EMOTIONAL EXPERIENCE DURING COUPLE SUPPORT INTERACTIONS: THE ROLE OF ATTACHMENT ANXIETY AND AVOIDANCE

by

E. Megan Lachmar

A thesis submitted in partial fulfillment
of the requirements for the degree

of

MASTER OF SCIENCE

in

Family, Consumer, and Human Development
(Marriage and Family Therapy)

Approved:

_____	_____
Ryan B. Seedall, Ph.D. Major Professor	W. David Robinson, Ph.D. Committee Member
_____	_____
Kay Bradford, Ph.D. Committee Member	Mark McLellan, Ph.D. Vice President for Research and Dean of the School of Graduate Studies

UTAH STATE UNIVERSITY
Logan, Utah

2017

ABSTRACT

Emotional Experience During Couple Support Interactions:

The Role of Attachment Anxiety and Avoidance

by

E. Megan Lachmar, Master of Science

Utah State University, 2017

Major Professor: Dr. Ryan B. Seedall
Department: Family, Consumer, and Human Development

Attachment begins with an infant and caregiver and is determined by sensitivity and quality of responsiveness. These interactions determine internal working models of attachment, shaping the way adults view others and themselves. This inherently influences adult romantic relationships, with insecure attachment styles resulting in worse relationship outcomes. Much of the research thus far on attachment in intimate partnerships has focused on areas of relationship conflict. However, daily interactions couples have when they are not fighting is a potentially very important aspect missing from the literature. In this study, we examined the way partners support each other when discussing personal issues rather than relationship conflict. In addition to collecting self-reports of perceptions of couple support, we used psychophysiological measures to determine the internal emotional experience during couple interactions.

(110 pages)

PUBLIC ABSTRACT

Emotional Experience During Couple Support Interactions: The Role of Attachment Anxiety and Avoidance

E. Megan Lachmar

The Marriage and Family Therapy clinic at Utah State University conducted a study called the Relationship Checkup in which couple data was collected in an initial 2-hour session and feedback was provided for them in a follow-up 1-hour session. This checkup included completing self-report surveys, having an in-person interview, as well as couple interactions. The current study was carried out within the context of this broader relationship checkup, focusing on the couple support interactions, in which partners discussed a personal issue they would like to change about themselves.

Although a substantial amount of attention has been given to the role of attachment during couple conflict, much less attention has been given to social support processes. Yet the purpose of therapy is not only to diminish disruptive conflict but also to enhance positive relationship processes, making a greater understanding of social support processes crucial to the therapy process.

The results of this study indicate that partners with higher levels of avoidant attachment perceived they were receiving and providing less support. This reveals that couple therapists may need to assist these partners in reaching out and providing support. Additionally, results show that for women, discussing a personal issue soothed them physiologically. Therefore, rather than focusing on couple conflict, couples therapists can also build positive relationship interactions through couple social support.

ACKNOWLEDGMENTS

This thesis would not have been possible without the constant support, mentorship, and guidance of Dr. Ryan Seedall. I am so grateful to have the chance to learn from Ryan about research, writing, therapy, and academia in general. I am also extremely thankful for my committee members, Drs. Dave Robinson and Kay Bradford, who helped immensely and gave great insight into my project.

I would not be in this setting if it weren't for my amazing parents, Tom and Barbara Lachmar. They taught me how important education was and gave me the chance to pursue my dreams. I am also thankful for my amazing siblings who provide moral support and love throughout my education. Additionally, I would like to thank my wonderful cohort, Lacey, Ty, Julie, Matt, and Jake, who were there throughout the whole process encouraging me to finish.

E. Megan Lachmar

CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER I

INTRODUCTION

Couple relationship dynamics are often influenced by previous experiences, tracing all the way back to infancy. Attachment theory posits that bonds form during infancy based on interactions between infants and their primary caregiver, whom, according to Bowlby during the development of the theory, was typically the mother (Bowlby, 1988). The caregiver acts as a secure base in which the infant can explore the environment around them while still receiving the comfort they need when necessary. These attachment bonds are formed based on the infant's ability to rely on the caregiver to consistently meet their emotional and physical needs. Attachment bonds shape the way infants view others as trustworthy, safe, warm, and caring. As infants grow, this paradigm becomes an individual's internal working model of attachment and determines whether they can rely on others to be safe, sensitive, and responsive (Bowlby, 1988).

In adulthood, working models of attachment form secure or insecure attachment styles based on previous experiences during infancy combined with those experiences in adult intimate relationships (Bartholomew, Cobb, & Poole, 1997; Collins & Feeney, 2000). On the insecure spectrum, there are two dimensions: anxious and avoidant attachment. In intimate adult relationships, those individuals with anxious attachment tend to need more reassurance, seek higher levels of closeness, and often fear rejection or abandonment in their relationships (Bartholomew et al., 1997; Collins & Feeney, 2000). Those with avoidant attachment emphasize independence and become uncomfortable with emotional closeness or in emotionally vulnerable contexts (Bartholomew et al.,

1997; Collins & Feeney, 2000). Both self-report measures and narrative-discourse assessments have been used in research and therapy to assess the attachment styles of individual partners in couple relationships (Brennan, Clark, & Shaver, 1998; George, Kaplan, & Main, 2002).

The goal in adult couple relationships is for the intimate partner to become the secure base in which individuals reference their attachment, much like the role of their primary caregiver during infancy. In couple relational dynamics, there are significant differences with insecurely and securely attached individuals. Those partners with secure style of attachment have better outcomes, such as higher levels of relationship satisfaction and relationship stability (Givertz, Woszidlo, Segrin, & Knutson, 2013). On the other hand, insecure partners may experience more negative outcomes in intimate relationships. Insecurely attached partners may perceive more negative content, behave more negatively, and be more highly distressed based on internal emotional experience during relationship interactions (Creasey, 2002; Gouin et al., 2009). Securely attached partners benefit from longer lasting, stable relationships with more positive experiences, such as higher levels of trust (Givertz et al., 2013).

Because working models of attachment are most activated during times of distress, couple conflict has been extensively researched because of its likelihood to elicit this distress in the context of intimate relationships. Research on couple conflict has revealed a pattern of overall unhealthy communication patterns in relationships consisting of individuals with insecure styles of attachment (Domingue & Mollen, 2009). Further, other findings have indicated that partners may have difficulty during conflict, such as

those with higher levels of avoidant attachment struggling to detect their partner's distress (Edelstein & Shaver, 2004). Based on research in regard to psychophysiology, those with insecure styles of attachment tend to be more reactive during conflict as well as having difficulty coming down from stress after conflict when measured using cortisol levels as well as interleukin-6 production (an inflammatory response affecting the immune system; Beck, Pietromonaco, DeBuse, Powers, & Sayer, 2013; Gouin et al., 2009).

While couple conflict is important, this research misses the meaningful, positive day-to-day interactions couples have. The way couples support each other on topics of personal, rather than conflict-laden issues, is an important component of relational dynamics that has been relatively uninvestigated in couple research. Social support encompasses these daily interactions and although not extensive in the literature, current research has revealed differences in support behaviors and perceptions with regards to partners' attachment style (Pasch, Harris, Sullivan, & Bradbury, 2002). The provision and reception of support branches from roots of attachment theory in that humans' earliest interactions with their primary attachment figure determine whether they trust others to be dependable and responsive (Collins & Feeney, 2010).

In the context of social support, there are differences between secure and insecure attachment styles. Based on research findings, those with insecure attachment styles rate partners' support behavior as more negative and less supportive in comparison to their secure counterparts (Collins & Feeney, 2004). Further, avoidant individuals in particular have more difficulty when partners are distressed, perhaps feeling uncomfortable with the

emotional intimacy required in order to comfort them (Edelstein & Shaver, 2004). They may also have difficulty asking for support when they need it, deemphasizing their dependence on others (Collins & Feeney, 2010; Davila & Kashy, 2009). On the contrary, anxiously attached individuals seek support using more indirect means, such as sulking, pouting, whining, and clinging behaviors (Shaver & Mikulincer, 2012).

Overall, though some findings have revealed associations between attachment style and social support, more research is needed to understand the role of attachment in the perceptions of support received and provided to intimate partners. Attachment theory provides a solid foundation for this research considering social support conversations can be impacted by working models of attachment and whether partners' view one another as a secure base or safe haven, such as the theoretical tenets suggest (Bowlby, 1988; Collins & Feeney, 2000, 2004). Additionally, this is important because although researchers have looked extensively at couple conflict and attachment, we have missed looking deeper into what is occurring during the majority of time couples are interacting, when they are not fighting. From a therapeutic standpoint, more research in this area is needed in order to better inform the attachment-based lens that therapists often use during their work with couples (Johnson, 2004). This study will not only explore the relationship between self-reported attachment and perceptions of support provided and received, it will also examine the relationship between attachment and psychophysiological experience during social support interactions. I am hopeful that findings from this study will provide a step toward a more comprehensive understanding of couple relationships and therefore, insight into how to facilitate healthy social support interactions within therapy.

CHAPTER II

LITERATURE REVIEW

Attachment reveals important dynamics between adult intimate partners, which has been examined particularly during couple conflict. Although research has been studied extensively on processes of distressed couples during conflict, there is a need for studies to look at what both healthy and distressed couples do when they are not fighting (Heyman, 2001). The purpose of the current study is to examine adult attachment styles within the context of intimate partner social support interactions, while also understanding the internal physiological processes that occur during these support conversations.

Attachment theory posits that the primary caregivers' sensitivity and responsiveness in supporting infants greatly influences a child's pattern of attachment (Bowlby, 1988). These create internal working models of attachment that determine whether we perceive others as trustworthy and supportive (Bowlby, 1988; Collins & Feeney, 2004). In adulthood, working models of attachment fall on dimensions of insecure and secures styles of attachment (Bartholomew et al., 1997; Collins & Feeney, 2000). Although these attachment constructs have been extensively studied in regard to their effects on couple conflict, much less research has examined spousal support interactions, in which personal distress is the focus instead of relationship-specific conflict. Finally, by using physiological measures of attachment, the ways that attachment styles influence internal emotional processes in the context of social support dialogues will be examined.

The following review of literature will cover (a) attachment theory in infancy and adulthood; (b) attachment in couple relationship processes including social support processes; and (c) the physiological processes that underlie these constructs.

Attachment in Infancy

Attachment theory provides a foundation for the way people view others as trustworthy, safe, and comforting, forming from birth and following individuals across the lifespan. During infancy, bonds of attachment, first introduced by Bowlby (1969, 1973, 1988), are naturally formed between a child and their primary caregiver, whom, particularly when the theory first emerged, was the infant's mother. This primary caregiver becomes the infant's attachment figure for which innate emotional bonds are created as essential references for internal working models of self and other throughout life (Bartholomew et al., 1997; Collins & Feeney, 2004). Strong, secure emotional bonds of attachment are formed when an infant can consistently depend on an attachment figure to provide warmth, reassurance, safety, and sensitivity in regards to physical and emotional needs (Bartholomew et al., 1997; Collins & Feeney, 2004). The overall goal is for the caregiver to become a secure base from which the infant can explore the world around them and also receive comfort, closeness, and physical proximity in times of distress and uncertainty (Bowlby, 1988; Sullivan & Davila, 2010). In this manner, the primary caregiver promotes the infant's exploration but also conveys the possibility that the infant return and receive comfort whenever necessary (Ainsworth & Bell, 1970; Bartholomew et al., 1997; Bowlby, 1988). For this section on infancy and attachment I

will cover (a) the contribution Mary Ainsworth made to attachment theory; (b) psychophysiology during infant attachment experiences; and (c) internal working models of attachment formed during infancy.

Foundation of Attachment Theory

Much of the empirical basis for attachment theory was developed as a result of the work of Mary Ainsworth. Ainsworth's basis in collecting a vast amount of naturalistic observational data of infants and caregivers provided a foundation for examining the mother-infant interactional patterns (Ainsworth, Blehar, Waters, & Wall, 1978). Initially observing mothers and infants in Uganda Africa, Ainsworth discovered important differences in the quality of infant-mother relationships (Ainsworth, 1967). Of this observational data, maternal sensitivity to infants' signaling was found to be an important factor in the attachment patterns of the infant. This means that when infants were in need of support, whether physically or emotionally, the quality and immediacy of responsiveness from their primary caregiver determined their development of trust and feelings of security. Later on, Ainsworth observed families in Baltimore that had newborn infants by way of home visits (Ainsworth et al., 1978). Again, maternal sensitivity and speed of responsiveness to infant signaling was found to influence the quality of the parent-child relationship. More sensitive caregiving in the first three months was associated with less crying later on as well as less contact-seeking behavior and better quality of contact when it did occur (Bell & Ainsworth, 1972).

The Strange Situation Procedure. Mary Ainsworth's naturalistic observational background in studying the quality of infant-mother relationships led to the development

of the Strange Situation Procedure (Ainsworth & Bell, 1970). This procedure is a laboratory observational method used to examine one-year-olds' attachment behaviors with their primary caregiver during exploration. Various conditions are set up for the procedure in which the primary caregiver is present, absent, or a stranger is present (Ainsworth & Bell, 1970). Particular emphasis was placed on the infant's reaction to the return of the mother after absence. Many different behaviors were observed that paralleled the interactions Ainsworth had seen during previous naturalistic observations, such as ignoring the mother upon return or displaying manifestations of anger toward the mother, while others sought comfort and contact (Ainsworth & Bell, 1970).

Anxious attachment behaviors in children were displayed in the form of proximity maintaining, such as clinging onto the primary caregiver. Upon return, these infants were often inconsolable and would continue to cry even in the face of support attempts from caregivers, which is often an effect of inconsistent caregiving (Ainsworth, 1979; Ainsworth & Bell, 1970). Thus, the child is uncertain whether they can depend on the attachment figure to provide the support they need (Ainsworth & Bell, 1970; Bowlby, 1988). On the other hand, infants with avoidant styles of attachment did not seem to acknowledge their primary caregiver's absence during the strange situation. Although it was evident that they felt distress similar to other infants, they did not signal that distress. Ainsworth found that these infants were more likely to have their bids for support and comfort consistently rejected by the caregiver, such as often being ignored or unfulfilled emotionally and physically (Ainsworth & Bell, 1970).

Psychophysiological arousal and attachment. For those higher in avoidance, even in infancy there is a discrepancy between outward behavior and inner physiological process. For example, although infants in the strange situation seemed indifferent about their mothers' separation and return, other tests have revealed that their internal distress, such as heart rate, was equivalent to or higher than their anxious or secure counterparts during this period (Edelstein & Shaver, 2004; Sroufe & Waters, 1977). This reveals that although some type of coping strategy is occurring that allows the infant to repress behavior and act as though they do not care about getting their needs met, internally they are still just as distressed as others who express their needs overtly.

Internal Working Models of Attachment

The strange situation procedure measures the type of attachment behavior infants exhibit in relation to their primary caregiver. This attachment behavioral system between an infant and caregiver develops to become an internal working model of attachment referenced throughout the infant's lifespan (Bartholomew et al., 1997; Bowlby, 1969; Collins & Feeney, 2004). This model is based upon experiences of interactions between the infant and primary caregiver. When infants are distressed, they turn to their caregiver for comfort and physical proximity. If the mother is available and provides sensitive and consistent support and nurturance, this need for closeness will be met and secure attachments will form. In particular, caregivers may need to provide a safe haven in which infants can rely on them for support and caregivers adapt support to specific situations and the needs of the infant (Collins & Feeney, 2000). However, if the mother is inconsistent, insensitive, or unaware of their child's needs for support, insecure

attachments are likely to develop, such as was observed in Ainsworth's naturalistic observations and laboratory settings. These attachment styles are an internal monitor for relating to others as the child grows into an adult and determines whether they are worthy of love and whether others are deemed trustworthy (Bartholomew et al., 1997; Collins & Feeney, 2004).

Attachment Theory in Adulthood

As we age, our primary caregiver is no longer linked to our literal or tangible sense of security. However, as we age we use these models as references for our experiences in adult romantic relationships (Bartholomew et al., 1997; Collins & Feeney, 2004). The premise of this emotional framework is rooted in two main concepts: whether we deem ourselves worthy of love and affection and if we can trust others to be warm and responsive, just as Ainsworth discovered in her observations of infants and their mothers (Bartholomew et al., 1997; Bowlby, 1969, 1973, 1988). Our comfort with emotional closeness, the extent to which we worry our partner will leave us, and other intimate dyadic relationship functions are based in predetermined experiences we had with our primary caregiver. Just as infants are in need of a sense of security, particularly during times of threat, pain, and anxiety, adults turn to their partners to soothe them in times of distress (Bartholomew et al., 1997; Collins & Feeney, 2004).

Attachment Measures in Adulthood

Although there is a spectrum-like quality in terms of adult attachment bonds, attachment style is commonly conceptualized as secure and insecure models of

attachment (Bartholomew et al., 1997; Collins & Feeney, 2000). This can be measured in adulthood to represent similar patterns as in the Strange Situation Procedure, but instead of observations, they are conscious representations of our patterns in relationships. The self-report measures reveal the two main styles of insecure attachment, one in which the individual fears being rejected and abandoned, labeled anxious attachment style (Collins & Feeney, 2000; Sullivan & Davila, 2010). The other is deemed avoidant attachment, in which the individual finds intimacy threatening or distressing and struggles with emotional closeness and vulnerability (Collins & Feeney, 2000). Both anxiety and avoidance can be experienced in a broad range, with the possibility of simultaneously experiencing high levels of both styles at one time (Bartholomew et al., 1997; Collins & Feeney, 2000).

While measuring these constructs can seem difficult, developmental psychology uses narrative-discourse methods to examine adult attachment representations, such as the Adult Attachment Interview (AAI; George et al., 2002). This measure is carried out in interview style, taking up to an hour initially with further time needed to transcribe and examine the content obtained during the interview (Seedall & Wampler, 2012). Social psychology uses self-report measures of attachment, such as the Experiences in Close Relationships Scale (ECR; Brennan et al., 1998), provide an effective and less cumbersome way for researchers and especially, clinicians to examine individuals' attachment styles, and therefore revealing their anxious or avoidant tendencies in adult romantic relationships (Brennan et al., 1998). While narrative-discourse methods measure unconscious patterns of attachment and self-report methods reveal conscious levels of

attachment in close relationships, there is little empirical overlap between the two methods.

Attachment and Couple Relationship Processes

Attachment style plays a vital role in adult intimate relationships because of its continuous presence and automatic activation during interactions between partners, particularly when distressing or threatening (Ainsworth & Bell, 1970; Bartholomew et al., 1997; Collins & Feeney, 2004). This constant, underlying evaluation of whether the self is capable of love and warmth and whether others are deemed receptive and caring is a key element in understanding how couples interact (Bartholomew et al., 1997). Couples with secure attachment style may benefit from outcomes such as long lasting, high quality relationships characterized by substantial levels of trust (Givertz et al., 2013; Mondor, McDuff, Lussier, & Wright, 2011). Those with insecure attachment, however, are associated with lower levels of interpersonal trust, lower relationship quality, and greater loneliness in marriage (Givertz et al., 2013). Further, these attachment styles impact couples therapy as well, with one partner's insecurity creating greater symptom distress during and after therapy (Parker, Johnson, & Ketring, 2012). Thus, these internal working models of attachment have far reaching implications in terms of the wellbeing and longevity of adult couple relationships.

Anxious Attachment Style

In couple relationships, attachment strategies reveal differences in the way individuals interact with each other, paralleling the attachment behaviors observed during

the Strange Situation Procedure (Ainsworth & Bell, 1970). For instance, some may seek closeness to a degree that is never fully satisfied and they may feel uncertain as to whether they can depend on their partner (Shaver & Mikulincer, 2012). In adulthood, this anxious internal working model manifests itself as a magnified sense of emotional reassurance and need fulfillment from a romantic partner (Bartholomew et al., 1997). The anxious individual is unsure whether they can trust the partner to be there, creating insecurity and incessant worry over abandonment and rejection in the relationship (Collins & Feeney, 2000; Dandurand & Lafontaine, 2013). When couples receive therapy, this anxious attachment style may result in higher distress for one or both partners. For males, research has revealed that if they have a female partner high in attachment anxiety, they have greater symptom distress during and after therapy (Parker et al., 2012).

Avoidant Attachment Style

On the opposite end of the spectrum, avoidant attachment develops to become avoidant attachment style in adulthood, based on consistently being unable to count on others for warmth and reassurance (Collins & Feeney, 2000; Dandurand & Lafontaine, 2013). As a result, they may feel uncomfortable with self-disclosure and emotional vulnerability, seeking safety through distance (Shaver & Mikulincer, 2012). In fact, those with anxious attachment tend to fear rejection even when it may not exist; while those with avoidance may overemphasize independence and overinflate their competence in the face of failure, while depending on others may be typical for securely attached individuals (Shaver & Mikulincer, 2012; Edelstein & Shaver, 2004). These strategies

may complicate patterns in which individuals with insecure attachment may feel threatened as a partner either demands closeness or pulls away. This may lead to a sense of frustration and helplessness as partners try to secure their attachment needs of support through insecure tendencies. In therapy, this may lead to a particularly difficult dynamic, as those with avoidant attachment style may be unable to provide the emotional vulnerability so crucial to the process of couples therapy. In fact, one study revealed that male partners with avoidant attachment style had female partners with greater symptoms of distress (Parker et al., 2012).

Attachment and Couple Conflict

Internal working models of attachment, both on the spectrum of anxious and avoidant attachment styles, filter the lens through which we view others and ourselves throughout our lives and are most likely to be activated during times of distress (Bowlby, 1969). Because internal working models of attachment are referenced in times of stress and adversity, couple conflict is an area extensively researched in the context of attachment and adult intimate relationships (Gouin et al., 2009; Pasch et al., 2002). Since adult romantic relationships often expose individuals to emotional vulnerability, during couple disagreements anxious or avoidant tendencies may manifest themselves to a greater magnitude. Indeed, interactions during couple conflict have been studied in relation to attachment and can impact the way individuals perceive themselves and their partner as well as the way they behave during these distressing interactions. During conflict, often the partner and relationship areas are a source of distress, heightening the

need for attachment related strategies. Thus, couple conflict may be particularly telling in terms of the attachment strategies partners use to try and fulfill their attachment needs.

Attachment Styles and Couple Conflict

Research has revealed fundamental differences in the way couples fight based on individual attachment styles (Gouin et al., 2009; Pasch et al., 2002). For example, some studies have found that those participants who reported higher levels of attachment avoidance also displayed increased negative behaviors and decreased positive behaviors during discussions of marital conflict (Creasey, 2002; Gouin et al., 2009). Further, in another study, women higher in attachment anxiety had greater difficulty recognizing their partner's feelings of upset and stress when the male partner was higher in attachment avoidance (Beck et al., 2013). These husbands with higher attachment avoidance had difficulty approaching anxious wives to give support (Beck et al., 2013). One study even revealed that relationships in which both partners reported insecure attachment had higher levels of unhealthy communication patterns overall (Domingue & Mollen, 2009). This way of interacting may be directly related to patterns related to internal working models of attachment; the defensive desire to be distant from the avoidantly attached perspective, and the insatiable desire to become closer in the case of anxious attachment.

Studies have also revealed that secure men and women displayed more positive behavior and less negative behavior during couple conflict (Creasey, 2002). This may result from their fundamental trust that an attachment figure will consistently be there to provide them support whenever they signal it. This is revealed in another study where

couple partnerships with a secure woman displayed more positive behaviors than those couples with an insecure female partner (Domingue & Mollen, 2009). Those couples with two secure individuals reported more constructive communicative means during conflict discussion (Domingue & Mollen, 2009). In another study, secure attachment style predicted less likelihood of rejection during arguments in comparison to insecure styles of attachment (Simpson, Rholes, & Nelligan, 1992).

Psychophysiological Arousal and Couple Conflict

It is in the context of attachment relationships that individuals learn how to regulate their emotions (Parker et al., 2012). Just as infants turn to caregivers to provide emotional soothing for their psychological and physiological wellbeing, adults turn to their romantic partners to receive this vital assurance (Beck et al., 2013). Thus, attachment style plays into important emotional processes and may influence physiological arousal during couple interactions (Gouin et al., 2009). In addition, couple conflict and the processes of physiological arousal are particularly interesting since the conversations elicit distress surrounding the attachment relationship itself, between the partners in the intimate adult relationship. Therefore, an individual's attachment style can influence various aspects of behavior during conflict, such as levels of rejection, criticism, and other negative interactions. In a similar way, stress responses elicited during couple conflict also vary depending on individual partner's style of attachment. This internal physiological feedback can be monitored through skin-conductance, heart rate, salivation, and other means of obtaining biofeedback.

Physiological arousal and avoidant attachment style. Avoidant strategies parallel emotional suppression, something that although reduces the outward expression of emotion, actually increases cardiovascular arousal because of the effort it takes to conceal feelings (Ben-Naim, Hirschberger, Ein-Dor, & Mikulincer, 2013; Seedall & Wampler, 2012). This reveals a repressive coping strategy in which negative feelings are avoided and therefore, reported feelings and actual emotional experience are incongruent (Seedall & Wampler, 2012). Research has indicated that avoidant attachment style is linked to higher physiological arousal as measured by skin conductance reactivity for both relational and individual distress (Diamond, Hicks, & Otter-Henderson, 2006; Gouin et al., 2009). Further, it has been revealed that greater increases in physiological arousal from baseline to couple interactions correlates with more negative reports of quality of marriage (Menchaca & Dehle, 2005). In one study, individuals that reported higher levels attachment avoidance had higher physiological arousal immediately after couple conflict (Gouin et al., 2009). In another study related to emotional processes and couple disagreement, cortisol responses to conflict resolution were associated with females' avoidant attachment style and males' anxious attachment style among young college couples (Gouin et al., 2009; Powers, Pietromonaco, Gunlicks, & Sayer, 2006). Other findings have revealed that individuals higher in avoidant attachment demonstrated a lack of congruence by reporting more positive feelings about their partner when physiologically distressed, whereas those low in attachment avoidance demonstrated greater congruence between what they reported and their physiological response (Seedall & Wampler, 2012).

Physiological arousal and anxious attachment style. Recent research has revealed that attachment insecurity, particularly anxious attachment style, is linked to higher cortisol levels or more irregular responses during relationship conflict (Beck et al., 2013). Men with anxious or avoidant partners had higher cortisol levels during discussion and slower recovery time afterwards (Beck et al., 2013; Powers et al., 2006). Couples in which the female was anxious and the male avoidant had higher levels of cortisol activity prior to conflict discussion, when compared to all other attachment style pairings (Beck et al., 2013). For instance, it is more difficult for anxious women to detect their avoidant partner's distress as detected through physiological measures (Beck et al., 2013). Couples in which both partners were secure had more stable recovery time and less reactivity during conflict discussion (Beck et al., 2013). So, although those higher in anxious attachment may become more physiologically distressed during conflict, they also paradoxically seek closeness and comfort by signaling their distress in an exaggerated way, something that may inevitably push their partner away during the process and create a frustrating cycle in which their anxious needs are continuously unsatisfied. Further, although studies have been done using skin conductance level and attachment, findings related to anxiety and physiology, particularly skin conductance, are less clear (Holland & Roisman, 2010).

Perceptions of Couple Conflict

In addition to conflict behaviors differing with regard to insecure versus secure individuals in romantic relationships, the way they perceive conflict may vary as well (Domingue & Mollen, 2009). Those with anxious attachment style are more likely to

perceive negative and less positive emotions during other couples interactions, as shown through facial expressions, potentially revealing their hypervigilance to signals of disapproval and potential abandonment from their partners (Domingue & Mollen, 2009; Wood, Werner-Wilson, Parker, & Perry, 2012). Avoidant spouses viewed themselves and their partners as less responsive overall during couple conflict discussion (Beck Pietromonaco, DeVito, Powers, & Boyle, 2014). This may represent the emotional repression, in which avoidant partners may view conflict as a threat, requiring them to get closer than they are comfortable with (Domingue & Mollen, 2009; Seedall & Wampler, 2012). In contrast, secure adults view their partners as responsive and dependable, making them more likely to view conflict discussion as a way to increase closeness and understanding (Domingue & Mollen, 2009).

Attachment in Couple Social Support Processes

Examining distressed couples during conflict reveals dysfunctional interactions, but it does not contribute to understanding how healthy couples interact when they are not fighting (Heyman, 2001). While couple conflict is an important aspect of relationship functioning, research is scant in the area of social support processes, or the manner in which partners support one another in personal areas of distress, and the implications of how support is received or provided (Pasch et al., 2002). Studying social support within the dynamics of couple interactions is important because although conflict will occur in all relationships, this may be minimal in contrast to the vast amount of daily interactions between partners that navigate the success or failure of these most intimate bonds. More

importantly, the functionality of attachment could play a vital role in unveiling the processes of support provision and reception in adult intimate relationships. Attachment posits that internal working models constructed when we are infants determine whether or not we can trust and depend on others for comfort and reassurance, such as is elicited during periods of personal distress. Therefore, social support processes could be a key component for uncovering important, but often overlooked, relationship dynamics in the context of attachment style (Pasch et al., 2002).

The provision and reception of support branches from roots of attachment theory in that humans' earliest interactions with their primary attachment figure determine whether they trust others to be dependable and responsive (Collins & Feeney, 2010). Just as infants depend on their caregivers to be a secure base in times when they need support, reassurance, and emotional soothing, adults turn to their intimate partners to gain this security as well (Beck et al., 2013; Bowlby, 1988). A parent as a secure base in infancy parallels the safe haven adults seek in times when external distress leads them to rely on intimate partners for support (Collins & Feeney, 2000). Attachment then shapes the social support processes, in which individuals have a predetermined basis of attachment that affects how they will signal, receive, provide, and respond to their partner's support or need of support.

Further, fear of rejection or abandonment as well as discomfort with closeness can influence the way we react and cope with distress (Collins & Feeney, 2004; Creasey, 2002; Domingue & Mollen, 2009; Gouin et al., 2009). In the function of social support, the source of distress is from one's personal issue or a romantic partner's personal issue,

potentially eliciting working models of attachment in the reception and provision of support. For example, in one study, researchers assigned a public speech task to support receivers in order to elicit personal distress (Collins & Feeney, 2004). Then, they randomly assigned artificial positive or negative notes from their partner. Those with insecure attachment style (defined as one standard deviation above the mean in anxiety and/or avoidance) viewed low support notes from partners as being more hurtful and having greater negative impact on them (Collins & Feeney, 2004). Further, those with insecure attachment that received low-supportive notes subjectively rated their partner's past behavior, before receiving the note, as less supportive when compared to secure individuals. With unaltered, genuine notes from partners, individuals with insecure attachment style rated notes as containing more negative content in comparison to the secure individuals (Collins & Feeney, 2004). Overall, the attachment style of individuals influenced their perceptions of their partners support behavior. Those with insecure attachment rated their partners' notes as more negative, and their behavior as less supportive.

Avoidant Attachment Style and Social Support

In previous studies regarding attachment and social support, avoidant attachment was correlated with ineffective support seeking, potentially indicating their fear of depending on others from attachment patterns formed in infancy in which they were unable to count on responsiveness to support bids from caregivers (Collins & Feeney, 2010; Davila & Kashy, 2009). Further, partners with avoidant attachment style are less likely to seek support in times of high stress (Collins & Feeney, 2010; Davila & Kashy,

2009). A study revealed that avoidant husbands were just as supportive as their secure counterparts when their wives were not distressed; however, they were consistently less supportive when their wives were distressed (Edelstein & Shaver, 2004). Interestingly, the avoidance of individuals increased over time as they sought less support and felt less supported, creating a cyclical effect (Davila & Kashy, 2009). In terms of support provision, partners with avoidant attachment have been found ineffective caregivers because the intimacy necessary for support processes may be uncomfortable and thus, they may miss the signals for their partners needs (Davila & Kashy, 2009).

Although this parallels other research in which avoidant individuals react less extremely after a breakup, they also found that these participants became more distressed than their secure counterparts when permanently separating from an attachment figure during divorce (Edelstein & Shaver, 2004). This may imply that some internal effort has been acquired in order to defend against unresponsive relating to partners, a coping strategy that often will defend their fear of vulnerability, but that cannot withstand the intensity of some stressors that may come up throughout their lives. For avoidant partners, it is also difficult to ask for assistance from partners and, when they do ask, they have more difficulty clearly communicating their needs (Beck et al., 2013). Research is still missing, however, in relation to avoidant attachment and the internal processes occurring during social support interactions as well as the perceptions of social support.

Anxious Attachment Style and Social Support

Those with insecure attachment styles respond less emotionally to support and sought support more indirectly than secure individuals (Beck et al., 2014). Individuals

with anxious attachment style were less likely to provide support during periods when their partners were ineffective support seekers (Beck et al., 2014). Individuals with anxious attachment style tend to use strategies to elicit their partner's attention involving clinging and controlling responses, such as begging or requesting to go places with a partner when typically gone to alone (Shaver & Mikulincer, 2012). Further, anxious individuals depend on indirect methods of seeking support making it less likely that partners will be able to receive the message and support them, such as sulking, whining, or pouting (Shaver & Mikulincer, 2012). For these anxiously attached individuals, studies have revealed lower support seeking activation, implying that fear of rejection and negative perception of others responsiveness may interfere with their ability to effectively seek support (Shaver & Mikulincer, 2012).

Attachment anxiety is correlated with higher distress, which creates an increase in seeking support from a partner in order to soothe and reassure the anxious individual. Interestingly, those higher in anxious attachment viewed partners as needing more support and according to their partners, provided less support when they needed it (Davila & Kashy, 2009; Feeney & Collins, 2001). Thus, these anxious partners were deemed ineffective caregivers, providing less support, responsiveness, and displaying more negative support behaviors (Collins & Feeney, 2000). Their inherent tendencies to fear abandonment or rejection may lead them to never feel fully satisfied with support received and feel ill equipped to handle partners' support needs in return.

Secure Attachment Style and Social Support

People with secure attachment reveal healthier support seeking, providing, and receiving (Davila & Kashy, 2009). In particular, secure individuals reported providing more support, seeking more support, and that partners sought more support as well (Davila & Kashy, 2009). In fact, those with higher levels of secure attachment provided support even when their partner sought support less clearly (Collins & Feeney, 2010). Secure attachment style also predicted more effective support seeking in times of distress as opposed to those with higher levels insecure attachment (Gouin et al., 2009). Further, participants' perceptions of support were influenced by attachment style and relationship quality, revealing an interaction between attachment and the processes by which couples support each other on a daily basis (Collins & Feeney, 2010). These secure partners also perceived greater support receipt (Davila & Kashy, 2009).

This evidence reveals that secure partners are better able to signal their need for support and feel more reassured and comforted by the support they receive. They also seem to be effective caregivers, reciprocally increasing their support provided when partner's report needing more support (Collins & Feeney, 2000; Davila & Kashy, 2009). Results of the effectiveness of social support in romantic partners can be found in basic attachment orientations. Secure partners have a history of receiving support from their caregiver, revealing less convoluted perceptions of actual support received, better ability to respond to partners' signals, and the ability to seek support when needed with assurance that it will be effectively provided to them.

Physiological Arousal and Social Support

Limited in quantity, the majority of studies on social support and attachment focus on observational coding and self-report measures of both attachment and social support (e.g., Beck et al., 2014; Collins & Feeney, 2000; Davila & Kashy, 2009). However, people often give self-report without insight into the physiological state of their bodies during these important encounters in intimate relationships. Therefore, within the context of support, self-report measures for both anxious and avoidantly attached individuals yield different results when compared to unconscious or physiological measures (Edelstein & Shaver, 2004; Shaver & Mikulincer, 2012).

Although studied in the context of couple conflict, internal arousal, and moment-to-moment responses of partners during social support interactions has yet to be examined (Seedall & Wampler, 2012). This may be a vital portion of understanding social support processes within an attachment lens since the outward manifestations of a secure or insecure individual may tell a very different story than the emotional processes occurring internally during their interactions. In therapy, this could help connect the therapist's understanding of attachment style with the internal processes occurring during couple interactions. Understanding the physiological state of the body can drastically change the insight we have into the person's experience in close relationships and eliminate the biases associated with self-reports and uncover what is unseen in interpersonal dynamics. One of the reasons for this is based in the idea that attachment may filter the emotional experience of an individual between what they actually feel and what they report they experienced. Therefore, further research is necessary in order to

delve into the perceptions of partner's support given and received as understood within the context of physiological arousal and its impacts on adult intimate relationships.

Purpose of the Current Study

In order to fully gauge the processes by which attachment plays a role in couple support interactions, attachment, perceptions of support received and provided, as well as physiological arousal were examined in the present study. Attachment style and perceptions of support were looked at in order to understand the relationship between attachment avoidance or anxiety and perceptions of the effectiveness and quality of support provided and received by partners. Further, this study is one of the first to explore the relationship between attachment avoidance and anxiety and psychophysiological experience during social support conversations. The specific questions I used to answer these questions were:

1. What is the relationship between attachment (avoidance and anxiety) and perceived social support (provided and received)?
2. What is the relationship between attachment (avoidance and anxiety) and psychophysiological experience during social support interaction?

These research questions helped unveil important relationship dynamics regarding the connection between attachment style and perceptions of social support. The provision and reception of support is applicable to the daily interactions of couples, which is an aspect that research on couple conflict may be missing. Further, understanding not only their perceptions, but also the internal emotional experience during the social support

interactions help clarify the connection of psychophysiology during these interactions in relation to attachment style. In addition, current research of heterosexual couples constitutes a distinguishing gender factor and research has revealed gender-distinct findings in regards to attachment style. Therefore, understanding differences between males and females as applied to social support interactions provide potential information about these relational dynamics in the context of gender.

CHAPTER III

METHODS

The current study on social support and attachment was conducted within the framework of a relationship checkup (Fleming & Cordova, 2012). The relationship checkup is a two-session intervention designed to enhance relationships and provide strengths-based assessment and feedback. However, for purposes of the current study, only surveys and data gathered from couples prior to and during the initial session of the checkup were used. The following will outline: (a) procedures for the relationship checkup; (b) recruitment of participants; (c) demographic variables; and (d) measures used in the current study.

Procedures

Overview of the Relationship Checkup

This study was conducted within the broader context of a relationship checkup procedure (see Fleming & Cordova, 2012, for an example). The process of participating in this study included filling out surveys, participating in an initial 2-hour relationship checkup, and a feedback session (which was not used for the purposes of the current study). The entire relationship checkup incorporated 9 stages (see Appendix B and C for an outline and protocol). For the current study of social support processes, attachment, and physiological arousal, we looked specifically at stages 1, 2, 4, and 5.

In stage 1, couples were required to fill out self-report assessments through an online system called Qualtrics prior to coming in for the relationship checkup. These

assessments include measures of: attachment, social support from family and friends, emotional and physical safety in their current relationship, as well as depression, anxiety, and stress. Once these were completed, couples would come in for the initial session of the relationship checkup, which was a 2-hour long process.

When the couple came in for the checkup, they were told an overview of the relationship checkup process and then were split up to determine if any physical violence is present in the relationship. During this separated time, partners were asked to think of a personal, rather than relational, aspect or topic they would like to change about themselves, priming them for stages 4 and 5 of the checkup. They ranked this topic on a scale of 1-10 in order to obtain a moderately distressing topic that will elicit activation of internal working models of attachment. However, topics above an 8 were discouraged in order to do no harm and for partners to feel comfortable with discussing the topic without feeling overwhelmingly distressed.

After this separated time, there was a 5-minute break in which the couple was instructed to wash their hands. This is done because the next stage involves hooking participants up to skin-conductance monitors in order to assess their physiological arousal during the series of couple interactions (Stages 2 through 8). Participants were then connected to a Biopac machine with wires connected to adhesive electrodes on the index and middle fingers of their nondominant hand, in order for them to still be able to fill out the social support self-report measures in between discussions. Physiological arousal was measured ten times per second using a digital biofeedback device called the GSR 100C Biopac with settings at 5.0 micromhos and 10 Hz (Seedall, 2011).

The relationship checkup then officially began and couples were asked to clear their minds while the therapist left the room for three minutes in order to obtain a physiological baseline (Stage 2). When the therapist re-entered the room, Stage 3 began, which incorporates oral interview questions, adapted from Gottman's Oral History Interview (Buehlman, Gottman, & Katz, 1992). At the conclusion of this 15- to 20-minute interview, a randomly selected partner was asked to begin talking about the issue they wanted to change about themselves and the couple engaged in this social support conversation for duration of 10 minutes (Stage 4). During this time, the therapist did not engage in the interaction but was there for assistance, if necessary.

After the first partner brought up their personal social support issue and the couple discussed it for 10 minutes, each partner was given a self-report assessment. The person who brought up their issue completed a questionnaire regarding how well they felt supported during the interaction (see Appendix D). The other partner completed a questionnaire on how well they felt they supported their partner during the interaction. Once this occurred, the other partner was asked to bring up their social support topic and engage in a conversation about it for 10 minutes (Stage 5). At the conclusion of this, they were given self-report measures again, this time switching provider and receiver of the partner support.

For stage 6, the couple discussed an area of conflict for 10 minutes. During Stage 7, the couple filled out a distraction task assessment, in which they ranked important areas of romantic relationships. During Stage 8, the therapist asked the couple a few final general interview questions regarding their relationship as well as their experience during

the session. Stage 9 occurred as a follow-up session 1-2 weeks later where the couple receives feedback on areas of strengths and areas for improvement in their relationship (For a detailed outline of the stages of the relationship checkup and the relationship checkup protocol, see Appendix B and C).

Training. Those therapists facilitating the relationship checkup with couple participants were marriage and family therapy (MFT) graduate students in Utah State University's MFT master's program. There were a total of 20 therapists that participated in the study by facilitating the relationship checkups, which consisted of 9 men and 11 women therapists. They were trained by researchers prior to facilitating a session and were given a step-by-step protocol (see Appendix C) to follow during the relationship checkup. They were also required to observe at least one full relationship checkup conducted by another therapist prior to being able to do one on their own. In addition, research assistants were trained in setting up and monitoring the Biopac skin-conductance software to ensure its veracity through the entire first session of the relationship checkup.

Recruitment and Sample

Participants recruited for the relationship checkup were those 18 years or older and in romantic relationships with no required relationship length. Further, cohabiting, dating, engaged, and married couples were all able to participate. The overall goal of recruitment was to gather a diverse sample from the community. Participants for this study were recruited through relationship checkup flyers and word of mouth (see Appendix A). The flyers contained information about what the relationship checkup

would provide, including: couple strengths, couple satisfaction, emotional cohesion, interactional patterns, as well as the $30 per person incentive provided for those who participate in the study. Flyers were handed out through the university (on campus child-care lab, university organization exposition) as well as locally in various locations including: religious establishments, laundry mats, restaurants, as well as online via www.craigslist.com and www.KSL.com (a local personal advertising website). The various recruitment methods were for purposes of gathering a diverse sample. In this sense, participants were both clinical referrals and non-clinical couples recruited from a wide variety of places in the community.

Initially, couples were able to participate no matter their couple satisfaction scores. However, in order to obtain a sample with greater variability in terms of satisfaction and dissatisfaction, a few months into the study, couples were screened out if both partners scored above the 104.5 cutoff, revealing they were satisfied according to the Couple Satisfaction Index (CSI; Funk & Rogge, 2007). These couples were still able to participate in the relationship checkup, but were not included for purposes of the current study. Additionally, those who reported intimate partner violence were screened out if physical violence occurred within the last three months, if it left a mark or required a hospital visit, or if partners did not feel safe to engage in couple discussions during the study.

Demographic Variables

Participants

A total of 102 couples expressed interest in this study. However, 50 couples (49.0%) actually participated in the study. Of the 52 couples (51.0%) not included, four couples (3.9%) still participated despite being screened out for their couple satisfaction scores. Two same-sex couples (1.96%; one homosexual and one lesbian) participated in the checkup but were not included in this study because of the dyadic data analyses in which gender is a distinguishing factor for analysis. Although future research should address same-sex couples, our research analyses unfortunately put limitations on including these couples in our study. In addition, 20 couples (19.6%) completed some or all of the surveys but never came in for the relationship checkup, and 21 couples (20.5%) called initially but then either decided they were not interested anymore or did not show up for the relationship checkup.

Participant Demographics

Demographic variables can be seen in Table 1a, 1b, and 1c. Participants had a mean age of 27.68 years (range: 18-55) and had been together between 4 months and 33 years (M = 4.90; SD = 5.42). Participants had between 0 and 9 children (M = 1.08; SD = 1.77). In terms of relationship status, 68 participants (68%) reported being in their first marriage, with 6 more participants (6%) reporting that they were in a later marriage, and 22 participants (22%) reporting that they were seriously dating, living together, or

engaged to be married. Additionally, there were 4 participants who did not respond to the relationship status question (4%).

With respect to race/ethnicity, the large majority of participants identified as Caucasian or white (*n* = 89; 89%). Other racial/ethnic identities represented were American Indian/Alaska Native (*n* = 1; 1%), Asian/Pacific Islander (*n* = 4; 4%), Mexican-American/Hispanic (*n* = 3; 3%), Middle Eastern (*n* = 1; 1%), Biracial (*n* = 1; 1%), and "Other" (*n* = 1, 1%). For religious identification, 75 participants (75%) identified as some Christian denomination, while 25 (25%) identified as non-Christian (whether religious or nonreligious). The range of the demographic in terms of self-identification of religiosity included: Jewish, Lutheran, Latter-day Saint, None, Non-denominational, and Spiritual. In terms of sexual orientation, 96 participants (96%) identified as heterosexual, 3 (3%) identified as bisexual, and 1 (1%) indicated being polyamorous. For employment status, 35 (35%) reported being employed full-time, 31 (31%) part-time, 19 (19%) as students, 14 (14%) as homemakers, and 1 (1%) as unemployed. Fifty-six participants identified as being in the bracket below $30,000 per year. Forty-two participants reported being $30,000 or above in terms of annual household income. For the purposes of analyses, some of the demographic variables were dichotomized, such as: religion, race, and income (see Table 1c). Further, other variables such as education were altered for analyses into four categories: High School/Some College, Bachelor's Degree, Advanced Degree, and Other.

Table 1a

Summary of Demographic Characteristics of the Sample

Variable name	n (%)
Relationship status	
Living together	9 (9)
Engaged to be married	5 (5)
Married, first marriage	68 (68)
Married, later marriage (Widowed, Divorced)	6 (6)
Dating	8 (8)
Missing	4 (4)
TOTAL	100
Number of children	
No children	55 (55)
1-3 children	31 (31)
>3 children	14 (14)
TOTAL	100
Education Level	
High school or equivalent	6 (6)
Vocational/technical school (2 year)	2 (2)
Some college	41 (41)
College graduate (4 year)	36 (36)
Master's degree (MS)	10 (10)
Doctoral degree (PhD)	4 (4)
Other	1 (1)
TOTAL	100
Employment status	
Employed full-time	35 (35)
Employed part-time	31 (31)
Unemployed	1 (1)
Homemaker	14 (14)
Student	19 (19)
Retired	0 (0)
TOTAL	100
Household income	
Under $10,000	22 (22)
$10,000 - $19,999	23 (23)
$20,000 - $29,999	11 (11)

(*table continues*)

$30,000 - $39,999	15 (15)
$40,000 - $49,999	9 (9)
$50,000 - $74,999	10 (10)
$75,000 - $99,999	3 (3)
$100,000 - $150,000	3 (3)
Over $150,000	2 (2)
Missing	2 (2)
TOTAL	100
Religion	
Catholic	3(3)
Protestant	3(3)
Latter-day Saint (Mormon)	67 (67)
Jewish	1 (1)
Lutheran	1 (1)
Non-denom. Christian	1 (1)
Spiritual	1 (1)
Humanist	1 (1)
Other	1 (1)
None	21 (21)
TOTAL	100
Race/Ethnicity	
American Indian or Alaska Native	1 (1)
Asian or Pacific Islander	4 (4)
Caucasian/White	89 (89)
Mexican-American/Hispanic	3 (3)
Biracial	1 (1)
Middle Eastern	1 (1)
Other	1 (1)
TOTAL	100
Sexual Orientation	
Heterosexual	96 (96)
Bisexual	3 (3)
Polyamorous	1 (1)
TOTAL	100

Table 1b

Summary of Demographic Characteristics of the Sample by Gender

	Males		Females	
	M	*SD*	*M*	*SD*
Age (years)	28.82	7.59	26.54	7.19

Table 1c

Summary of Categorical Characteristics of the Sample by Gender

	Males (%)	Females (%)
Education level		
High school/some college	50	48
Bachelor's degree	32	40
Advanced degree	18	10
Other	0	2
Employment status		
Employed full-time	46	24
Employed part-time	32	30
Unemployed	0	2
Homemaker	2	26
Student	20	18
Household income		
Under $30,000	54	58
Over $30,000	44	40
Religion		
Christian	72	78
Non-Christian	28	22
Race/Ethnicity		
Caucasian	88	98
Non-White/Minority	12	2
Marital Satisfaction (CSI)		
Dissatisfied	44	56
Satisfied	56	44

Measures

Prior to the relationship checkup, partners were required to fill out self-report questionnaires to measure couple satisfaction, attachment, feelings of social support from family, friends, and a special person, emotional and physical safety in their current relationship, as well as depression, anxiety, and stress. Additionally a measure was used during the relationship checkup procedure to assess the perceptions of partner social support based on the in-session conversations.

Attachment

To measure attachment, the Experiences in Close Relationships Scale (ECR) was used and participants were required to fill it out online prior to coming in for the checkup (Brennan et al., 1998). The scale consists of 36 questions, with 18 items measuring anxious attachment style and the other 18 measuring avoidant attachment style. The questions regarding anxiety include those like “I fear being rejected or abandoned” and “I worry about being alone.” The avoidant questions include “I get uncomfortable when someone wants to get very close to me” and “I try to avoid getting close to others.” All of the items on the questionnaire are measured using a 1-7 Likert scale with 1 being “disagree strongly” and 7 being “agree strongly.” Since attachment style is a large component of our study’s research questions, this measure will be useful in determining participants’ attachment styles so that we can test our hypotheses. Further, studies have revealed high levels of internal consistencies for this measure in samples of graduate students with coefficient alphas ranges .89 to .92 for the anxiety subscale and .91 to .95

for the avoidance subscale (Brennan et al., 1998; Wei, Russell, Mallinckrodt, & Vogel, 2007). Test-retest reliability was also revealed as .70 for both subscales of anxiety and avoidance (Brennan, Shaver, & Clark, 2000). In the current study, the total reliability total for this scale was .92, while the subscale for avoidance and anxiety were .90 and .93, respectively (see Table 2). The mean for avoidance was 3.13 with anxiety being 3.84. Additionally, the standard deviations for avoidance and anxiety were .93 and 1.18.

Table 2

Psychometric Properties of Predictor Variables and Covariates

Variable name	*n*	*M*	*SD*	α	Range	
					Potential	Actual
Attachment avoidance	100	3.13	.93	.90	1.00 – 7.00	1.28-5.11
Attachment anxiety	100	3.84	1.18	.93	1.00 – 7.00	1.72-6.61
Couple support scale (self)	99	61.12	10.95	.90	11.0-77.0	30.0-77.0
Couple support scale (partner)	100	55.33	7.94	.80	10.0-70.0	29.0-70.0
Couple satisfaction index	100	103.01	32.11	.98	0-161.0	46.0-159.0
MSPSS	100	63.8	10.87	.91	12.0-84.0	15.0-84.0
DASS21 Total	100	15.07	11.06	.93	0-63.0	1.0-55.0
Depression subscale	100	5.02	4.69	.90	0-21.0	0-21.0
Anxiety subscale	100	3.02	3.74	.85	0-21.0	0-18.0
Stress subscale	100	7.03	3.96	.81	0-21.0	0-20.0
Intimate justice scale	100	35.55	11.67	.90	15.0-75.0	15.0-64.0

Couple Support

The Couple Support Scale (CSS) is a 13-item measure developed for the purposes of this study since there is not a known self-report measure of partner support in the research literature (see Appendix D). Two forms of the scale were developed with the only change between them being whether the person filling it out was the support provider or receiver. One form of the measure (CSS-Self; CSS-S) is used to assess how well a partner felt supported on their personal issue, while the other is used to assess how well an individual felt they supported their partner (CSS-Partner; CSS-P). The CSS was created based on the Social Support Interaction Coding System (SSICS) developed by Bradbury and Pasch (1997). In this observational coding system, coders were trained to examine couples in four different areas of couple social support: positive or negative emotional and instrumental support as well as support that is off-task or distracting. In the Couple Support Scale (CSS), items on the self-report measure parallel each of these categories. For example, instrumental support represents giving advice, and a question on the CSS examining this is “my partner suggested ways to solve the issue.” An example of emotional support on the scale is “my partner helped me express and/or clarify my feelings.” For off-task, a question includes: “my partner tried to distract me by talking about unrelated things.” These items represent face validity of the measure because they reveal aspects of partner social support (see Appendix D).

Factor analysis of CSS. Because the Couple Support Scale was developed for the purposes of this study, we did a more extensive process using factor analyses to examine the content validity of the measure. First, we looked at the reliability and determined the

reliability of both versions of the scale with all 13 items. Cronbach's alpha was acceptable for both the CSS-S (.90) and the CSS-P (.80). We then examined the factor structure of both versions using exploratory factor analysis. Factors were rotated using the Promax rotation method with Kaiser normalization, an orthogonal rotation that allows small correlation between factors in order to maximize fit (Tabachnick & Fidell, 2007).

For the CSS-S, two factors were extracted and their loadings rotated, accounting for 57.5% of the total variance (factor 1 = 45.6% and factor 2 = 11.9%) and with an inter-factor correlation of .53. The reliability for the items that made up factor 1 was .88, which included items: 2, 4, 5, 7, 8, 10, 11, and 13. After looking further at the content of these items, they seemed to be related to more positively themed support questions. The reliability for the items that made up factor 2 was .79, which included items: 1, 3, 6, 9, and 12. These items seemed to be more negative reaction support questions, which were reverse coded on the scale.

For the CSS-P, four factors were extracted and their loadings rotated accounting for 67.3% of the total variance (factor 1 = 34.5%, factor 2 = 13.3%, factor 3 = 11.6%, factor 4 = 7.9%). Once rotated, inter-factor correlations ranged from .21 (factors 2 and 4), to .56 (factors 1 and 3) with an overall mean of .36 (*SD* = .13). The identified four-factor structure of this partner scale was somewhat different than the two-factor structure of the CSS self-version. Factors 1 and 3 were more related to a combination of positive instrumental and positive emotional support, while factor 2 demonstrated negative support themes. Factor 4 was more ambiguous, representing both positive mood and off-task support items (Pasch et al., 2002). Cronbach's alpha for factor 1 was .81, which

included items: 3, 6, and 7. The reliability for factor 2 was .75, which were tentatively more negative support items, including: 2, 8, 10, and 13. Factor 3 had a reliability of .72, which included item numbers 1 and 9. The reliability of factor 4 was negative due to a negative average covariance among items, which violates the reliability assumption model. This fourth factor included items: 5, 11, and 12.

Because of this violation, it led us to reevaluate and look more closely at the items for both the CSS-S and CSS-P. There was naturally a lot of overlap between the self and partner support scales in our effort to create congruence in the two versions of social support. In looking more closely at the conceptual idea of social support, we found that items 5 and 12 of the partner scale seemed to represent distraction. Although conceptually important items, they could be construed either positively or negatively, depending upon interpretation. As a result, we opted to remove these items from the measure. These items on the partner version called into question whether they were conceptually clear aspects of social support. So, to improve factor structure and reliability of partner version, but also to create uniformity with the self-version, we opted to take these items out of both scales. Further, in reviewing the rest of the items, there was an additional question regarding understanding (question number 9 on the partner-version), which seemed unclear conceptually. The item read: “I felt like I understood my partner,” which made us less confident about the wording of this item and whether it was tapping into social support rather than cognitive understanding of one’s partner. However, on the self-version it read differently, “My partner understood me and my issue,” which may conceptually be tapping into social support of the issue. So, we opted to remove this item

from only the partner version since the wording on it seemed unclear, but left it in the self-version.

New Scales

Self. For the CSS-S, the new revised scale included items: 2, 3, 4, 5, 6, 7, 8, 9, 10, 12, and 13. The reliability of the new 11-item scale was .90, which did not diminish the integrity; in fact it was the same reliability as prior. We removed the two items from the self-scale in order to maintain uniformity of the CSS measure. The new 11-item version yielded 2 factors again that were extracted and loading rotated, accounting for 60.6% of variance (factor 1 = 49.7%, and factor 2 = 10.9%), with an inter-factor correlation of .59, (see Table 3a). The reliability for factor 1 was .87, and included items: 2, 4, 5, 7, 8, 10, and 13. Similar to before, factor 1 items were positively themed. The second factor, items 3, 6, 9, and 12, had a Cronbach alpha of .79. These items also remained negatively themed.

Partner. The new 10-item scale for partner social support included items: 1, 2, 3, 4, 6, 7, 8, 10, 11, and 13. The Cronbach's alpha of the total scale was .82, which represented a slight improvement over the previous 13-item scale. After running the factor analysis for this partner version, the scale yielded two factors extracted and loading rotated, which accounted for 55.9% of variance (factor 1 = 39.6% and factor 2 = 16.3%), with an inter-factor correlation of .38 (see Table 3b). The reliability for factor 1 was .82, which still included positively emotional and instrumental themed support items: 1, 3, 4, 6, 7, and 11. The second factor had a Cronbach's alpha of .71, which included primarily negative support items, with only one exception: "I was warm and affectionate towards

my partner." This item loaded on both, and only slightly more on the second factor (factor 1 was .44; factor 2 was .53); however because it fit so well conceptually on factor one, we placed it on factor 1. The final items included on factor 2 were: 2, 8, and 10. Although the second factor's reliability of .71 is below standard cutoff for moderate reliability (typically .80), we felt the conceptual clarity that it provided was acceptable. Although we only used the total scores for both the CSS-S and CSS-P in our analyses, we felt like our examination of the factors and their internal consistencies provided ample evidence that these measures were psychometrically sound, reliable, and valid representations of social support received and provided.

Skin Conductance

Participants were connected to skin-conductance monitors during the phase of the relationship checkup including the baseline and social support conversations. Skin conductance is also called galvanic response and is a valid measure for determining the internal processes via instant sweat response feedback (Hempel et al., 2005; Seedall, 2011). It is useful as an accurate measure of the sympathetic division of the autonomic nervous system, the predominant mediator of sweat glands (Dawson, Schell, & Filion, 2007). While measuring heart rate, the parasympathetic nervous system is also activated, which measures resting and active periods as opposed to emotional arousal (Seedall, 2011). With skin conductance, however, the sympathetic nervous system is solely activated, making it a good indicator of internal moment-to-moment emotional arousal, uninfluenced by physical activity (Seedall, 2011). Further, skin conductance is also a fairly unobtrusive measure in comparison to other physiological methods, such as heart

rate or blood pressure. In order for skin conductance to be a good indicator of distress across participants during the social support conversations, the averages were residualized, meaning adjusted according to their baselines in order to be accurately compared across participants (Seedall, 2011). However, a total of 6 baselines were missing from our final analyses due to technological problems (n = 6; 6%), as well as 4

Table 3a

Pattern Matrix for 11-item Couple Support Scale-Self

Item	Component	
	1	2
CSS-Self #2: "My partner gave me constructive feedback"	**.728**	.210
CSS-Self #3: "My partner seemed withdrawn, bored, and/or distant"	-.391	**.976**
CSS-Self #4: "My partner suggested ways to solve the issue"	**.663**	-.105
CSS-Self #5: "My partner understood me and my issue"	**.634**	.159
CSS-Self #6: "My partner seemed defensive"	.259	**.648**
CSS-Self #7: "My partner seemed interested in and responsive to what I had to say"	**.503**	.281
CSS-Self #8: "My partner helped me express and/or clarify my feelings"	**.908**	-.217
CSS-Self #9: "My partner seemed annoyed with and/or critical towards me"	.257	**.628**
CSS-Self #10: "My partner My partner tried to make me feel better about myself"	**.857**	-.132
CSS-Self #12: "My partner seemed overwhelmed by what I was saying"	.082	**.723**
CSS-Self #13 "My partner was warm and affectionate towards me"	**.730**	.119

Table 3b

Pattern Matrix for 10-item Couple Support Scale-Partner

Item	Component	
	1	2
CSS-Partner #1: "I was interested in and responsive to what my partner had to say"	**.564**	.134
CSS-Partner #2: "I found myself feeling defensive"	-.154	**.816**
CSS-Partner #3: "I gave my partner constructive feedback"	**.929**	-.248
CSS-Partner #4: "I helped my partner express his/her thoughts"	**.613**	.005
CSS-Partner #6: "I suggested ways that my partner could solve the issue"	**.764**	-.164
CSS-Partner #7: "I was supportive and encouraging towards my partner"	**.797**	.182
CSS-Partner #8: "I found myself annoyed with and/or critical towards my partner"	-.148	**.925**
CSS-Partner #10: "I found myself feeling withdrawn, bored, and/or distant"	.171	**.586**
CSS-Partner #11: "I tried to help my partner feel better about himself/herself"	**.402**	.255
CSS-Partner #13: "I was warm and affectionate towards my partner"	.443	**.525**

Table 4

Descriptive Statistics for Physiological Arousal

Variable Name	*n*	*M (SD)*
Relaxation baseline	94	6.72(3.08)
Social support conversation		
Self (own issue)	96	8.98(3.41)
Other (partner issue)	96	8.86(3.26)

(4%) self and 4 (4%) partner support conversations. Due to the residualizing required for using skin-conductance, all six participants with missing baselines were not used for psychophysiological analyses. However, multilevel modeling was a useful approach for missing data because it uses pairwise rather than listwise deletion, therefore minimizing the loss of data.

Covariates

In addition to the Couple Support Scales and the Experiences in Close Relationships Scale, there are other self-report measures that were controlled for in the current study. The Depression and Anxiety Scale as well as the Couple Satisfaction Index were both used as covariates. Additionally, the Intimate Justice Scale and the Multidimensional Scale of Perceived Social Support were used.

Depression, anxiety, and stress. The Depression, Anxiety, and Stress Scale (DASS21) is a questionnaire with 21 items looking at an individual's level of recent depressive, anxious, and stress-related symptoms (Lovibond & Lovibond, 1995). The measure produces an overall score, but typically the three subscales of depression, anxiety, and stress are utilized separately. Some of the questions measuring depression were "I felt that I had nothing to look forward to" and "I felt down-hearted and blue." Anxiety related questions included: "I felt that I was using a lot of nervous energy" and "I felt I was close to panic." Questions assessing stress were those such as "I found it difficult to relax" and "I was intolerant of anything that kept me from getting on with what I was doing." The Likert scale from 1-4 started with "did not apply to me at all" to "applied to me most of the time," in reference to feelings over the past week. The

Cronbach's alpha, which measures internal consistency, for the DASS21 scores for this study were all considered high and acceptable for the purpose of this study. The total DASS21 score for this study was .93. Further, the subscale of depression was .90, anxiety was .85, and stress was .81.

Couple satisfaction. The 32-item Couple Satisfaction Index (CSI) was given to participants prior to coming in for the relationship checkup (Funk & Rogge, 2007). This measure assesses partner's satisfaction with their current romantic relationship. Along with asking the general question of how happy they are in their relationship, there are questions such as "How often do you and your partner have fun together" and "How well does your partner meets your needs?" The cut-off score for dissatisfaction is 104.5, with those above categorized as satisfied. At first, this measure was given to everyone that wanted to participate. Later, this measure was used as a screening tool to assess qualification for the study based on variability of satisfied and unsatisfied couples. The Cronbach's alpha for the CSI in our study was .98, which reveals relatively high internal consistency. This is comparable to the average Chronbach's alpha of .94 over multiple studies using meta-analysis (Graham, Diebels, & Barnow, 2011).

Emotional and physical safety. In addition to depression, anxiety, stress, and couple satisfaction, the Intimate Justice Scale (IJS) was used as a covariate for purposes of this study (Jory, 2004). This measure was designed to evaluate emotional and physical safety in couple relationships. The Cronbach's alpha for this measure was high in the current study at .90.

Social support. We also used the Multidimensional Scale of Perceived Social Support (MSPSS), which measures overall social support from others, which is different than the partner social support we specifically examined for this study (Zimet, Dahlem, Zimet, & Farley, 1988). In fact, it measures not only the support from a special person, but also family and friends. Cronbach's alpha for the MSPSS was .91, which reflects a high internal consistency acceptable for the purposes of this study.

CHAPTER IV

RESULTS

The overall purpose of this study was to examine romantic relationships and attachment-related dynamics within the context of social support interactions. Although many studies have looked at couple dynamics within conflict interactions, few have looked closely at other romantic relationship interactions, such as supporting a partner during a non-relational issue. In order to examine these interactions we used a framework of attachment style, looked at psychophysiological arousal during support conversations, and perceptions of support provided and received within partner dyads. The following outline will provide a deeper look into the general approach used to analyze the data, preliminary analyses used to organize and structure data, and finally, the statistical analyses that reveal answers to the primary research questions.

General Approach to Data Analysis

For the general analyses of the study, the primary approach was dyadic data analysis (Kenny, Kashy, & Cook, 2006). Since partners in couples are inherently related to one another, dyadic analysis was used, as it incorporates potential influence of couples by examining partner and actor effects (Kenny et al., 2006). Dyadic data analysis provides a way to analyze data that are inter-related, rather than traditional analyses in which participant scores are assumed to be independent of one another. Discounting the partner effects of the participant data can increase the likelihood of Type I or II errors in the results and, therefore, should not be used for analyses such as the study of romantic

partners (Kenny et al., 2006). Dyadic data analysis combats this by taking into account the potential mutual influence partners have on each other's relationship outcomes (Kenny et al., 2006).

Within the structure of dyadic data analysis, several models exist, including the actor-partner interdependence model (APIM; Kenny et al., 2006). This model allows for mixed-variables within and between dyads while taking into effect how much a participant's partner contributes to outcome variables (partner effects). Therefore, APIM can be used in order to determine the role of mutual influence in terms of individual outcome variables (Kenny et al., 2006). As a result, APIM not only allowed us to examine how Partner A's attachment related to his/her own feelings of social support but also how it related to Partner B's feelings of support. In this manner, the APIM allowed us to explore these relationships in a richer, more complete way (see Figure 1 for the general model layout).

Preliminary Analyses

Missing data. Missing data was a relatively minor problem for the demographics and self-report measures. There were .55 % of answers missing out of the 11 demographic variables (4 missing: relationship status; income: 2 missing). The only other missing data of self-reports was from the CSS Self-version in which one item was missing from one questionnaire and, therefore, could not be used. There were a few problems with the biofeedback and six participants' baseline skin conductance was

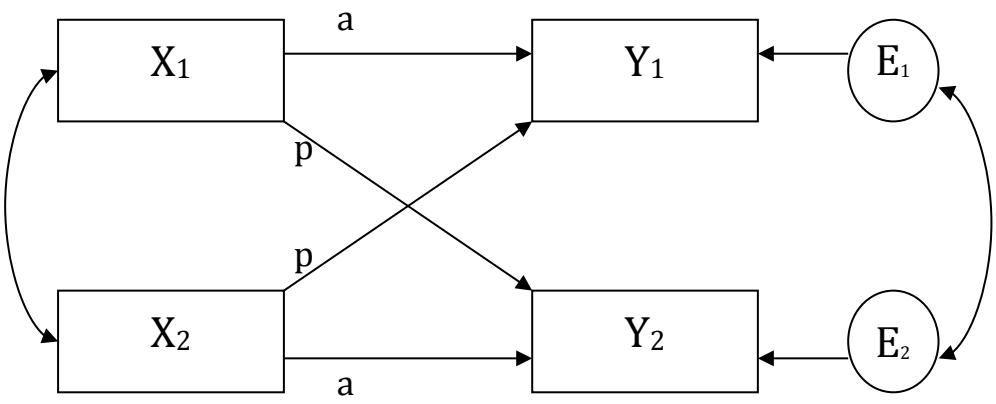

Figure 1. The Actor-Partner Interdependence Model (APIM; Kenny et al., 2006).

missing from the data of a hundred participants (6% of total biofeedback missing). Four participants' biofeedback was missing from both the self and partner social support issue. Because of the missing baselines, six participants' physiology could not be used in terms of data analysis. Therefore, 94% of all participant data could be used in the final analyses for purposes of answering the research questions. However, by using multilevel modeling, pairwise versus listwise deletion was used, optimizing the amount of biofeedback we were able to use from participants.

Predictor variables. During preliminary analysis, bivariate correlations were examined between attachment avoidance and anxiety from the ECR measure and other covariates in the study (see Table 5). Attachment anxiety and avoidance were positively

correlated at $r = .24$, $p < .05$, which is slightly higher than previous studies using the experiences in close relationships scale (Seedall, 2011). Attachment anxiety and avoidance were both negatively correlated with general feelings of social support from family, friends, and a special person (MSPSS): $r = -.49$, $p < .001$ for avoidance and $r = -.34$, $p < .001$ for anxiety. They were also negatively correlated with couple satisfaction (CSI): $r = -.28$, $p < .01$ for avoidance and $r = -.36$, $p < .001$ for attachment anxiety. Attachment anxiety and avoidance were also positively correlated with the intimate justice scale (IJS): $r = .27$, $p < .01$ for avoidance and $r = .29$, $p < .01$ for anxiety. The depression, anxiety, and stress subscales (DASS21) were also positively correlated with avoidant and anxious attachment. Depression and avoidance: $r = .29$, $p < .01$; Anxiety and avoidance: $r = .21$, $p < .05$; Stress and avoidance: $r = .23$, $p < .05$. Depression and anxious attachment: $r = .45$, $p < .001$; Anxiety and anxious attachment: $r = .50$, $p < .001$; and stress and anxious attachment: $r = .48$, $p < .001$. In all, relationships between variables were in the expected direction.

Outcome variables. Although skin conductance is a very useful measure of psychophysiological arousal in the form of sympathetic nervous system activity, there is typically some individual and environmental variation in skin conductance scores. Because of this, it was important to residualize the skin conductance data (Diamond et al., 2006). This was accomplished in two steps. First, we calculated difference scores for skin conductance by subtracting skin conductance scores during a relaxation baseline from skin conductance scores during each social support task. We then included (and thus controlled for) the average skin conductance level during the relaxation baseline in all

Table 5

Bivariate Correlations for Predictor Variables and Covariates

	ECR Avoidance	ECR Anxiety
ECR Avoidance	--	--
ECR Anxiety	.24*	--
Relationship Status	-.24*	-.09
Religion	.26**	.22*
Social Support	-.49***	-.34***
Couple Satisfaction	-.28**	-.36***
Intimate Justice Scale	.27**	.29**
DASS		
Depression	.29**	.45***
Anxiety	.21*	.50***
Stress	.23*	.48***

*$p \leq .05$, **$p \leq .01$, ***$p \leq .001$

analyses involving psychophysiological arousal.

Dyadic data preparation. In order to prepare for dyadic data analysis, a pairwise data set was made in which both males and females were included as actors and partners to coincide with the Actor-Partner Interdependence Model (APIM; Kenny et al., 2006). Categorical variables were coded (e.g., men coded -.5 and women .5), and all continuous variables of the self-reported measures were grand mean centered (Kenny et al., 2006). In addition, bivariate correlations for men and women and between men and women were calculated (see Table 6). All correlations between men and women were small, with one

Table 6

Bivariate Correlations for Demographic and Covariate Variables

	1	2	3	4	5	6	7	8	9	10	11
Attachment avoidance (1)	-.03	.20	-.48**	-.40**	-.29*	.29*	.13	.17	-.23	-.33*	-.05
Attachment anxiety (2)	.30*	.30**	-.19	-.07	-.37**	.42**	.42**	.43**	.14	.11	-.04
Couple support scale-self (3)	-.23	-.09	.07	.59**	.32*	-.03	-.04	.09	.27	.27	-.14
Couple support scale-partner (4)	-.14	-.17	.60**	-.00	.35*	-.14	-.22	-.18	.22	.34*	-.10
Couple satisfaction index (5)	-.27	-.33*	.14	.20	-.11	-.54**	-.36**	-.48**	.10	.07	.14
DASS 21 Dep (6)	.31*	.43**	-.19	-.17	-.33*	.17	.56**	.69**	.18	.19	-.00
DASS 21 Anxiety (7)	.27	.51**	-.23	-.18	-.26	.69**	.20*	.71**	.16	.07	.07
DASS 21 Stress (8)	.31*	.45**	-.23	-.10	-.27	.71**	.74**	.22*	-.25*	-.36**	-.15
Skin conductance- self (9)	-.15	-.19	.09	.10	.15	-.15	-.14	-.07	.00	.84**	-.06
Skin conductance- partner (10)	-.03	-.11	.06	.12	.14	-.16	-.12	-.07	.91**	.13	-.01
Relationship length (11)	.03	-.29*	-.13	.07	-.13	.05	-.20	-.09	-.07	-.09	.01

Upper-right cells—Correlations between variables for men
Lower-left cells – Correlations between variables for women
Trace—Correlations between men and women

*$p \leq .05$, **$p \leq .01$

approaching a medium effect size ($r = .30$ at $p < .01$), which was attachment anxiety between men and women.

Decision process for analysis. As is customary within the APIM, gender was used as a distinguishing dichotomous variable in our data analyses. Our general strategy was that, if there were interactions or main effects involving gender that did not at least approach significance ($p < .10$), we would conduct a deviance test in order to examine whether the additional complexity of gender was justified as a distinguishing variable (Seedall, 2011). However, a gender main effect or interaction approached significance in each of our analyses, meaning that we retained it as a distinguishing variable in all analyses.

In addition to the dichotomous variable of gender, continuous variables that were not significant were removed in order to control for noise that was not directly applicable to the interactions of attachment style and the couple support scales mentioned previously. If significant interactions in the initial analyses involved both ECR scores and gender, post hoc analysis was conducted in order to determine the "high" and "low" dimensions of attachment anxiety and avoidance as well as the category of men and women, separately. Simple slope of the regression line was then uncovered in terms of significance in direct relation to the initial analysis (Seedall, 2011).

Research Questions and Their Analyses

Research question 1: What is the relationship between attachment (avoidance and anxiety) and perceived social support (provided and received)?

Perceived social support received. The overall goal for this research question was to understand the relationship between attachment and intimate partner support. For this first research question, dyadic data analysis was conducted in two analyses.

When examining perceived support received, there was no significant main effect for gender or any gender interactions. There was also not a significant main effect for actor anxiety, b = -.02, t(73.7) = -.02, p = .98, or partner anxiety, b = .70, t(75.8) = .69, p = .49, with respect to feeling supported. There was, however, a significant main effect of actor avoidance (the partner who was talking about their own issue) on feelings of support, b =-3.81, t(85.1) = -3.22, p < .01, with those higher in avoidance feeling less supported. Additionally, there was a significant main effect for partner avoidance and feeling supported, b = -2.38, t(87.3) = -2.02, p = .05, with partners of those higher in avoidance also feeling less supported.

Perceived social support provided. In terms of perceptions about support provided, there was no statistically significant gender main effect or interaction. There were also no significant main effects for actor anxiety, b = -.42, t(66.87) = -.52, p = .60, or partner anxiety b = -.28, t(67.29) = -.34, p = .73. We did find a significant main effect for actor avoidance, b = -2.07, t(81.33) = -2.15, p < .05, meaning those higher in avoidance reported providing less support. However, there were no partner effects for avoidance, b = -.49, t(81.87) = -.47, p = .64.

Research question 2: What is the relationship between attachment (avoidance and anxiety) and psychophysiological experience during social support interaction?

Physiological experience during own support issue. For this research question, we examined the psychophysiological arousal measured from the skin conductance monitor during the social support discussions. For physiological arousal of the person discussing their own issue and receiving support, there were no significant main effects or interaction for actor avoidance, $b = -.16$, $t(73.01) = -.75$, $p = .46$, or partner avoidance, $b = .18$, $t(69.60) = .78$, $p = .44$, (see Table 9a). In terms of demographic variables and covariates, there was a significant main effect for income, $b = -1.10$, $t(49.95) = -3.16$, $p < .001$, with those lower in income more likely to experience distress when discussing their issue.

Table 7

Estimates of Fixed Effects for Couple Support Scale-Self Version

	b	*SE*	*df*	*t*	Sig.
Gender (A)	2.13	1.79	44.4	1.19	.24
Avoidance (A)	-3.81**	1.18	85.1	-3.22	.002
Avoidance (P)	-2.38*	1.18	87.3	-2.02	.05
Anxiety (A)	-.02	1.0	73.7	-.02	.98
Anxiety (P)	.70	1.01	75.8	.69	.49
Gender* avoidance(A)	3.65	2.54	69.9	1.44	.16
Gender* avoidance(P)	-4.27	2.53	70.9	-1.69	.10
Gender* anxiety(A)	1.76	1.91	83.8	.92	.36
Gender* anxiety(P)	2.59	1.93	85.6	1.34	.18

Note. The following were removed from the final analysis because of non-significance: age, race, relationship status, income, MSPSS, CSI, IJS, and DASS21.

*$p \leq .05$, ** $p \leq .01$, *** $p \leq .001$

Table 8

Estimates of Fixed Effects for Couple Support Scale-Partner Version

	b	*SE*	*df*	*t*	Sig.
Gender (A)	-.13	1.39	41.79	-.09	.93
Relationship status (A)	-3.81	2.34	49.13	-1.63	.11
MSPSS (P)	.08	.09	75.71	.95	.35
Avoidance (A)	-2.07*	.96	81.33	-2.15	.034
Avoidance (P)	-.49	1.04	81.87	-.47	.64
Anxiety (A)	-.42	.80	66.87	-.52	.60
Anxiety (P)	-.28	.82	67.29	-.34	.73
Gender* avoidance(A)	2.88	2.06	67.94	1.40	.17
Gender* avoidance(P)	-.53	2.01	64.36	-.26	.79
Gender* anxiety(A)	-1.40	1.53	80.61	-.91	.36
Gender* anxiety(P)	.89	1.51	78.49	.59	.56

Note. The following were removed from the final analysis because of non-significance: age, race, income, CSI, IJS, and DASS21.

*$p \leq .05$, ** $p \leq .01$, *** $p \leq .001$

With respect to attachment anxiety, there was a significant interaction between actor anxiety and gender, $b = -.73$, $t(75.68) = -2.29$, $p < .05$. Post Hoc simple slopes analyses helped us understand these relationships further. We were able to delineate the males and females in order to determine what significant interactions occurred in terms of

gender and avoidant attachment style during the "self" issue (receiving support from their partner). After following through with Post Hoc simple slope analyses, there was a significant interaction between female participants and anxious attachment style: b = -.51, $t(92)$ = -2.40, $p < .05$ (see Table 9b). This implies that while discussing their own issue, for women, those with higher anxious attachment scores had lower physiological arousal during the discussion of their own issue. However, it was not significant for male participants and anxious attachment: b = .23, $t(92)$ = 1.13, p = .26. Additionally, for women and attachment anxiety of the partner, it was not significant: b = -.29, $t(92)$ = -1.25, p = .22; and for men it was not significant: b = .05, $t(92)$ = .25, p = .80.

Physiological experience during partner's support issue. For the next portion of research question number two, we analyzed the physiological arousal of participants when providing support during their partner's issue. There were no significant main effects for actor anxiety, b = .06, $t(73.33)$ = .36, p = .72, or partner anxiety, b = -.20, $t(65.27)$ = -1.25, p = .22. Again there was a significant main effect of income on psychophysiological arousal, b = -.96, $t(50.29)$ = -2.89 $p \leq .01$, with lower participant income associated with higher distress. There was only one significant interaction between gender and actor avoidance, b = .85, $t(68.18)$ = -2.11, $p < .05$. The other non-significant interactions were as follows: gender and avoidance of partner: b = -.27, $t(64.07)$ = -.65, p = .52; gender and attachment anxiety of the actor: b = -.47, $t(73.05)$ = -1.53, p = .13; gender and anxiety of the partner: b = -.25, $t(66.46)$ = -.75, p = .45.

Table 9a

Estimates of Fixed Effects for Physiological Arousal During "Self" Issue

	b	*SE*	*df*	*t*	Sig.
Gender (A)	-.07	.36	38.42	-.19	.85
Income (A)	-1.10***	.35	49.95	-3.16	.00
MSPSS (P)	.03	.02	77.84	1.70	.09
Avoidance (A)	-.16	.21	73.01	-.75	.46
Avoidance (P)	.18	.23	69.60	.78	.44
Anxiety (A)	-.12	.16	73.88	-.78	.44
Anxiety (P)	-.11	.17	68.22	-.68	.50
Gender* avoidance(A)	.73	.43	72.53	1.70	.09
Gender* avoidance(P)	-.19	.41	65.45	-.47	.64
Gender* anxiety(A)	-.73*	.32	75.68	-2.29	.03
Gender* anxiety(P)	-.35	.33	68.69	-1.07	.29

Note. The following were removed from the final analysis because of nonsignificance: age, race, relationship status, CSI, IJS, and DASS21.

*$p \leq .05$, ** $p \leq .01$, *** $p \leq .001$

Table 9b

Follow-up Model for Research Question 2 (Self)

	b	*SE*	*df*	*t*	Sig.
Man	3.38***	.45	84	7.22	.00
Woman	3.22***	.45	85	7.20	.00
Income (A)	-1.22***	.33	59	.3.74	.00
Baseline mean (A)	-.06	.05	79	.1.14	.26
Man*avoidance (A)	-.52	.27	92	-1.92	.06
Man*avoidance (P)	.29	.26	92	1.13	.26
Man*anxiety (A)	.23	.21	92	1.13	.26
Man*anxiety (P)	.05	.20	92	.25	.80
Woman*avoidance (A)	.22	.28	92	.77	.44
Woman*avoidance (P)	.07	.30	92	.24	.81
Woman*anxiety (A)	-.51*	.21	92	-2.40	.02
Woman*anxiety (P)	-.29	.23	92	-1.25	.22

*$p \leq .05$, ** $p \leq .01$, *** $p \leq .001$

Upon follow-up with post hoc simple slope analyses for gender and actor avoidance, no significant results were found for men and women with high or low avoidance in terms of the outcome variable of physiology during the partner issue. For men and attachment avoidance of the actor, the results were: $b = -.46$, $t(91.91) = -1.62$, $p = .11$. For men and attachment avoidance of the partner, the results were: $b = .23$,

t(91.66) = .90, *p* = .37. For women, the post hoc analyses of attachment avoidance of the actor were: *b* = .40, *t*(91.97) = 1.46, *p* = .15. The following were the results for women and attachment avoidance of the partner: *b* = -.06, *t*(91.80) = -.23, *p* = .82.

Table 10

Estimates of Fixed Effects for Physiological Arousal During "Partner's" Issue

	b	*SE*	*df*	*t*	Sig.
Gender (A)	.12	.34	38.87	.34	.73
Income (A)	-.96**	.33	50.29	-2.89	.01
MSPSS (A)	.03	.02	63.70	1.79	.08
Avoidance (A)	-.02	.22	74.57	-.10	.92
Avoidance (P)	.08	.20	66.06	.41	.68
Anxiety (A)	.06	.16	73.33	.36	.72
Anxiety (P)	-.20	.16	65.27	-1.25	.22
Baseline mean (A)	-.11*	.05	62.43	-2.05	.05
Gender* avoidance(A)	.85*	.40	68.18	2.11	.04
Gender* avoidance(P)	-.27	.41	64.07	-.65	.52
Gender* anxiety(A)	-.47	.30	73.05	-1.53	.13
Gender* anxiety(P)	-.25	.33	66.46	-.75	.45

Note. The following were removed from the final analysis because of non-significance: age, race, relationship status, CSI, IJS, and DASS21.

*$p \leq .05$, ** $p \leq .01$, *** $p \leq .001$

Summary of Results

Overall, the results indicate some unique relationships between both attachment anxiety and avoidance in terms of the self-report of partner support perceptions and physiology during support conversations. When examining the relationship between attachment and perceptions of social support, significant relationships were found for attachment avoidance. Those higher in avoidance felt less supported when discussing their issue. Partners also felt less supported when their partner was higher in avoidance. They also reported that they provided less support. This aligned well with the fact that their partners indeed felt less supported when discussing their issue. Conversely, the relationship between attachment and distress (as measured by psychophysiological arousal) yielded significant findings only attachment anxiety. Specifically, women higher in attachment anxiety experienced lower levels of distress when discussing their own issue.

In terms of demographic variable and covariates, only income was significant during any of the analyses. Those lower in income were more likely to experience distress during issues where they received and provided support. This may reveal a similarity with previous research linking increased financial strain with increased stressors and therefore less regulated stress response systems, such as cortisol, impacting sweat response (Lucas-Thompson & Hostinar, 2013). However, it could also be due to the significant correlation between age and income ($r = .54$, $p < .01$), since previous research has uncovered a negative correlation between age and physiological sweat response (Seedall, 2011).

CHAPTER V

DISCUSSION

Attachment style in adulthood impacts intimate relationships in a multitude of ways. Internal working models of attachment are activated during distress and influence perceptions of the internal and external world in terms of trust, reliance, and sensitivity (Bartholomew et al., 1997; Collins & Feeney, 2000). Those with higher levels of attachment anxiety and avoidance suffer negative outcomes in their adult romantic relationships including: lack of trust, less relational stability and longevity, and more unhealthy patterns of communication (Givertz et al., 2013; Mondor et al., 2011). Previous research has honed into the dynamics of attachment style in the context of couple conflict (Beck et al., 2013; Creasey, 2002; Domingue & Mollen, 2009; Gouin et al., 2009; Pasch et al., 2002). Those studies revealed negatively themed interactions and heightened internal distress for those with insecure attachment style, both anxious and avoidant (Diamond et al., 2006; Gouin et al., 2009). Social support or partner support interactions differ from couple conflict interactions in an important way. Contrary to couple conflict, within social support interactions, the source of distress is individual in nature and does not come from within the relationship. As a result, there are likely some nuances involved with how to signal need and respond appropriately within these types of interactions.

The purpose of the current study was to examine attachment dynamics within social support interactions, including perceptions of social support and psychophysiological arousal when receiving/providing support. Findings highlighted that individuals who reported higher levels of attachment avoidance and those whose partner

reported higher levels of avoidance felt less supported when they discussed something they would like to change about themselves. Additionally, those with higher levels of avoidance also perceived themselves as providing less support to their partners during their partner's issue. Although there were not many attachment-related differences in psychophysiological arousal, findings did identify that women high in attachment anxiety had lower levels of internal arousal when talking about their own issue. In the remainder of this section, I will highlight (a) several important implications of my findings for couple relationships; (b) the clinical implications of my findings; and (c) limitations and the potential for future research.

Avoidance and Social Support

Perhaps the most important finding of this study relates to the relationship between attachment avoidance and social support. In general, people with avoidant attachment do not feel comfortable with closeness, vulnerability, and openness due to an underlying model of others as unresponsive and undependable (Bartholomew et al., 1997; Collins & Feeney, 2000). Results of this study revealed that those individuals with higher levels of attachment avoidance reported feeling less supported after discussing their issue. In addition, partners of those higher in avoidance also felt less supported. Those with avoidant attachment also acknowledged that they were less supportive of their partner. So, the fact that they reported less support overall may indicate a gap between how avoidant partners' are actually providing and receiving support and their knowledge of and/or discomfort with the emotional intimacy necessary to openly provide and receive it.

Although there was a significant finding between avoidant attachment and lower support provision and reception, both the actor and partner with avoidant attachment were *aware* of this insufficient support. Those with avoidant attachment or with partners higher in avoidance reported feeling less supported, acknowledging that something is not working when receiving support. In turn, participants with avoidant attachment acknowledged their inability to effectively provide support by rating themselves lower, which indicates a sense of awareness as well. Although this reveals avoidant participants' knowledge that the support conversations were not going well, we still do not know, and perhaps they do not know, *why* it is not going well. Perhaps they are less knowledgeable, confident, and/or comfortable with the internal emotional processes within themselves and their partner, potentially making it difficult to sensitively signal, receive, provide, and respond during these specific couple interactions.

Previous research gives some insight into the current findings in terms of avoidant attachment and social support. In terms of support provision, partners with avoidant attachment have been found to be ineffective caregivers because the intimacy necessary for support processes may be uncomfortable and thus, they may miss their partner's signals (Davila & Kashy, 2009). One study revealed that avoidant husbands were just as supportive as their secure counterparts when their wives were not distressed; however, they were consistently less supportive when their wives were distressed (Edelstein & Shaver, 2004). This lack of support may indicate they had difficulty detecting partner distress, and perhaps they have learned that distress equates with their partner needing emotional closeness, something not inherently easy for them to provide. Being unable to

detect signals of distress or having problems responding to signals when detected may make it more difficult to know when and how to provide the support their partner needs.

Research has also revealed a link between avoidant attachment style and difficulty asking for support; in fact, partners with avoidant attachment style were less likely to seek support in times of high stress (Collins & Feeney, 2010; Davila & Kashy, 2009). In addition, it is also difficult for avoidant partners to ask for assistance in general and, when they do ask, they have more difficulty clearly communicating their needs (Beck et al., 2013). During couple conflict, avoidant partners view the interaction as a threat, in which avoidant partners may feel pushed to get more emotionally intimate than they are comfortable with; eliciting their internal attachment strategies that heighten the need for distance (Domingue & Mollen, 2009; Seedall & Wampler, 2012). The same phenomenon could be occurring within social support conversations with an intimate partner. The avoidant partner(s) feel uncomfortable with the discussion since it requires closeness and a threat to their sense of reliability on oneself. Their inherent defensive responses (such as unresponsiveness and inaccessibility) may prevent them from optimally providing and receiving support in conversations with their romantic partner (Edelstein & Shaver, 2004).

Although people with avoidant attachment may have difficulty with these conversations, social support interactions may be a safer route for these couples since it does not elicit the significant internal physiological distress of couple conflict discussions and is not focused on relationship-specific problems. For instance, the current findings did not reveal any physiological differences in those with avoidant attachment, whereas

previous research has revealed those with higher avoidance as maintaining higher levels of emotional distress during couple conflict (Diamond et al., 2006; Gouin et al., 2009). The current study's findings may mean they are able to acknowledge their inability to effectively provide and elicit support while at the same time not becoming as distressed with the nature of the conversation. However, they have a habit of deemphasizing dependence on others due to avoidant internal working models of attachment and, therefore, do not have the skills or practice to confidently provide or receive support during couple interactions (Collins & Feeney, 2010; Davila & Kashy, 2009).

Social Support and Psychophysiological Arousal

In addition to avoidance, this study revealed interesting information about those with anxious attachment style. Anxious attachment is associated with a desire to be close along with the fear of rejection and abandonment (Bartholomew et al., 1997; Collins & Feeney, 2000). The current results indicated that women higher in anxiety felt less distressed while discussing their own social support issue, even though they did not report feeling more supported by their partner. This may seem somewhat counterintuitive because attachment insecurity has regularly been associated with less positive relationship outcomes, including more negative experiences during couple interactions such as conflict. However, findings from this study highlight the soothing effect that can result for women high in attachment anxiety from having a partner present and attending to their thoughts about something they want to change about themselves.

The current findings differ from previous findings on couple conflict since the

nature of social support discussions are external from the relationship itself, making it less threating in potential for rejection from an intimate partner (Bartholomew et al., 1997; Collins & Feeney, 2000). Unsurprisingly, previous research has revealed that attachment insecurity, particularly anxious attachment style, is linked to higher cortisol levels or more irregular responses during relationship conflict (Beck et al., 2013). Further, couples in which the female was anxious and the male avoidant had higher levels of cortisol activity prior to conflict discussion, when compared to all other attachment style pairings (Beck et al., 2013). On the other hand, when therapy-like interactions were the context of these conversations, those higher in attachment anxiety felt more positively toward their partner (Seedall, 2011). Thus, the current study's findings that anxious women are actually soothed by social support conversation reveals a phenomenon that potentially makes social support interactions a useful way to enhance positive couple experience in addition to focusing on and working through conflict-laden issues.

Delving deeper into the processes of why social support conversations may be comforting, perhaps the nature of the current study provided anxious women with the feeling that their attachment figure was accessible to their needs, which provided comfort and the closeness they often desire (Bartholomew et al., 1997; Collins & Feeney, 2000). This aligns with other studies on partner social support in which researchers found that anxious individuals are primed to readily access support from attachment figures not only when distressed, but also in non-threatening situations (Shaver, Schachner, & Mikulincer, 2005). In this manner, individuals with anxious attachment were more likely to seek reassurance on a daily basis (Shaver et al., 2005). However, other studies have revealed

lower support seeking activation, implying that fear of rejection and negative perception of others' responsiveness may interfere with their ability to effectively seek support (Shaver & Mikulincer, 2012). They are also more likely to depend on unclear methods of support seeking such as begging, sulking, whining, or pouting (Shaver & Mikulincer, 2012).

Therefore, although the social support discussion was a positive interaction from a psychophysiological standpoint, mixed findings of the past may mean those with anxious attachment still need to work on how to effectively elicit support. They may have been comforted during the conversation because of the setup of the discussions in this study, in which their partners' were told to provide support rather than having to elicit it from them, which provided automatic closeness, but not by their own constructive means of seeking support. Furthermore, since they did not *report* feeling more supported, perhaps their anxious internal working models are still resulting in an unattainable desire for closeness; therefore they are still unsatisfied with their partner's support provision. In this manner, it is still unclear as to whether this psychophysiological soothing effect is long-lasting or if in turn, it may have a rebound effect in the search for the insatiable desire for closeness stemming from insecure working models of attachment (Seedall, Butler, Zamora, & Yang, 2015). This means the calming effect of the conversation may be short lived before the anxious needs resurface in the relationship and the partner is unsatisfied with the level of closeness and requires reassurance once again.

Uncovering the particular gender dynamics in terms of anxiety and social support is interesting since previous studies have also discovered specific couple dynamics in

terms of gender. Some of these findings have been mentioned, such as couples in which the female was anxious and male was avoidant had the highest levels of cortisol activity prior to conflict discussion, exemplifying polar opposite needs of closeness and distance (Beck et al., 2013). Perhaps there is a specific dynamic with women high in anxious attachment that is not present for men. Research indicates that women naturally tend toward the anxious spectrum and men toward the avoidant, which, like previously mentioned, creates distress as one tries to get closer and the other tries to create distance (Feeney, 1999). Therefore, for men it is not as socially acceptable to be desirous of closeness and reassurance that anxious attachment needs exemplify. This may create internal discord between wanting closeness and being fearful of appearing weak through a societal lens; which is a potential underlying reason men were not soothed by the social support conversation in the same way the females were. In order to understand these gender disparities further, it would be beneficial for future research to address these questions within the context of couple relationships and attachment.

Income and Physiological Distress

In addition to the overarching findings on attachment style, social support, and physiology, there were unexpected findings related to income and physiology. During the social support conversations, there was a negative relationship between income and physiology. Thus, higher income was associated with lower distress levels when participants were discussing social support issues. Research has shown that economic strain is correlated with more stressors and thus affects the human stress response system,

such as cortisol (Lucas-Thompson & Hostinar, 2013). Although never studied together previously, the current research findings on income and physiology may be representative of individuals with lower income having more stressors in general, which in turn may be affecting their psychophysiological distress on a daily basis as well as affecting their physiology during the social support conversations (Lucas-Thompson & Hostinar, 2013). However, it may also be related to the nature of the sample in general of the present study since there is a significant positive correlation between age and income, and a previous study revealed that older individuals had lower skin conductance levels than their younger counterparts (Seedall, 2011). However, in that study, the findings of age were present when skin conductance was not residualized (i.e., looking only at raw skin conductance levels). As a result, the fact that these findings were present after residualizing skin conductance point towards a more robust finding that points towards the need for additional research.

Clinical Implications

The results of the current study indicate that individuals high in avoidance do not feel as supported and acknowledge they are not as supportive to their partners as well. Additionally, women high in anxious attachment style feel less distressed when talking about their own social support issue. The current findings provide some additional insight into the clinical implications of partner support interactions within intimate partner relationships. As opposed to couple conflict, understanding how couples can increase positive daily interactions through partner social support can help increase intimacy and

resiliency when couple problems do arise. In turn, improving the sensitivity and responsiveness of the couple in a safe context and thereby securing their bonds of attachment (Johnson, 2004; Mikulincer & Shaver, 2009).

Avoidance and Social Support in Therapy

Specifically, this research uncovered the association between attachment avoidance and a lack of feeling supported and feeling successful at providing support. Other findings have revealed that individuals higher in avoidant attachment demonstrated a lack of congruence by reporting more positive feelings about their partner when in fact they were actually physiologically distressed (Seedall & Wampler, 2012). The difference with the current study is that those with avoidant attachment had *awareness* of the poor support by reporting they were feeling less supported and that they were providing less support as well. This awareness is vital for change in the therapy context and since the current study revealed no heightened distress for those with avoidant attachment, it may make teaching within the context of non-relational problems a safe route for them to master skills without it being as threatening or distressing as a couple conflict issue.

Although they are aware of the poor outcome of their social support conversations, they may not be aware of the internal processes occurring that make signaling and responding to their partner more difficult. Thus, therapists need to understand that avoidance may mean feeling less confident about being supported and knowing how to be supportive. This may mean providing scaffolding for social support skills such as including sensitivity and responsiveness so they can learn how best to support their partner and how their partner can support them (Mikulincer & Shaver,

2009). In the therapeutic context of securing attachment relational bonds, building trust and security through social support conversations may be just the route to enhance relational security, particularly for those with avoidant attachment who may lack inherent confidence and skills for effective social support interactions (Johnson, 2004).

Anxiety, Social Support, Psychophysiology and Gender in Therapy

Along with avoidant attachment, this research provides interesting insight into the physiological soothing effect emotional closeness has on those with anxious attachment. It is interesting that these women felt less distressed when their partners were simply physically present for 10 minutes to talk about their wife's issue, without being taught new skills or told to do anything but discuss the issue. It is helpful to understand this soothing effect in the context of social support because it may provide an easier avenue for helping couples secure relational bonds than distressing couple conflict in which the anxious person may feel threatened that they will be rejected or abandoned. This reveals a potentially different way of addressing couple issues in the therapy room. Often therapists will start with the pervasive couple conflict or the deepest issue occurring. Although helpful, perhaps the couple dynamics would be improved by balancing this with the couple supporting each other in their individual lives so the focus of the relationship and therapy is not solely on couple conflict.

Additionally, therapists need to take into consideration the gender disparities found in the current study between women and men with anxious attachment. Although women may be comforted by the social support conversations during therapy, men may

have a more complicated feeling of comfort and shame for needing more emotional support. There is also still the question as to whether this calming influence on women has a long-lasting effect or whether there is a rebound effect when closeness is not maintained longer than the 10-minute discussion (Seedall et al., 2015). This implies that therapists still need to teach anxiously attached individuals the skills to clearly express their attachment needs and teach their partners how to best provide security and responsiveness on a daily basis. Additionally, by understanding the soothing effect these conversations may have on women higher in anxiety, it could be helpful to find out what elements of the process are especially useful so the partner understands more about how to sensitively respond. By utilizing social support conversations in therapy as a means to teach skills of signaling and responsiveness, trust and security in the couple relationship can be built, potentially making the soothing effect seen in the current study last for a longer duration of time. This in effect provides the person with anxious attachment a safe haven to rely on in times of stress and adversity, which may be an easier route through social support then conflict discussions alone (Collins & Feeney, 2000).

Overall, therapists can utilize the information uncovered in this study to further enhance the security of couple relationships within the context of daily support conversations. Social support can be a useful way to help partners with avoidant attachment understand the internal processes occurring in couple interactions. Additionally, social support conversations are a way for those with anxious attachment to receive closeness and a safer way than conflict to express how their partner can effectively support them.

Limitations and Implications for Future Research

The current study revealed associations between attachment style and social support, something underrepresented in the current literature of intimate relationships. A limitation of the current study includes the sample's lack of diversity, at least in terms of race/ethnicity. Although a variety of age, the large majority of participants were Caucasian and of various Christian denominations. It would be helpful for future studies to aim at collecting a more diverse sample to help with generalizability and insight into different cultures and ethnicities in terms of social support and attachment. Further, a larger sample overall would be helpful in regards to increasing the power statistically and making sure all significant correlations that exist are found, especially with respect to psychophysiological arousal (i.e., skin conductance), for which variability of scores can be relatively low. Although the current study provided a fair number of participants, with some biofeedback problems the sample lost valuable data on the physiological component.

Additionally, many couples displayed interest in the study initially but ended up never participating in the checkup and it is unknown how these individuals and couples may differ from the participants utilized for the analyses in this study. In the future, more research is needed in the area of social support, attachment, and psychophysiology in order to confirm and add to the current study's findings. Further, even though the current study has therapeutic implications, it was not conducted in order to explain therapeutic processes. Therefore, it would be beneficial to conduct a therapy-focused study using clinical couples in order to fully understand the role of facilitating social support in the

process of therapeutic change. Overall, more research is needed in terms of studying therapeutic processes and how these social support conversations can be applied in couple relationships to enhance their security and overall couple satisfaction.

Conclusion

In spite of limitations, the current study moves the literature forward by providing insight into the attachment and social support correlation of couples. Particularly in the context of therapy, this information can be important for facilitating secure attachment bonds between intimate partners (Johnson, 2004). Regardless of the therapy model, therapists can use this information to understand an important dynamic of couple relationships that has been, for the most part, overlooked in literature. The current study uncovered some insight into the difficulty those with avoidant attachment may have with the process of the reception and provision of support to their romantic partner. Additionally, it provided insight into the fact that those with avoidant attachment are aware of their social support shortcomings, making them potentially easier to teach new skills in this area. Further, the safety of these discussions may hold new context for coupes to secure relational attachment since the findings suggest that the conversations did not significantly increase distress the way research has revealed couple conflict does in the past. In fact, the social support conversation for women with anxious attachment actually had a soothing effect. Thus, if therapists can apply these findings into their daily therapeutic practice, it may result in enhancing couple security through innovative means that are emotionally safer for those with insecure attachment styles. Overall, I am

confident that findings from this study shed light on attachment-related support dynamics in couple relationships and provide impetus for therapy and future research in this area.

REFERENCES

Ainsworth, M. D. S. (1967). *Infancy in Uganda: Infant care and the growth of love.* Baltimore, MD: John Hopkins Press.

Ainsworth, M. D. S. (1979). Infant-mother attachment. *American Psychologist, 34*(10), 932-937.

Ainsworth, M. D. S., & Bell, S. M. (1970). Attachment, exploration, and separation: Illustrated by the behavior of one-year-olds in a strange situation. *Child Development, 41*(1), 49-67.

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Erlbaum.

Bartholomew, K., Cobb, R. J., & Poole, J. A. (1997). Adult attachment patterns and social support processes. *Sourcebook of social support and personality.* New York, NY: Plenum Press.

Beck, L. A., Pietromonaco, P. R., DeBuse, C. J., Powers, S. I., & Sayer, A. G. (2013). Spouses' attachment pairings predict neuroendocrine, behavioral, and psychological responses to marital conflict. *Journal of Personality and Social Psychology, 105*(3), 388-424.

Beck, L. A., Pietromonaco, P. R., DeVito, C. C., Powers, S. I., & Boyle, A. M. (2014). Congruence between spouses' perceptions of observers' ratings of responsiveness: The role of attachment avoidance. *Personality and Social Psychology Bulletin, 40*(2), 164-174.

Bell, S. M., & Ainsworth, M. D. S. (1972). Infant crying and maternal responsiveness. *Child Development, 43,* 1171-1190.

Ben-Naim, S., Hirschberger, G., Ein-Dor, T., & Mikulincer, M. (2013). An experimental study of emotion regulation during relationship conflict interactions: Moderating the role of attachment orientations. *Emotion, 13*(3), 506-519.

Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment.* New York, NY: Basic Books.

Bowlby, J. (1973). *Attachment and loss: Vol. 2. Separation.* New York, NY: Basic Books.

Bowlby, J. (1988). *A secure base*. New York, NY: Basic Books.

Bradbury, T. N., & Pasch, L. A. (1997). Assessment of social support in marital interaction: The social support interaction coding system. *Archives of Psychiatric and Clinical Evaluation, 8* (2), 147-153.

Brennan, K. A., Clark, C. L., & Shaver, P. R. (1998). Self-report measurement of adult attachment: An integrative overview. In J. A. Simpson & W. S. Rholes (Eds.), *Attachment theory and close relationships* (pp. 46-76). New York, NY: Guilford Press.

Brennan, K. A., Shaver, P. R., & Clark, C. L. (2000). *Specifying some mediators of attachment-related anxiety and avoidance.* Unpublished manuscript. State University of New York, Brockport.

Buehlman, K., Gottman, J., & Katz, L. (1992). How a couple views their past predicts their future: Predicting divorce from an oral history interview. *Journal of Family Psychology, 5,* 295-318.

Collins, N. L., & Feeney, B. C. (2000). A safe haven: An attachment theory perspective on support seeking and caregiving in intimate relationships. *Journal of Personality and Social Psychology, 78*(6), 1053-1073.

Collins, N. L., & Feeney, B. C. (2004). Working models of attachment shape perceptions of social support: Evidence from experimental and observational studies. *Journal of Personality and Social Psychology, 87,* 363-383.

Collins, N. L., & Feeney, B. C. (2010). An attachment theoretical perspective on social support dynamics in couples: Normative processes and individual differences. In K. T. Sullivan & J. Davila (Eds.), *Support processes in intimate relationships* (pp. 89-120). New York, NY: Oxford University Press.

Creasey, G. (2002). Associations between working models of attachment and conflict management. *Journal of Counseling Psychology, 49,* 365-375.

Dandurand, C., & Lafontaine, M. (2013). Intimacy and couple satisfaction: The moderating role of romantic attachment. *International Journal of Psychological Studies. 5*(1), 74-90.

Davila, J., & Kashy, D. A. (2009). Secure base processes in couples: Daily associations between support experiences and attachment security. *Journal of Family Psychology, 23*(1), 76-88.

Dawson, M. E., Schell, A. M., & Filion, D. L. (2007). The electrodermal system. In J. T. Cacioppo, L. G. Tassinary, & G. G. Bernston (Eds.), *Handbook of psychophysiology* (3rd ed., pp. 159-181). New York, NY: Cambridge University Press.

Diamond L. M., Hicks, A. M., & Otter-Henderson, K. (2006). Physiological evidence for repressive coping among avoidantly attached adults. *Journal of Social and Personal Relationships, 23*(2), 205-229.

Domingue, R., & Mollen, D. (2009). Attachment and conflict communication in adult romantic relationships *Journal of Social and Personal Relationships, 26,* 678-696.

Edelstein, R. S., & Shaver, P. R. (2004). Avoidant attachment: Exploration of an oxymoron. In D. J. Mashek & A. Aron (Eds.), *Handbook of Closeness and Intimacy* (1st ed., pp. 397-414). Mahwah, NJ: Erlbaum.

Feeney, B. C., & Collins, N. L. (2001). Predictors of caregiving in adult intimate relationships: An attachment theoretical perspective. *Journal of Personality and Social Psychology, 80,* 6, 972-994.

Feeney, J. (1999). Issues of closeness and distance in dating relationships: Effects of sex and attachment style. *Journal of Social and Personal Relationships, 16*(5), 571-590.

Fleming, C. J. E., & Cordova, J. V. (2012). Predicting relationship help seeking prior to a marriage checkup. *Family Relations, 61,* 90-100.

Funk, J. L., & Rogge, R. D. (2007). Testing the ruler with item response theory: Increasing precision of measurement for relationship satisfaction with the Couples Satisfaction Index. *Journal of Family Psychology, 21*(4), 572 -583.

George, C., Kaplan, N., & Main, M. (2002). *The adult attachment interview* (3rd ed.). Unpublished manuscript, University of California, Berkeley.

Givertz, M., Woszidlo, A., Segrin, C., & Knutson, K. (2013). Direct and indirect effects of attachment orientation on relationship quality and loneliness in married couples. *Journal of Social and Personal Relationships, 30*(8), 1096-1120.

Gouin, J. P., Glaser, R., Loving, T. J., Malarkey, W. B., Stowell, J., Houts, C., & Kiecolt-Glaser, J. K. (2009). Attachment avoidance predicts inflammatory responses to marital conflict. *Brain, Behavior, and Immunity, 23,* 898-904.

Graham, J. M., Diebels, K. J., & Barnow, Z. B. (2011). The reliability of relationship satisfaction: A reliability generalization meta-analysis. *Journal of Family Psychology, 25*(1), 39-48.

Hempel, R. J., Tulen, J. H., van Beveren, N. J., van Steenis, H. G., Mulder, P. G., & Hengeveld, H. W. (2005). Physiological responsivity to emotional pictures in schizophrenia. Journal of Psychiatric Research, *39*, 509-518.

Heyman, R. E. (2001). Observation of couple conflicts: Clinical assessment applications, stubborn truths, and shaky foundations. *Psychological Assessment*, *13*(1), 5-35.

Holland, A. S., & Roisman, G. I. (2010). Adult attachment security and young adults' dating relationships over time: Self-reported, observational, and physiological evidence. *Developmental Psychology, 46*, 552-557.

Johnson, S. (2004). *The practice of emotionally focused couple therapy: Creating connection* (2nd ed.). New York, NY: Brunner-Routledge.

Jory, B. (2004). The Intimate Justice Scale: An instrument to screen for psychological abuse and physical violence in clinical practice. *Journal of Marital and Family Therapy, 30*(1), 29-44.

Kenny, D. A., Kashy, D. A., & Cook, W. L. (2006). *Dyadic data analysis*. New York, NY: Guilford.

Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the depression anxiety stress scales (DASS) with the beck depression and anxiety inventories. *Behaviour Research and Therapy*, *33*(3), 335-343.

Lucas-Thompson, R. G., & Hostinar, C. E. (2013). Family income and appraisals of parental conflict as predictors of psychological adjustment and diurnal cortisol in emerging adulthood. *Journal of Family Psychology, 27*(5), 784-794.

Menchaca, D., & Dehle, C. (2005). Marital quality and physiological arousal: How do I love thee? Let my heartbeat count the ways. *Journal of Family Therapy*, 33, 117-130.

Mikulincer, M., & Shaver, P. R. (2009). An attachment and behavioral systems perspective on social support. *Journal of Social and Personal Relationships, 26*(1), 7-19.

Mondor, J., McDuff, P., Lussier, Y., & Wright, J. (2011). Couples in therapy: Actor-partner analyses of the relationships between adult romantic attachment and marital satisfaction. *The American Journal of Family Therapy, 39,* 112-123.

Parker, M. L., Johnson, L. N., & Ketring, S. A. (2012). Adult attachment and symptom distress: A dyadic analysis of couples in therapy. *Journal of Family Therapy, 34*, 321-344.

Pasch, L. A., Harris, K. M., Sullivan, K. T., & Bradbury, T. N. (2002). The social support interaction coding system. In N P. Kerig & D. Baucom (Eds.), *Couple observational coding systems* (pp. 319-334). New York, NY: Guilford.

Powers, S. I., Pietromonaco, P. R., Gunlicks, M., & Sayer, A. (2006). Dating couples' attachment styles and patterns of cortisol reactivity and recovery in response to a relationship conflict. *Journal of Personality and Social Psychology*, *90*(4), 613-628.

Seedall, R. B. (2011). The relationship between attachment and emotional experience during semi-natural and therapy like couple interactions [Unpublished doctoral dissertation] Michigan State University: East Lansing.

Seedall, R. B., Butler, M. H., Zamora, J. P., & Yang, C. (2015). Attachment change in the beginning stages of therapy: Examining change trajectories for avoidance and anxiety (Unpublished manuscript). Utah State University, Logan.

Seedall, R. B., & Wampler, K. S. (2012). Emotional congruence within couple interaction: The role of attachment avoidance. *Journal of Family Psychology, 26*(6), 948-958.

Shaver, P. R., & Mikulincer, M. (2012). Attachment anxiety and motivational patterns in close relationships. In L. Campbell, J. L. Guardia, J. M. Olson, & M. P. Zanna

(Eds.), *The science of the couple: The Ontario symposium volume 12* (pp. 17-39). New York, NY: Psychology Press.

Shaver, P. R., Schachner, D. A., & Mikulincer, M. (2005). Attachment style, excessive reassurance seeking, relationship processes, and depression. *Personality & Social Psychology, 31*(3), 343-359.

Simpson, J. A., Rholes, W. S., & Nelligan, J. S. (1992). Support seeking and support giving with couples in an anxiety provoking situation: The role of attachment styles. *Journal of Personality and Social Psychology, 62*(3), 434-446.

Sroufe, A. L., & Waters, E. (1977). Heart rate as a convergent measure in clinical and developmental research. *Merrill-Palmer Quarterly, 23,* 3-27.

Sullivan, K. T., & Davila, J. (2010). *Support processes in intimate relationships*. New York, NY: Oxford University Press.

Tabachnick, B. G., & Fidell, L. S. (2007). *Using multivariate statistics* (5th ed.). New York, NY: Pearson.

Wei, M., Russell, D. W., Mallinckrodt, B., & Vogel, D. L. (2007). The Experiences in Close Relationship Scale (ECR)-short form: Reliability, validity, and factor structure. *Journal of Personality Assessment, 88*(2), 187-204.

Wood, N. D., Werner-Wilson, R. J., Parker, T. S., & Perry, M. S. (2012). Exploring the impact of attachment anxiety and avoidance on the perception of couple conflict. *Contemporary Family Therapy, 34I,* 416-428.

Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). The Multidimensional Scale of Perceived Social Support. *Journal of Personality Assessment*, *52*(1), 30-41.

APPENDICES

Appendix A

Relationship Checkup Flyer

Appendix B

The 9 Stages of the Relationship Checkup

Stage 1

Couple fills out self-report assessments online through Qualtrics prior to coming in for t he checkup.

Stage 2

Once the couple comes in for the first session, a baseline is obtained by asking the couple to clear their minds for three minutes after they have been hooked up to biofeedback machine.

Stage 3

Oral interview for 15-20 minutes including questions about how the couple met, etc.

Stage 4

Social support discussion for 10 minutes regarding topic of 1st partner (with assessments after).

Stage 5

Social support discussion for 10 minutes regarding topic of 2nd partner (with assessments after).

Stage 6

Couple conflict topic discussion for 10 minutes.

Stage 7

Distraction task assessment where couple ranks important aspects of romantic relationships.

Stage 8

Final interview questions asking about the experience in the first session and how typical this is to their regular way of interacting outside of the checkup.

Stage 9

Follow up session for 1 hour with feedback on the strengths and areas for improvement in their relationship with the option to continue with therapy.

Appendix C

Relationship Checkup Research Protocol

PHASE 1: Informed Consent

Research Associate:

1. Couple arrives and is greeted.
2. Tell/show the couple where the snacks and bathrooms are located.
3. Ask them if they are willing to turn their cell phones off, or if they would like they can leave them with the research associate and they can remain on. The research associate will answer them to ensure that there are no emergency calls.
4. Research associate goes into a room with both participants.
5. Informed Consent

The first part of this process is for you to read a basic overview of this study and provide your consent to participate and have your information used in research we are doing. You are welcome to read silently, or I am happy to ready it for you. Do you have a preference?

- Ask if they have any questions about the informed consent

I just want to highlight a few things that are really important. One thing is that what you do here is completely confidential. You will be assigned a participant number, and no names or identifying information will be attached to any of your materials, including the video. In addition, everything will be locked up in a secure place that only the primary investigators can access. Also, if at any time you feel unable to continue, please notify any member of the research team, and we will let you have a break or end the research session. Do you have any questions for me?

PHASE 2: Assessment Packet

Therapist:

1. You will give both partners the assessment packet to complete.
2. While one partner begins the packet, you will invite the other into a separate room.
3. In the other room, you will say the following:

I wanted to meet with you for a few minutes about a couple of things. First is that we it is really important to us that you feel safe while you are here. For that

reason, I need to ask you if you or your partner have engaged in any physical violence [pushing, shoving, hitting, etc.) with each other in the past three months.

If they report that there has been violence, you will need to assess the degree and frequency of violence. For example, you will want to ask how often it occurred and what typically happened. You will then ask whether the physical violence ever left marks or required a hospital/doctor's visit. If it did, you will need to screen out the couple and refer them for therapy. Otherwise, you will just need to make sure that both partners feel safe.

I also want to talk to you a little bit about how this session will proceed. After you finish the paperwork, I will interview you both for about 20-25 minutes regarding your couple relationship. You will then participate in a few conversations with your partner. For one of these, you will discuss with your partner for 10 minutes something that you would like to change about yourself. It needs to be a personal problem rather than a relationship problem. What comes to mind when you think about that?

Let them know that they can take their time and that they can brainstorm and find one a topic.

- Ask them to rate their distress level (1-10) regarding the issue, with 10 extremely high distress and 1 being very little distress. **Make sure that they do not report a distress level higher than 7.** If it is higher than a 7, explore whether a different topic would be better.
- Confirm that they feel COMFORTABLE and SAFE discussing that topic with their partner. If they do not, please help them choose another issue.

4. Thank the partner for his/her time and take them back to where the other person is completing the assessment packet. Then take the other person into the other room and repeat the process.

5. After they complete the assessment packet, thank them and then tell them the following:

We are now going to take a quick five minute break. The part of the meeting after the break will last about an hour, during which he will be attached to a measure of skin conductance, which helps us know what is going on internally as you talk to your partner. As a result, if you think you might need to use the restroom, please do so now. Also, regardless of whether you need to use the restroom, please wash your hands so that the skin conductance reading is correct.

6. While they are taking the five minute break, please look at the Problem Solving Checklist they completed as part of their assessment packet. Make sure that there is an issue that they both marked that they can discuss. If there are multiple issues,

choose a moderately distressing one. It may be useful to choose two potential issues for the couple to discuss.

7. When they return, you will then attach the skin conductance electrodes to the index and middle fingers of their non-dominant hand. You can say the following:

   Okay, now we will move to the next part of our meeting. During this part, we will be taking a measurement of your skin conductance to understand more about what is going on internally as you talk with me and your partner. To do this, I need to attach these two stickers with gel in them. Do you have any questions for me about the skin conductance?

8. Once you have answered their questions, place the skin conductance electrodes on their fingers. In order for a proper connection to be established with the skin, you will need to wait five minutes before beginning to record. As a result, you will need to help them decide on a topic for them to discuss during the conflict resolution segment. You can say the following:

   During the break, I looked over one of the forms you filled out to see what topic you might discuss during the conflict resolution task. It seems that you both agree that _____ is an issue in your relationship. Is that a topic that you are both willing to discuss in here in a little while, or would you like to discuss a different topic? The goal will be to make steps towards a resolution.

9. If they indicate that they are fine with that topic, please proceed. If one of them indicates that they would like a different one, present a different issue from the form. If necessary, give them back the forms and have them choose a topic to discuss together before continuing.

<u>Research Associate:</u>

1. While the therapist is meeting with the couple, prepare the skin conductance software:
2. Open up AcqKnowledge software (it should automatically detect the hardware: #000911)
3. Make sure hardware is set to 5, 10 Hz, DC, and DC.
4. Select MP150 > Set Up Channels
5. In the bottom left of the box, click on “Add New Module.”
6. Select GSR100c from the menu and click on “Add.”
7. Move the red channel switch to match the top of the skin conductance device (one is channel 1 and the other is channel 2). Click on “OK.”
8. Double check that the GSR100C Configuration matches what is shown on the front of the skin conductance device. Change it to match, if necessary. Click on “OK.”
9. Click on “Calibrate.”

10. In the "Input Channels Setup" box, please make sure channel one is labeled, "Male," and channel two is labeled "Female."
11. Exit out of the box and you are ready to go!

PHASE 3: Couple Interview

Therapist:

1. Once they have agreed on a moderately distressing topic to discuss and five minutes have passed since attaching the electrodes, you will need to connect the electrodes to the skin conductance cables. At this time, make sure that the electrodes are sticking to the partners appropriately. If they are not, you may need to get a little bit of clear tape and help it stay in place.

2. They will then be asked to clear their minds and relax for about 3 minutes.

We are going to begin the interview in just a few minutes. However, right now I would like you to take about three minutes and focus on relaxing and clearing your mind. If possible, avoid talking to each other and just try and relax.

3. At the conclusion of the three minutes, reenter the room.

Research Associate:

1. **Begin recording video first and then physiological data.**

Therapist:

4. Instruct the couple you will be interviewing them for about 15-20 minutes about their couple relationship.

For the next 15-20 minutes, I'm going to ask both of you some questions about your couple relationship. When I ask the questions, either one of you can respond, but keep in mind that I would like to hear from both of you about equally during the interview.

5. Conduct the couple interview (15-20 minutes)

1. Tell me a little bit about how you two met.
- What first attracted you to him/her?
- How did you know that you wanted to be with him/her?
- What are some of your best memories of your early relationship?

2. How does your relationship compare to your parents' relationships?
- What parts of your parents' relationships have you tried to repeat?

- What parts of your parents' relationships have you tried to change?

3. What are some of the ways that you both work to improve your relationship?

- How do you show each other that you care?
- What ways have you found to stay connected to each other?

4. Based on your experience, what advice would you give to others you are beginning close relationships?

PHASE 4: Couple Interactions

Therapist:

1. Thank the couple for their responses on the interview, and let them know that they will now begin a few conversations with each other.

Thank you for your responses and being willing to talk about your couple relationship with me. For the next half hour or so, you will engage in a few conversations with each other. For this first part, you will talk with each other about something you want to change about yourself. _____, you have been randomly chosen to start first. What I would like you to do is to talk together for 10 minutes about what you would like to change about yourself. I will let you know when it has been 10 minutes, and then you will each answer a few questions about your experience. Then _____ will introduce his/her topic and you will talk about it. Do you have any questions?

2. After 10 minutes, stop the couple and thank them for talking about the issue. Then give them the questionnaire regarding their perceived social support. Make sure that they get the correct version, according to whether it was the person's issue or not. Give them a few minutes to complete the questionnaire, and then ask them to talk about the other person's issue.

Now I would like _____ to introduce his/her issue, and you can both talk about it for 10 minutes.

3. After 10 minutes, stop the couple and thank them for talking about the issue. Then give them the questionnaire regarding their perceived social support. Make sure that they get the correct version, according to whether it was the person's issue or not. Give them a few minutes to complete the questionnaire.

4. Next, you will introduce the conflict discussion.

This conversation is an issue in your relationship about which you typically have conflict. I believe the issue that you decided on was _____. Now I

would like you to talk for 10 minutes about that issue, with the goal to make steps towards a resolution. As with the other conversations, I will let you know when your 10 minutes is done.

5. After 10 minutes, ask them to talk for four minutes about the topics that they typically agree on the most as a couple.

6. After the four minute discussion, you will ask them to complete brief 18-card q-sort where each will choose the 6 cards they feel most represent positive relationships. Partners will then talk for 4-5 minutes and compare each person's results.

Now I would like each of you to take these 18 cards. On them is described some important aspects of couple relationships (and their opposites in parentheses). I'd like you to first choose the six cards that you feel like are most important. Then when you have both done that, I will have you talk for 4-5 minutes and compare your results.

7. Please make sure they leave the six most important cards out for us to write down.

8. Let the couple know that you have just a few more questions for them about what they just experienced.

1. What was it like for you to discuss an area of disagreement in your relationship?

- How do you typically handle disagreements in your relationship?
- How has your way of dealing with conflict changed since you were first together?

2. What do you feel are your greatest strengths as a couple?

3. What do you feel are the areas you most want to work on as a couple?

9. Now let them know they are finished. Disconnect the skin conductance and let them know they can throw the electrodes away. Thank them for their time, and schedule their follow-up (feedback) session for about three weeks later.

Appendix D

Couple Support Scale-Self (Seedall, 2012)

Think about the interaction you just had with your partner. Then read each statement carefully and indicate how much you agree with it.

1	2	3	4	5	6	7
Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree

1. My partner tried to distract me by talking about unrelated things.	1	2	3	4	5	6	7
2. My partner gave me constructive feedback	1	2	3	4	5	6	7
3. My partner seemed withdrawn, bored, and/or passive.	1	2	3	4	5	6	7
4. My partner suggested ways to solve the issue.	1	2	3	4	5	6	7
5. My partner understood me and my issue.	1	2	3	4	5	6	7
6. My partner seemed defensive.	1	2	3	4	5	6	7
7. My partner seemed interested in what I had to say.	1	2	3	4	5	6	7
8. My partner helped me express and/or clarify my feelings.	1	2	3	4	5	6	7
9. My partner blamed and/or criticized me.	1	2	3	4	5	6	7
10. My partner tried to make me feel better about myself.	1	2	3	4	5	6	7
11. My partner lightened the mood by helping me laugh.	1	2	3	4	5	6	7
12. My partner seemed overwhelmed by what I was saying.	1	2	3	4	5	6	7

Couple Support Scale-Other (Seedall, 2012)

Think about the interaction you just had with your partner. Then read each statement carefully and indicate how much you agree with it.

1	2	3	4	5	6	7
Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree

1. I was interested in what my partner had to say.	1	2	3	4	5	6	7
2. I found myself feeling defensive.	1	2	3	4	5	6	7
3. I gave my partner constructive feedback.	1	2	3	4	5	6	7
4. I helped my partner express his/her thoughts.	1	2	3	4	5	6	7
5. I distracted my partner to make him/her feel better.	1	2	3	4	5	6	7
6. I suggested ways that my partner could solve the issue.	1	2	3	4	5	6	7
7. I was supportive and encouraging towards my partner.	1	2	3	4	5	6	7
8. I found myself blaming and/or criticizing my partner.	1	2	3	4	5	6	7
9. I felt like I understood my partner.	1	2	3	4	5	6	7
10. I found myself withdrawing and/or becoming bored.	1	2	3	4	5	6	7
11. I tried to help my partner feel better about himself/herself.	1	2	3	4	5	6	7
12. I lightened the mood by helping my partner laugh.	1	2	3	4	5	6	7