineness), gestalt techniques (e.g., two-chair and empty-chair dialogues), and other experiential methods, such as focusing (Gendlin, 1996). The goal of the treatment is to evoke core maladaptive emotions (e.g., shame, fear), transform them by evoking adaptive emotional responses (e.g., assertive anger, sadness, and compassion), and activate adaptive relational action tendencies. These emerging adaptive emotional responses and action tendencies are incorporated into a new view of the self and others, and used to transform personal narratives (Greenberg, 2011; Greenberg & Watson, 2006). A number of clinical trials have shown EFT to be efficacious for a range of disorders including, depression, (Ellison, Greenberg, Goldman, & Angus, 2009; Goldman, Greenberg, & Angus, 2006; Greenberg & Watson, 1998; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003), complex trauma (Paivio, Jarry, Chagigiorgis, Hall, & Ralston, 2010; Paivio & Nieuwenhuis, 2001), and social anxiety disorder (Shahar, Bar-Kalifa, & Alon, 2017).

Recently, researchers compared ABFT and individual EFT for young adults suffering from unresolved anger toward a parent (Diamond et al., 2016). Thirty-two young adults suffering from unresolved anger received 10 weeks of either ABFT or EFT. Clients were assigned to treatment condition based on geographical location. Before beginning treatment, participants completed self-report questionnaires assessing their levels of unresolved anger toward their target parent; current state anger toward their parent; attachment anxiety and avoidance in relation to their target parent; and psychological symptoms. These measures were completed again at midtreatment and immediately posttreatment. In addition, because emotional processing is a purported central change mechanism in both treatments, an independent group of coders rated two sessions from each case for amount of productive emotional processing. Findings showed that both treatments led to significant and equivalent decreases in unresolved anger, state anger, attachment anxiety, and psychological symptoms, though only ABFT was associated with decreases in attachment avoidance. Intraclass correlation coefficients showed no significant therapist effects. The fact that the two treatments were equivalent on four of the five dependent measures speaks to the many similarities between these two models. At the same time, the greater decrease in attachment avoidance in ABFT makes theoretical sense. In ABFT, in-session attachment/identity episodes, during which the young adult and parent work together in an effort to promote closeness and mutual validation, as opposed to avoidance, are considered the central change process. Findings also showed that there was significantly more emotional processing in EFT. This finding is consistent with EFT's emphasis on emotional processing as a primary change mechanism per se. In contrast, in ABFT, the primary focus of treatment is on shaping young adult–parent interactions and increasing mutual vulnerability, and emotional processing and expression are a means to this end. Interestingly, despite the fact that there was more emotional processing in EFT, greater emotional processing predicted larger decreases in psychological symptoms (but not other outcome measures) equally across both treatments, underscoring the fact that it plays a critical role in both approaches. This finding echoes results from prior research showing that productive emotional processing during EFT is correlated with treatment outcome (Auszra, Greenberg, & Herrmann, 2013; Greenberg, Auszra, & Herrmann, 2007), particularly when such emotional processing occurs in conjunction with reflective processing (Missirlian, Toukmanian, Warwar, & Greenberg, 2005).

The purpose of this study was to utilize a qualitative approach to more fully explore how each treatment affected clients, and which in-therapy processes clients identified as facilitating change. We were particularly interested in uncovering treatment outcomes and change processes not captured by the standardized measured used in the Diamond et al. (2016) study. According to Hill, "a major advantage of a qualitative approach is that researchers can come close to understanding the felt experience from the individual's perspective. Rather than imposing an agenda or worldview on participants, as is frequently the case in quantitative research using standardized instruments that ask specific questions and designate response options, participants in qualitative research are asked to express their inner experiences and reactions in their own words" (In Stiles et al., 2006, p. 75). Typically, the data generated are contextualized, richer, and more complex than data collected using standardized measures. In contrast to quantitative approaches, which are more geared to hypotheses testing, qualitative, narrative approaches allow for discovering new, unexpected phenomena (McLeod, 2011; Stiles et al., 2006).

There is a growing body of research using qualitative methods to examine therapy outcome and process across psychotherapy treatment models and clinical populations. Timulak and colleagues conducted two qualitative meta-analyses and identified a number of core categories reflecting how clients describe positive treatment outcome (Timulak, 2007; Timulak & Creaner, 2010). Levitt, Pomerville, and Surace (2016) recently conducted a qualitative meta-analysis of 109 studies examining clients' experiences in psychotherapy, including how they understood the process of change. Only a few studies, however, have utilized qualitative methods to compare and contrast outcomes and processes in two distinct treatments delivered in the same clinical trial (Göstas, Wiberg, & Kjellin, 2012; Hill et al., 2000; Nilsson, Svensson, Sandell, & Clinton, 2007). Such studies are important, as they offer the possibility of capturing not only common treatment outcomes and change mechanisms but also model-specific effects and change processes that may not have appeared using traditional quantitative approaches.

This current study utilized the consensual qualitative research approach (CQR; Hill, 2012; Hill et al., 2005; Hill, Thompson, & Williams, 1997) to analyze qualitative interviews from 26 clients who participated in the Diamond et al. (2016) study examining ABFT and individual EFT for unresolved anger. The interviews were conducted six months after clients completed treatment. The objective was to understand, in clients' own words, if and how the treatment affected them, and to what processes they attributed their change. We were interested in outcomes and processes common to both treatments, as well as those that differentiated between therapy approaches. The goal was to use qualitative data to complement and perhaps extend prior quantitative findings comparing ABFT and individual EFT for unresolved anger.

Method

Participants

Clients. Twenty-six of the 32 clients who participated in Diamond et al. (2016) clinical trial were interviewed as part of this study. To be included in the clinical trial, clients had to indicate that their anger: (a) was of significant intensity; (b) had persisted for at least a year; and (c) currently bothered them and negatively impacted upon the quality of their relationship with their target parent. For a more detailed description of recruitment procedures and client demographics, see Diamond et al. (2016). The six clients from the clinical trial who were not interviewed as part of this study were either out of the country ($n = 1$); had changed their phone number and could not be reached ($n = 2$); or were not interested in being interviewed ($n = 3$).

The current sample ($n = 26$) was, on average, 25.8 years old ($SD = 3.0$), primarily female (70%), of Jewish background, and secular. Twenty-two were undergraduate students and four were graduate students. Eighteen reported that their anger was primarily directed toward their mother and eight reported that their anger was primarily directed toward their father.

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

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

Interviewers. Follow-up interviews were conducted by eight advanced undergraduate psychology students. Seven were female and one was male. They were, on average, 25 years of age. The interviewers were trained by the first author, a senior Ph.D.-level clinical psychologist and postdoctoral fellow. Training included simulated demonstrations of how to use prompts to encourage more complete responses from participants, without introducing biases. Interviewers also conducted practice, simulated interviews before beginning to interview study participants.

Qualitative judges and auditor. Analyses were conducted by three judges, all female. Two were psychology graduate students and the third was the first author, a senior Ph.D.-level psychologist working in a public mental health service. All three judges were trained by the last author to apply the CQR method. Training included reading articles and chapters by Hill and colleagues about using the CQR method, and reading published studies which had employed the CQR method. Both the first and last authors had extensive prior experience conducting qualitative analyses, including using the CQR method. The auditor, the last author, was a male psychology faculty the member. He had been involved with the planning of the study but had not participated in any of the earlier steps in analyzing the data. Consequently, he was able to provide an independent perspective on the coding scheme.

Treatments

Clients had received 10 weeks of either ABFT ($n = 12$) or individual EFT ($n = 14$). They had been assigned to treatment type based on geographical location (i.e., whether they lived closer to the clinic delivering ABFT or EFT), rather than on a random basis.

ABFT is a manualized empirically supported treatment originally designed for treating depressed and suicidal adolescents. It has proven efficacious in a number of clinical trials (Diamond et al., 2002, 2010, 2014). The treatment is rooted in the structural tradition (Minuchin, 1974), attachment theory, developmental research and recent conceptualizations regarding the role of emotions and expression of attachment needs in psychotherapy (Fosha, 2000; Greenberg, 2011). The treatment delivered in the Diamond et al. (2016) study was an adaptation of ABFT, designed for adults suffering from unresolved anger toward a parent.

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

EFT (Elliott & Greenberg, 2007; Greenberg, 2011; Greenberg, Rice, & Elliott, 1993; Greenberg & Watson, 2006) is a manualized, individual, empirically supported treatment. It is based on client-centered principles (e.g., unconditional positive regard, empathy, and genuineness) and utilizes experiential interventions such as focusing, systematic evocative unfolding, empty-chair dialogues, and two-chair dialogues to deepen emotional process-

ing. A strong relational bond with the therapist allows the client to feel safe enough and valued enough to productively engage in the task of attending to and exploring their most vulnerable emotions (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2014). Therapist acceptance, congruence, and empathy also contribute to clients' affect regulation by providing interpersonal soothing. Over time, this interpersonal soothing is internalized, contributing to the client's capacity to self-sooth and regulate painful emotions (Greenberg & Watson, 2006). The central goal of treatment is to elicit primary maladaptive emotions, such as shame or fear, and to transform them by recruiting primary adaptive emotions such as sadness at loss and assertive anger. EFT, also known as process-experiential therapy, has proved efficacious in 18 outcome studies with various populations, including depressed, abused, and traumatized individuals (Elliott et al., 2004).

In the context of the Diamond et al. (2016) study, experiential interventions, including empty-chair dialogues, were used to process unresolved anger. Empty-chair dialogue is a specific intervention designed to modify the affective information processing difficulties associated with unfinished business (Greenberg et al., 1993). The client is guided through an imaginary dialogue with the significant other, the purpose of which is to resolve unresolved emotional issues. The empty-chair dialogue facilitates arousal of emotion and restructuring of the relevant self-other schema, such that there is greater self-affirmation and a new understanding of the other. Paivio and Greenberg (1995) have demonstrated the efficacy of the empty-chair dialogue in resolving unfinished business.

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

Interview

Follow-up qualitative interviews were conducted six months after the completion of treatment. The interview was semistructured and was composed of open-ended questions. Interviewers began by asking the client generally about their experience of therapy. They then asked the client if she or he felt like the therapy had impacted upon them, in what way, and what had led to change when it occurred. Finally, clients were asked if there were things about the therapy they would have changed. When clients had a hard time generating responses, the interviewer used gentle prompts such as, "take your time," "whatever comes up is fine," and "could you say more about that."

Procedure

Six months after the completion of treatment, clients were contacted and asked to participate in a follow-up qualitative interview. They received an explanation regarding the purpose of the study and, if they agreed to participate, completed consent forms. Interviews were conducted either at the university clinic or at the participant's home, lasted ~1 hour in duration, and were audio-recorded and transcribed. After recordings of the interviews were transcribed, the transcriptions were analyzed by an independent team of judges. The study was approved by the university's human subject research committee.

Analytic Procedure

To analyze the transcripts, we utilized the CQR (Hill et al., 1997, 2005) approach. CQR is a method for organizing and making meaning of qualitative data. Typically, a small number of cases are analyzed to afford an in-depth understanding of each case. The method "incorporates elements from phenomenological (Giorgi, 1985), grounded theory (Strauss & Corbin, 1998), and comprehensive process analysis (Elliott, 1989)" (Hill et al., 2005, p. 196). Described as predominantly constructivist or interpretive in nature, with some post-positivist elements, CQR involves having judges identify core domains and specific ideas manifested in each participant's responses to open-ended questions, and then develop categories to describe consistencies in core ideas across cases. Throughout this process, emphasis is placed on having judges reach consensus through discussion and reflection on the data. Such consensus contributes to the trustworthiness or validity of the data (Hill et al., 1997, 2005).

Developing of domains. Domains are overarching clusters, which provide a conceptual framework for organizing the large amount of data generated by open-ended interviews. The three members of the research team (i.e., judges) first generated a priori domains (i.e., a "start list") based on the structure of the interview protocol itself. Then, they independently read five of the interviews. During this process, each piece of potentially meaningful data appearing in the transcript, be it a phrase, sentence or paragraph, was assigned to a given domain. In those cases in which data did not fit into one of the a priori domains, the judges proposed additional domains to reflect the emerging data and coded it accordingly. Irrelevant information was placed into an "other" domain. Once each of the judges had independently coded all five transcripts, the team met to discuss the coding. Through discussion, the team was able to reach consensus regarding an expanded list of domains that accounted for all relevant data found in all of the cases. Judges then used this expanded list of domains to code the 26 interviews. Two of the three judges coded each interview. Interviews were assigned to judges on the basis of rotating random pairs.

Constructing core ideas. To construct core ideas, each judge independently read all of the data within each domain for each interview they coded. They then identified what they considered as being the core idea associated with each unit of meaning (i.e., word, phrase, sentence, paragraph).

Cross-analysis (generating categories). Cross-analysis involves looking across cases to determine whether there were core ideas that seemed to cluster into categories. Each judge independently examined all of the core ideas within a given domain across the interviews they coded, and organized the data into categories. The team then met to compare categories and reach agreement

through consensus regarding which categories made the most sense and how to name them.

Auditing the data. Once the team had completed the task of generating domains, core ideas and categories, all data were presented to the auditor, including the transcripts themselves. The auditor reviewed the core ideas to see how well they reflected the raw data in the transcripts. Feedback from the auditor was then discussed by team members and incorporated into the final list of categories. The final lists of domains and categories appear in Table 1.

Determining the frequency (or representativeness) of each category. To convey how representative each category was of each of the treatments examined, we adopted Hill et al.'s (2005) convention of labeling categories as "general" (i.e., appearing in all or all but one of the cases), "typical" (i.e., appearing in more than half of the cases), and "variant" (i.e., appearing in at least three, but no more than half of the cases). Categories that appeared in two or less cases in a given group (i.e., treatment) were considered not representative of that group. In accordance with the suggestion of Ladany, Thompson, and Hill (2012), meaningful between-groups differences were defined as differences of at least 30% in frequency between the two groups. Both descriptive labels and within-group frequencies for each category appear in Table 1.

Results

Overview

Our analyses revealed three overarching domains: treatment outcomes, treatment processes, and overall experience of therapy. Within the treatment outcomes domain, there were four subdomains: positive interpersonal outcomes, negative interpersonal outcomes, positive intrapersonal outcomes, and negative intrapersonal outcomes. Within the treatment processes domain, there were two subdomains: positive interpersonal processes and positive intrapersonal processes. Across domains, there were 21 different categories. Eight of these categories were common to, and similarly representative of, both treatments. Seven other categories evidenced meaningful between-treatment differences. The final six categories were representative of one treatment but not the other, though there were not meaningful between-groups differences.

Treatment Outcomes

Positive interpersonal outcomes. Clients in both treatment conditions reported a number of positive interpersonal treatment outcomes, including that their relationship with their parent had changed for the better. As one ABFT client phrased it: *Our*

Table 1
Domains and Categories

Domains / Categories	Frequency (% of cases within treatment)			
	EFT (n = 14)		ABFT (n = 12)	
Treatment outcome				
Positive interpersonal				
My relationship with parents changed for the better	Variant	(50%)	Typical	(83%)[a]
Became more compassionate/forgiving toward parents	Variant	(50%)	Variant	(42%)
Relationships with others (not parents) improved	Variant	(50%)	Variant	(33%)
Changed way I look at parents, new perspective of parents	Variant	(36%)	Variant	(50%)
Negative interpersonal				
Therapy had negative impact on parent–child relationship	Variant	(36%)	Not rep	(8%)
Positive impact during active phase of treatment did not last	Not rep	(14%)	Variant	(33%)
Positive intrapersonal				
Less reactive to anger in relation to parents	Typical	(57%)	Variant	(50%)
Purification/cleaned out	Typical	(57%)	Variant	(25%)[a]
Acquired new coping strategies	Variant	(43%)	Variant	(50%)
Changed way I generally look at life	Variant	(36%)	Not rep	(17%)
Agency/confidence	Variant	(36%)	Not rep	(8%)
Increased individuation	Variant	(29%)	Not rep	(8%)
Negative intrapersonal				
Therapy made me more angry	Variant	(29%)	Not rep	(0%)
In-therapy processes				
Positive interpersonal processes				
Saying hard things that have never been said before directly to parents	Variant	(36%)	Typical	(83%)[a]
Parent participating in therapy was meaningful	Not rep	(0%)	Typical	(67%)[a]
Mutual vulnerability and disclosure, heard each other	Not rep	(0%)	Variant	(50%)[a]
Positive intrapersonal processes				
Productive emotional processing	Typical	(64%)	Typical	(83%)
Remembered and talked about previously avoided memories thoughts, feelings	Variant	(43%)	Not rep	(8%)[a]
Got my anger of my chest	Variant	(43%)	Not rep	(0%)[a]
Overall experience of therapy				
Too short and too narrowly focused	Typical	(57%)	Variant	(33%)
Hard	Variant	(29%)	Variant	(25%)

Note. Not rep = Not representative.
[a] Difference of at least 30% in between-treatment frequencies.

relationship is better since the therapy. When we talk, our conversations are deeper . . . we tell each other things more, share information . . . the situation has definitely improved, it is better now. Another client, who had participated in EFT, described it thus: *It feels like our relationship is now meaningful . . . that each time we speak, each time he (father) calls or we meet, the feeling is that he cares. Even if he only thought to call and show interest, it comforts something in me and suddenly things feel Okay. . . .* Reports of such improvements were typical of ABFT, and more representative of ABFT than of EFT.

Clients in both groups (variant) reported becoming more forgiving and compassionate toward their parents, and seeing their parents in a new light. As an example of increased compassion toward parent, one ABFT client stated: *Today, I am increasingly accepting of her and her behavior. You could say that I am more forgiving and I don't hold any resentment*. Another client, one who received EFT, described it in this manner: *I think the treatment helped us free ourselves from being stuck—the words forgiveness and compassion come to mind—it was like one long, ongoing process of forgiveness*. In regards to seeing their parent in a new light, one ABFT client reported that: *There was a moment I remember when, suddenly, I saw my mother in a different way completely, in a different light. Suddenly seeing that she is weak and not looking at her from a critical vantage point. To see her from a place of acceptance and not as some dictator . . . to have compassion . . . that was something new and it has stayed a part of our relationship since the treatment ended*. In an example from the EFT group, one client reported that: *The treatment was an amazing experience, one that really changed me . . . how I look at my parents. I think my attempt to understand what type of home he (father) came from, a home of holocaust survivors, helped soften my anger.*

Clients from both treatment groups also reported that their relationships with people *other* than their parents improved because of therapy (variant). For example, as one of the clients in the ABFT group described it: *The therapy positively influenced my relationships with my sisters and my relationship with my grandmother. It brought a sense of calmness to my life . . . the anger was something that very much bothered me so that, when something happened good with that, it spread and impacted upon many things in my life*. In the words of one of the EFT clients: *My ability to say to people, "O.K., that is your problem, not my problem," without getting annoyed. I still get annoyed and still get into conflicts with people in my life but I think less than I once did and perhaps in a more mature way . . . I learned a lot of things. I learned to control a lot of things.*

Negative interpersonal outcomes. Some of the clients in the EFT condition felt like therapy had a negative impact on their relationship with their parent (variant). For example, one such client reported: *I felt like it made me even more distant from my mother, from my family. It was like, all of the anger came up and things opened-up, and it increased my anger. It kind of gave me permission to stay away from her, not want to get closer to her. . . . I don't want to talk to her, to cope with her.* Although this category was not representative of clients in the ABFT condition, there was no meaningful between-groups difference. On the other hand, some clients in the ABFT condition reported that the positive impact during the active phase of treatment did not last. For example, one ABFT client reported: *Nothing that happened in the therapy held up in the long run. There was a small change in my mother during the therapy itself. Perhaps if the treatment had been longer we would have succeeded in establishing some changes in other patterns and it would have been a little more effective . . . I think more sessions with my mother alone would have helped . . . "* Although this category was not representative of the EFT condition, there was no meaningful between-groups difference.

Positive intrapersonal outcomes. Clients from both groups reported being less reactive to their anger toward their parent. As one EFT client described it: *My level of patience increased . . . let's just say my emotional piece of mind strengthened . . . the anger is quieter. It still exists and has not gone away completely, but it is more relaxed and affects me less . . . I act on it less and it is much better for me when it (the anger) is less activated.* Although this outcome was typical for the EFT condition and only variant for the ABFT condition, there was no meaningful between-groups difference.

Clients from both groups also reported feeling purified or cleaned out as a result of the therapy. One EFT client described her feeling thusly: *It feels like I opened it up, put disinfectant on it and cleaned it out, and now it is something that I can close up again, but this time it is clean. It is really strange but, since then, the things I opened have not come up again . . . I feel like I don't have any more dark places inside where I sweep things and I am afraid to go to. I went into those places, touched them, and now there is not some trauma inside waiting to come up. I brought everything to the surface. There were a couple of sessions in which I didn't stop crying—it was like purging the poison*. One of the ABFT clients said: *I am happy that my parents and I talked about the difficult things . . . I felt relief at saying the things that bothered me*. Whereas this outcome was typical among EFT clients, it was only variant among ABFT clients and the difference between groups was meaningful.

Some clients in both groups (variant) reported having acquired new coping strategies. One EFT client, for example, reported that the therapy: *. . . gave me tools to cope with things . . . during the course of the empty-chair exercise I understood, more or less, what he (father) did. . . . and I could take that with me . . .* One of the ABFT clients described it in the following manner: *It wasn't a "solution." It was a way of coping with the problem, not necessarily arriving at a solution but something that gave both of us a few more tools to keep coping with it.*

Finally, there were a number of positive intrapersonal outcomes representative of the EFT condition, but not the ABFT condition, though the differences between groups were not meaningful. More specifically, some of the EFT clients reported positive changes in the way they generally viewed their life (variant), increased individuation (variant), and an increased sense of agency/confidence (variant).

In terms of changing the way they generally look at life, one EFT client reported: *The therapy gave me a new way of looking at things . . . like another tool to say, "O.K., I didn't see it that way before," as if you move the camera and suddenly, "Wow, I didn't see that before because it was hidden behind the table" and if I sit here I will be able to see it and that is an interesting point of view.* In regards to increased individuation, one EFT client reported: *I felt like the process kind of marked the fact that I am a strong person . . . like I had undergone a journey to freedom and independence . . . For years I haven't lived at home and have been*

financially independent, but emotionally there was always something too connected . . . during the course of the therapy, I felt like it was O.K. to say that, "I am a big girl" and that "I am responsible and capable" and I felt that I got stronger. Really, I felt like I began the treatment weak in many ways—emotionally confused, and that I proved to myself that I am not like that. That was a big deal for me . . . I felt that the therapy helped me to choose for myself and that my choices came from a place of emotional independence and not from a place of worrying about what others would do. Finally, in regards to agency, one EFT client related: *The whole process was very, very positive for me . . . suddenly I realized that I need to take my time more and that I need my quiet and time alone to organize my thoughts, write, manage myself and to make decisions . . . . . and during the summer I had a really good experience with lots of internal quiet . . . sure there were difficult moments but I could cope with them . . . I really enjoy being able to organize things and now, even when there is lots of pressure, I remind myself to take care of things and that I will be O.K. . . . it's something I feel really good about, a real accomplishment and it has extended to all aspects of my life and increased my self-confidence and self-esteem.*

Negative intrapersonal outcomes. Some clients (variant) in the EFT condition reported that the therapy made them more angry at their parent. For example, one such client reported that: *The therapy reminded me of incidents that I was angry with her about . . .* I *didn't feel like I gained new perspectives or ways of behaving, just the same feelings or worse . . . it's like the therapy had the opposite effect than intended—I ended up being more angry.* This outcome was not reported by any of the ABFT clients; however, there was no meaningful difference between groups.

Treatment Processes

Positive interpersonal change processes. Clients in both conditions reported that saying hard things to their parents that they had never said before was important in regards to creating change. This process was typical of ABFT, and more representative of ABFT than of EFT (variant). In the words of one ABFT client: *The thing was, I was able to suddenly say to my mother everything that always bothered me—about the way she would treat me—and really be sure that she could receive what I was saying in a good way, that I could really express myself because before, it wasn't possible*. In another example, one EFT client reported: *Saying those things out loud, as if my mother was in the room, was what made it possible for me to take it out of the room and say it directly to my mother. To say, "I am angry at you and don't forgive you for what you did*." *Saying it helped me get closure. It was different than if I had just said it in theory or left it between me and myself.*

In addition, two positive interpersonal change processes were unique to ABFT and meaningfully different from EFT, likely because only ABFT included conjoint sessions. First, clients who participated in ABFT typically reported that the fact that their parents were willing to come to therapy and participate was meaningful in and of itself. As one ABFT client put it: *First of all, and more important than anything, the fact that my mother came to the sessions with a willingness to take part, without any problems, and that she came to every session and spoke with me about the sessions afterwards . . . that in and of itself was more than I thought would happen.* Second, some ABFT clients reported that being vulnerable, and seeing their parent's vulnerability, was transformative (variant). As one ABFT client reported: *It helped to hear my mother's story, to understand what she was going through herself. I hadn't known that side of her.*

Positive intrapersonal change processes. Clients from both groups typically reported that connecting with and productively processing their emotions promoted change. As one client from the EFT group described it: *I thought about it a lot . . . what he (the therapist) did was to simply cause the feelings to surface and to give them names, to confront every aspect of them—and all of this flooding, it causes you to work through things that you had sort of buried, or something like that. You surface them and cope with them and, at that moment, you begin to solve things, once you are aware of something that is there, it is a lot easier to cope with it than if there is some anger that you don't know where it is coming from, where it is going, or how to cope with it.* Another EFT client said it in this way: *I think the main thing was to understand that my anger came from a place of pain . . . In the beginning, I didn't get to the root of it. I didn't consciously avoid it but, unconsciously, we all defend and I was so sure that [my anger] didn't come from a place of pain, and suddenly it opened up and I discovered it and, at the moment that I started to have that insight, we began working from that place of pain . . .* As one ABFT client stated: *It was very frustrating because I would get angry and I couldn't understand why I was so angry . . . it was unclear and undefined . . . it was very frustrating because I didn't know how to say or explain it . . . I could only say to them that they were annoying me and I didn't know why . . . the therapy helped me uncover what I didn't see . . . I had been used to just staying in the feeling of "they are annoying" . . . the therapist asked me to give more details, to track/investigate the reasons . . . it was challenging and required me to work . . . it demanded that I be honest with myself, to be focused, to really try to understand the reasons and what exactly I was feeling, when I was feeling it. . . .* In another example, a client who received ABFT stated: *The therapy moved from focusing on my anger . . . to other emotions. That is, to change the anger, which doesn't really express what I am feeling, and simply change it into the real emotion I am feeling . . . like the fact that I was hurt by my parents so instead of saying I was hurt as a child because that is not something that is possible to say, instead being angry because my parents don't do what I want.*

Two positive intrapersonal change processes were unique to EFT. First, some clients (variant) who received EFT reported that coming into contact with previously avoided memories and feelings accounted for positive change in therapy. For example, one EFT client stated: *The therapy led me to think about things that I hadn't thought about before, or even say things out loud that I had thought about but never said before. It opened everything, opened it like a faucet*. Second, some EFT clients (variant) reported that getting their anger off their chest led to change. For example, one EFT client stated: *The feeling was that I let go of something, unburdened myself. I felt like a new person. As if I just got up from sleep and drank a strong cup of coffee. The anger became more moderate, and I felt more relaxed and calm*. Neither of these categories were representative of ABFT, and the differences between groups were meaningful.

Overall Experience of Therapy

Participants in both groups reported experiencing treatment as too short and too narrowly focused. This complaint was typical among EFT clients and variant among ABFT clients, though the difference between groups was not meaningful. For example, one EFT client remarked: *I came with a heavy story . . . I don't know to say what others came to therapy with, but my story was heavy emotionally. For me, 10 sessions was a bit too short . . . like a short blanket that couldn't cover everything—too few sessions for me at least.* In another example, one ABFT client stated: *The fact is that 10 sessions is nothing. The therapy touched on only the most burning issues. It would have been ideal if the treatment had continued for a longer period of time*.

Finally, some participants in both groups (variant) reported that the treatment was hard. For example, one ABFT client reported: *During conjoint sessions with my father and the therapist, it was almost unbearable. It was like I left those sessions with a migraine. It was very difficult for me . . . it was like my father wasn't listening. I tried to share with him but nobody was there listening . . . it took a lot of energy and those sessions were the hardest.* One of the EFT clients described it as follows: *The emotional experience was very difficult. That is, what I can say is that it was a difficult experience to go back and talk about things which I had blacked out and they surfaced and opened a box. What was most difficult was certain specific memories that came up, it was very hard to talk about, it was hard.*

Discussion

Young adults who participated in either ABFT or individual EFT for unresolved anger toward a parent reported a number of interpersonal and intrapersonal treatment gains, some of which were common to and similarly representative of both treatments, and some of which differentiated between the two treatments. Clients in both treatment groups reported that their relationships with their parents changed for the better. They also stated that therapy led to them to view their parents differently and with more compassion. In regards to intrapersonal outcomes, clients in both groups reported that they became less reactive to their anger, felt "cleaned out," and acquired new coping strategies.

The fact that clients from both treatment groups reported positive changes in their relationships with parents is encouraging. It is also consistent with prior quantitative findings from this same sample showing that, across treatment conditions, young adults experienced reduced attachment anxiety ("I worry that my parent doesn't really care about me") over the course of treatment (Diamond et al., 2016). Importantly, however, the manner in which clients described positive changes in their relationships with parents in this study (e.g., "the relationship became deeper, more meaningful") provides information not captured by the close-ended questions used in the original study, and extends our understanding of what positive change in relationships might mean. Client responses in this study suggest that young adults seek more than reduced conflict, better communication, or higher levels of care, and that meaningfulness and depth in relationships with parents may be important constructs to systematically measure in future studies.

The fact that clients in both groups reported gaining new perspective and increased compassion toward parents is consistent with the goals of both models. In EFT, the client's view of his or her parent shifts as the parent is portrayed in a new way, often in the context of chair-work. Resolution occurs when the client is able to more fully understand the injuring other and in some cases forgive them, or, in other cases, hold them accountable for the damage that has been done. In both types of resolution, clients usually adopt a more self-affirming and empowered stance (Greenberg & Malcolm, 2002). In a previous study of EFT for unfinished business, the authors found that cases in which clients manifested a shift in their view of other had better treatment outcomes (Greenberg & Malcolm, 2002). Likewise, in ABFT, anger is thought to resolve as parents recognize and validate their young adult's experience, take responsibility for their own behavior and its negative impact, disclose their own vulnerabilities and fears, commit to changing their responses according to their young adult's adaptive needs and, in some cases, apologize (Diamond et al., 2014, 2016). These qualitative findings converge with previously published quantitative findings from this sample showing that, across the two treatment models, young adults reported decreases in unresolved anger. Resolution of unresolved anger is defined, in part, as increases in acceptance of parents and increased appreciation of the challenges parents face (Diamond et al., 2016). Along the same lines, findings from a prior qualitative meta-analysis found that a changed view of other was a common treatment outcome in person-centered/experiential therapies (Timulak & Creaner, 2010).

Findings from this study also reveal meaningful between-treatment differences in outcomes not fully captured by the standardized, quantitative measures used in previous analyses of this sample. Specifically, whereas clients' reports that their relationships with their parents had become deeper and more meaningful were more representative of ABFT, clients' reports of feeling "cleaned out" or "purified" were more representative of EFT. The fact that ABFT clients more often reported improvements in their relationships with parents is not surprising. Helping family members to productively talk together and work through past hurts to improve their relationships is the primary focus and goal of the treatment. This finding also complements previously reported quantitative finding from this sample showing that ABFT, but not EFT, led to decreases in attachment avoidance (Diamond et al., 2016). In other words, clients who received ABFT were more likely to report increases in feeling more comfortable opening up to and depending upon their parents than clients who received EFT. It also echoes results from previous ABFT studies showing decreases in family conflict, and improvements in child–parent attachment, over the course of the therapy (Diamond et al., 2002; Diamond, Siqueland, & Diamond, 2003).

The fact that EFT clients more often reported feeling "cleaned out," together with the finding that other intrapersonal domains such as increased sense of agency and differentiation were only representative of EFT (though there were no meaningful between-groups differences), makes sense and reflects the unique emphases of the treatment model. Individual EFT is primarily focused on helping the client to access and work through their previously avoided emotions, rather than on repairing the adult child–parent relationship per se. The processing of such emotions facilitates the acknowledgment and legitimizing of attachment and identity needs (Greenberg & Pascual-Leone, 2006). Clients who successfully resolve unfinished business, such as lingering anger, do so by

affirming themselves as worthwhile and holding the other accountable. These processes are often accompanied by a sense of empowerment (i.e., agency, stronger sense of self; Greenberg & Malcolm, 2002). Indeed, findings from a prior qualitative meta-analysis found that feeling empowered was a common treatment outcome in individual person-centered/experiential therapies (Timulak & Creaner, 2010).

In regards to psychotherapeutic change processes, clients in both treatments typically reported that productively processing their emotions played an important role in their treatment's success. This finding was expected, as emotional processing is a prescribed and essential element of both treatments. In prior quantitative analyses of this sample, emotional processing was found to predict changes in psychological symptoms across both treatments (Diamond et al., 2016). Likewise, a number of previous studies of EFT have shown the link between productive emotional processing and treatment outcome (Auszra et al., 2013; Greenberg et al., 2007; Missirlian et al., 2005). It is worth noting that emotional processing has also been shown to predict outcome in other treatment approaches, including in studies of cognitive–behavioral therapies for fear and anxiety disorders (Foa, Huppert, & Cahill, 2006).

Clients also described unique change processes consistent with, and reflective of, their model's theory and focus. For example, EFT clients reported that the process of coming into contact with past memories and getting their anger "off of their chest" contributed to their treatment gains. In contrast, clients in the ABFT condition emphasized the importance of relational processes such as having their parent participate in the therapy, being able to talk with their parents about previously avoided thoughts and feelings, being vulnerable in each other's presence, and feeling heard. Not surprisingly, these relational processes represent the core elements of successful corrective attachment/identity episodes, the purported central change mechanism in ABFT (Diamond et al., 2014). These findings also converge with results from a study of EFT for couples, which showed that couples who revealed vulnerable emotion at least once during the mid-to-late phase of therapy reported greater overall improvement at the end of therapy than couples in which neither member expressed vulnerable emotion (McKinnon & Greenberg, 2013). Such findings suggest the critical role of expressed vulnerability in conjoint experiential treatments, whether it be ABFT or EFT for couples or families, and the importance of measuring mutual vulnerability in future studies.

It is worth noting that not all of the outcomes reported were positive. Some of the EFT clients described becoming angrier as the result of the therapy, though there was no meaningful between-groups difference. In these cases, it may be that the young adult's anger was successfully evoked but not productively processed. Some EFT clients reported that therapy negatively affected their relationships with their parents, though there was no meaningful between-groups difference. This finding echoes previous research suggesting that working with only one member of the family can lead to deterioration in family relationships (Szapocznik et al., 1989). In such cases, the young adult may not have been prepared to express their feelings to parents in a productive manner. One advantage of conjoint therapy is that the therapist can help both the adult child and the parent articulate their emotions and needs in a nonaccusatory manner, regulate themselves and respond to one another in an open, nondefensive way. This decreases the likelihood that negative interpersonal processes will escalate and increases the likelihood that individuals will feel heard, leading to greater intimacy and connection.

On the other hand, some of the clients who received ABFT reported that gains made during the active phase of treatment were not maintained at follow-up, though there was no meaningful between-groups difference. This finding was surprising, given substantial research showing the long-term efficacy of brief family therapy for a wide range of clinical presentations, including courses of therapy lasting only 10 sessions in length (Horigian et al., 2015; Lock, Agras, Bryson, & Kraemer, 2005). There is even research suggesting that the effects of family therapy tend to *increase* from posttreatment to follow-up (Bry, Catalano, Kumpfer, Lochman, & Szapocznik, 1998; Kolko, Brent, Baugher, Bridge, & Birmaher, 2000; von Sydow, Retzlaff, Beher, Haun, & Schweitzer, 2013). Nevertheless, for some clients, 10 sessions may not have been sufficient. Indeed, some clients in both groups complained that the treatments were too brief and narrowly focused, while at the same time difficult and challenging.

A number of methodological strengths increase our confidence in the validity of our findings. First, the treatments delivered were empirically based, empirically supported and delivered with integrity. Second, the qualitative analytic procedure was conducted in a systematic and rigorous manner. Finally, the sample size was robust for this type of qualitative research, with 12 or 14 participants in each condition. With that said, a number of methodological limitations temper our interpretation of the findings. First, clients' understanding and reports of what led to change was likely affected by their therapists' overt intervention strategy and focus of the treatment they received. It may be that other, equally important change processes were not reported because they were less readily apparent to the client. Second, two change processes, having the parent participate in sessions and mutual vulnerability, were dependent on the structure of the given model. Third, clients report about the therapy were retrospective. The amount and accuracy of the information clients remember six months posttreatment is an open question. Finally, these results reflect our judges' interpretation of the text. Other judges, with different backgrounds and biases, may have interpreted clients' responses somewhat differently.

This study is one of only a handful of psychotherapy research studies ever conducted using a qualitative approach to examine treatment outcome and processes in two bona fide treatments delivered to a single sample. Our findings suggest that there were both common and treatment specific outcomes and processes. Moreover, they complement and extend the results from previously published quantitative analyses of this same sample (Diamond et al., 2016). For example, our qualitative analyses revealed that treatment led to deeper, more meaningful relationships with parents, not just reductions in anger and anxiety. Likewise, our findings suggest the potential importance of systematically studying treatment outcomes such as agency and individuation, as well as processes such as mutual vulnerability, in the context of future studies. Our findings demonstrate the utility of combining qualitative and quantitative analytic approaches.

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