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Emotionally Focused Couple Therapy: A Military Case Study

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Emotionally focused therapy (EFT) is a brief, highly effective, empirically supported approach to changing distressed couples' rigid interaction patterns and emotional processes to create a secure bond (Johnson, 2004; Johnson, Hunsley, Greenberg, & Schlinder, 1999). EFT has been used with couples in many areas of the world and has been adapted for a wide variety of clients and problems (Johnson & Woolley, 2009; Woolley & von Hockauf, 2009). The approach targets absorbing affect states that organize "stuck" patterns of interaction in distressed relationships (Gottman, 1994; Heavey, Christensen, & Malamuth, 1995). These patterns become self-reinforcing, often taking the form of critical pursuit and defensive distance. EFT combines an experiential, intrapsychic focus with a systemic focus on cyclical interactional responses and patterns (Johnson, 2004). It is a constructivist approach in which clients are seen as the experts on their experience. Key elements of experience, such as attachment needs and fears, are unfolded and crystallized in therapy sessions. Clients are not pathologized. Rather, they are viewed as struggling with problems arising from a particular social context that would likely be just as problematic for the therapist to deal with if she found herself there (Neimeyer, 1993).

EFT integrates key elements of client-centered therapy (e.g., Rogers, 1951) and experiential therapy (Perls, 1973) with general systems theory principles (Bertalanffy, 1968), particularly as seen in structural family therapy (Minuchin & Fishman, 1981). Attachment theory (Bowlby, 1969, 1988) provides EFT with a developmental non-pathologizing theoretical context for understanding the importance of emotional bonds, interdependency, and adult love and intimacy. It is as if Rogers, Perls, and Minuchin were doing cotherapy, and Bowlby is sending in messages from behind the mirror telling them where to go!

The Role of Emotions

EFT views emotion as a primary signaling system that organizes key interactions in couple and family systems. In experiential therapy, clients are led to experience, become aware of, and process their emotions. Emotions are seen as powerful, healthy,

informative, and organizational (Johnson, 1996). The disowning of emotion and needs is viewed as problematic. Human beings are viewed as generally healthy and oriented toward growth with healthy needs and desires.

In relationships, emotions are the music of the relational dance. They form a basis of social connectedness, constantly giving us signals about the nature of our social bonds (Greenberg & Paivio, 1997; Johnson, 2004). Emotion orients partners to their own needs, organizes responses and attachment behaviors, and activates core cognitions concerning self, other, and the very nature of relationships (Johnson, 2009). It is also the primary signaling system in relationship-defining interactions (Johnson, 1998). Expressions of affect pull for particular responses from others and are central in organizing interactions.

Attachment Theory

Attachment theory (Bowlby 1969, 1988; Johnson, 2003) provides a theory of love and emotion in general. It helps us understand healthy and unhealthy functioning, the “why’s” behind couple conflicts, and it provides a map for what healthy functioning looks like. The EFT therapist perceives symptoms of marital distress as distorted expressions of normal attachment-related emotion (Johnson, 1986). The experiential focus on affect and the systemic focus on interpersonal patterns are understood within an attachment context of separation distress and an insecure bond. In attachment terms, a bond refers to an emotional tie, i.e., a set of attachment behaviors to create and manage proximity to attachment figures and regulate emotions. The accessibility and responsiveness of attachment figures are necessary to a feeling of personal security.

When an attachment figure is perceived as inaccessible or unresponsive, compelling fears, anger, and sadness arise. These emotions have what Tronick (1989) terms control precedence; they override other cues. Seeking and maintaining contact with others is viewed as the primary motivating principle in human beings and an innate survival mechanism, providing us with a safe haven and a secure base in a potentially dangerous world (Bowlby, 1988). When attachment security is threatened, affect organizes attachment responses into predictable sequences. Bowlby suggests that protest and anger will typically be the first response to such a threat, followed by some form of clinging and seeking, which then gives way to depression and despair. Finally, if the attachment figure doesn’t respond, detachment and separation will occur. The potential loss of an attachment figure, or even an ongoing inability to define the relationship as generally secure, is significant enough to prime automatic fight, flight, or freeze responses that limit information processing and constrict interactional responses (Johnson, 1996).

The goals of EFT, which arise out of attachment theory, are, first, to expand attachment-related affect and so expand interactional positions and, second, to do this in a manner that fosters emotional engagement and facilitates the expression of bonding needs to attain comfort and security. EFT is typically conducted in 8–20 sessions in which the therapist uses both experiential techniques to explore and reconstruct key emotional responses that arise in the session, then and uses directive, systemic techniques to shape new interactions. Change strategies occur

in the context of a positive therapeutic alliance that provides a secure base (Bowlby, 1988) for the therapy process. The role of the therapist is that of a process consultant, working with partners to construct new experiences and new interactions that redefine their relationship.

EFT Steps and Stages

The process of change in EFT has been delineated in nine steps within three stages. Stage one involves assessment and de-escalation of problematic interactional cycles and encompasses steps 1–4. Stage two, steps 5–7, emphasize the creation of specific change events where interactional positions shift and new bonding experiences occur. Stage three, which contains the last two steps (8 and 9), addresses the consolidation of change and the integration of these changes into the everyday life of the couple. These steps are described in linear form for clarity, but in reality the therapist circles through them in spiral fashion, often working in several steps at one time.

The nine steps of EFT are as follows:

Stage 1: Cycle de-escalation

- Step 1: Create an alliance and assess the core issues in the couple context from an attachment perspective.
- Step 2: Identify the problem interactional cycle that maintains attachment insecurity and couple distress.
- Step 3: Access key unacknowledged emotions underlying interactional positions.
- Step 4: Reframe the problem in terms of the cycle, the underlying emotions, and attachment needs.

Stage 2: Changing interactional positions

- Step 5: Promote identification with disowned needs and aspects of self and integrating these into relationship interactions.
- Step 6: Promote acceptance of the partner's new construction of experience in the relationship and new interactional behavior.
- Step 7: Facilitate the direct expression of specific needs and wants and create emotional engagement.

Stage 3: Consolidation/Integration

- Step 8: Facilitate the emergence of new solutions to old problematic relationship issues.
- Step 9: Consolidate new positions and new cycles of attachment behavior.

In EFT, the first shift, which usually occurs at the end of step 4, is de-escalation of the negative cycle. This is a first-order change (Watzlawick, Weakland, & Fisch, 1974). The way interactions are fundamentally organized hasn't changed; however, reactive emotional responses are less intense, negative attributions about the partner are less rigid, and responses toward the partner are generally less extreme. Partners

are more hopeful and experience the therapy sessions as a safe place to learn about their relationship. The couple begins to risk more engagement and to view the cycle, rather than their partner, as the enemy. At this point, a partner might say, "Well, things are better. We're fighting less, and I see him a little differently, but it's a truce. He still runs and hides, and I still want to go for him. We're still not dancing in the dark together." This shift sets the stage for the work of second-order change, reorganizing the interactional dance in the direction of safe attachment.

In the second stage (steps 5–7), there are two change events that are crucial turning points in EFT. The first is withdrawer reengagement, where the withdrawn partner becomes more active in defining the relationship and more emotionally accessible to his or her partner. So, for example, a silent and distant partner might become angry and assert her need for respect and support in the relationship in a way that gives her mate a chance to respond to that need. The second change event, a softening, occurs when a previously critical, active spouse is able to risk expressing needs with his or her partner from a position of vulnerability. Research on the process of change has found that this event predicts recovery from marital distress in EFT (Johnson & Greenberg, 1988; Bradley & Furrow, 2004). This softening event is a shift in the critical partner's position, both in terms of affiliation and control, which then restructures the cycle of interactions. It is also a prototypical bonding event where two now-accessible partners initiate a new cycle characterized by accessibility and responsiveness. This kind of bonding event (occurring when the second partner completes step 7) has the ability, because of its emotional salience in terms of basic attachment needs, to heal past injuries and wounds in the relationship and to redefine the nature of the bond. Once this kind of change event has occurred, the couple begins effectively solving previously problematic pragmatic issues and naturally moves into consolidating this new positive cycle.

The third stage of EFT, steps 8 and 9, involves consolidation and integration. In this final phase, couples work together to find new solutions to old problems (step 8). With secure attachment, previous problems are more easily resolved, as the problem is no longer a threat to their relationship's connection. Consolidating their new positions and cycle of interaction is the final action, step 9. These new positions foster accessibility and responsiveness, which consolidate the couple's new interactional pattern (Johnson, 2004).

Case Study

Scott, a navy medic, and Mary, a retired navy nurse, married 16 years with two teenagers, presented for therapy reporting poor communication and ongoing issues nearly two years after his most recent deployment. He had two deployments with marine battalions, one in Iraq in the early stages of the Global War on Terror, and the second in Afghanistan. During his second deployment, one of his troops committed suicide. He opted out of a third deployment, and the corpsman who took his place got "smoked" during a firefight. Scott reported that he felt extremely guilty, saying it should have been him fighting that battle.

This couple came for therapy as they were facing a career choice: a third deployment or retirement from active duty for Scott. He was leaning toward deploying again,

which, as she said, “would be like a knife in my heart.” She shared that if he deployed again, she felt it would be best for her if they divorced, as she did not think she could manage another deployment. For him, however, deployments provided a large sense of purpose. He said, “I miss the war. It is everything I’m trained to do.”

Treatment Process: Early Phase

Presenting Issues and Difficulties

In the first session, Scott revealed that he had been diagnosed with posttraumatic stress disorder and had some individual counseling after returning from his second deployment. As a medic, he shared how he had to hold it together as all his troops shared their experiences before, during, and after both deployments with him. “I was the doc,” he said. “I was supposed to be taking care of everyone else. What else was I supposed to do except stay on autopilot?” Numbing and avoidance were his primary symptoms, but he also experienced flashbacks and intrusive and racing thoughts.

As he coped being on autopilot, his wife became more and more anxious. She reported feeling very alone and having to manage everything by herself. Her stress and high degree of worry led to her having panic attacks. She reported more stress when he would talk about his desire to deploy again. Conversations about their future led to arguments, which resulted in more distance between them.

Assessment and Case Conceptualization

Their pattern of interaction was the classic pursue–withdraw pattern. As Scott shut down (going on autopilot), the more he shut Mary out. He would talk to her in “radio chatter”—described as “fewest words possible, no emotion”—which left her feeling unimportant and more alone. The more he shut down, avoided contact with her, and used radio chatter, the more she felt anxious and worried. She would get scared, her insides “twisting into knots and pretzeling” as she tried to get him to respond to her. The more she tried to get a response, the more he distanced and limited interaction with her. He stayed away from home, and she was growing more and more anxious. When he would come home, she would have lists ready for him, and she would read him the list of all he needed to accomplish before he could leave again. When he dismissed the lists, she would criticize and yell at him.

Treatment Goals

Both Scott and Mary loved each other and missed the connection they shared in their earlier years. For Scott, though, he struggled to remember what life felt like before the war, although he loved his family and did not want to lose his wife. He hoped he could still be there for her, but he was not confident he could be. Mary was ready to have Scott home, not just physically but emotionally. Since his deployments, she has longed to have her husband back and has been desperately wondering if she is still important to him.

Treatment Process: Middle Phase

By the end of the sixth session, the couple was able to see their negative pattern of interaction and step back from it as soon as it would start (end of Stage 1: De-escalation).

Mary: The other night, I realized that I was peppering him with a lot of questions. I started making lists and questioning him about what he had gotten done. I realized I was starting to poke him—that pursue thing we've talked about—sounding pretty critical.

Scott: I was getting more and more stern the more she questioned me. I felt frustrated, misunderstood, and disrespected. I started getting tight, feeling gripped.

Mary: But, then, I realized we were doing the cycle, getting caught in the loop. I know usually that means I'm feeling like I'm not that important to him ... I use the lists as a way to make sure he remembers us.

Therapist: (track, reflect) Right, when in doubt about how important you are to him, give him a list and start peppering him. That's one way your cycle gets cued—give him a list, he feels trapped, like he's in a vice, you start questioning him, and he withdraws, right?

Both: (nodding confirmation)

Therapist: But, do I hear that you both were able to step back from the cycle? To slow down and not let the cycle take over?

Scott: Yea, it was good. We did slow down and she said, "We're getting caught in that loop." That was good—I probably would have kept tightening, but when she said that, I could relax a little.

Therapist: (track, reflect) Relax, and stay in the conversation with her?

Scott: Yea, I stayed in the conversation and she slowed down. It was good, actually. She started talking about how worried she was, and I could listen. I didn't feel like I had to get ready for the next round of incoming.

Mary: It was good. It gave me hope that we can actually change for real. He stayed right there with me and I felt like he heard me. For the first time in a long time, I felt like he heard me.

Therapist: (tracking, reframe) This is when, in the past, Scott, you would say to yourself, "We're done. I'm out of here," and you leave the conversation, leave the room, leave the house feeling hopeless and alone. And, Mary, these are the moments that have been so hard for you? You have been so desperate to have him stay, stay in conversation, stay with you but haven't known how to share how much you miss him, how alone you feel, but then you give him lists? This is when you would start questioning him? But, the other night, it sounds like you were able to step back and catch the cycle as it was building. Is that what happened?

Both: (nodding their heads yes)

After six sessions, Scott and Mary were able to see when they were getting caught in their cycle, take a step back, and see their cycle as the enemy rather than each other. Scott started staying home more and started having more conversations with Mary. He seemed more engaged in therapy, more open to Mary; smiled more; and reported feeling more hopeful. Mary became less reactive, less critical, and more

open to hearing Scott's sense of being torn between his two loves: his family and his combat missions. She reported that she had more hope for their marriage.

In session 9 (Stage 2: Withdrawer re-engagement), Scott talked about his transition home from the wars and feeling caught between his competing attachments.

Scott: It's hard coming home after the war. There's a big letdown, and everything is different. I didn't know how to be with her. I didn't know what to do next. I felt like I was in a vise. So, I kept revving, feeling tight, as a way to keep myself guarded.

Therapist: (re-ecting, conjecturing) Right, staying tight kept you protected, guarded, a constant flow of adrenaline. Somehow this helped you feel safe?

Scott: Yea, but I didn't realize until lately how it was hurting Mary. I've been keeping myself guarded, tight, and distant without thinking of her.

Therapist: And, now you're thinking of her?

Scott: Yea, I've been thinking of her a lot (looks at her).

Therapist: (evoking) Feeling what when you think of her? When you look at her?

Scott: Feeling how much I let her down. How I left her to fend for herself and the kids.

Therapist: (validating, tracking) But when you got the list of questions from her, when she would get pushy (her word from previous session), it was hard to think of her. You would feel tight—like you were in a vise—and you would see. As desperate as she felt to get you to stay close to her, you felt desperate to get some space and get away. Does this fit?

Scott: Yea, it fits. It describes us over the last year and a half.

Therapist: (evoking, heightening) But, now, you're saying something different. You're saying, "I left her to fend for herself too long." And you feel what on the inside as you say, "I left her to fend for herself?"

Scott: I feel badly. I do. But, I also need her to give me space. I need her to understand how torn I have felt being home. Missing that deployment. Letting my guys go back without me.

Therapist: (softly) You feel badly about her but also torn ... that's a hard place to be ...

Scott: Yea, I feel really torn. It's hard being home, but I need her to know I love her. But, it's hard to give up going back or to think about not going back. I feel guilty no matter how it ends up—guilty for letting my guys down again; guilty for letting my wife down again. Either way, I lose, but no one wins.

Therapist: (conjecturing) Right, you lose but no one wins, and that leaves you feeling really frustrated, helpless, alone ... do these words fit?

Scott: All of that—frustrated, helpless, alone—yea ...

Therapist: (softly) And, when you've felt so helpless and alone, it's been really uncomfortable and hard to talk about with Mary?

Scott: Yea, hard to talk about with anybody. Until recently, I didn't think there was any value in talking about it all. Now I'm starting to get how talking helps us. Helps me. I don't want her to feel ignored.

Therapist: (heightening) Um hmm, you don't want her to feel ignored but, also, you don't want to feel pushed on by her. You want to be able to talk with her about what you're going through, but you don't want her to give you a list or to criticize you. Is that it—this is when you feel caught in a vise? It has

been hard to imagine sharing with her how alone and helpless you've felt. Hard to ask for comforting in these alone moments?

Scott: Well, that would be nice if she knew what I was going through.

Therapist: (enactment) Can you tell her? Can you tell her you need comforting, that you've felt helpless and alone? That you haven't known how to talk about all that you've been going through?

Scott: (tentatively looks at his wife). I have been going through a lot, not sure what to say, what to do. Not even sure what I feel. I've been so wound up and haven't known how to slow down, let you in. I've been living with a ton of frustration, feeling really helpless, which I hate. And, as much as I have pulled back, I don't like feeling this alone.

Therapist: (softly, reflecting, heightening) You have been feeling really alone, and it's been hard to let her in. You've been caught in this vise, needing comforting. And this has left you feeling really helpless and alone, right? Too scared to tell Mary how much you need her?

Scott: (soft voice, emotion in his throat) Yea, I have been too scared to tell you how much I need you. It's not that I haven't wanted to let you in; it's that I haven't known how. And, I do need you. I need to know I'm ok in your eyes. That you still love me even though I left you to fend for yourself and the kids.

Therapist: (to wife, evoking) Mary, what's it like to hear Scott share how much he needs you and how alone he's been? He was just so brave in sharing how unbearable it has been for him to be stuck feeling helpless and alone. How does this touch you?

Mary: (softly) Um, I'm not sure. I'm not sure if I believe what he's saying. I mean, I want to believe him, but it just doesn't sound like him. It's just really hard for me to imagine him needing me or feeling helpless and alone.

Therapist: (conjecturing) You've never seen these sides of your husband? You haven't known that he has needed you?

Mary: Right ... I'm not sure ...

Therapist: (reflecting, reframing) This is so new and different for both of you. You've thought of Scott as just not caring—even feeling unimportant to him—when actually he has always cared but hasn't known how to talk about it. So, when he says he needs you, that he has been helpless and alone, it's like you don't recognize him, since you don't usually see these parts of him?

Mary: Right, I haven't seen these parts of him. I guess he has kept them hidden. It's strange, actually, to hear him describe himself as helpless and alone. I never would have guessed that he felt that way. I mean, I don't want him to feel helpless and alone.

Therapist: (evoking, conjecturing). So, hard to believe, it's so different than what he has shared with you in the past. But, part of you is saying, "I want to be there for him. I don't want him to feel helpless and alone." Part of you is touched by his sharing? You feel for him?

Mary: (slowly) Yea, yea, I do feel for him. I am surprised, but touched too.

At this point in therapy, Scott becomes much more engaged emotionally and continues to share his experiences with his wife. As she continues to accept his experience and softens her criticalness, his emotional engagement deepens and stabilizes.

In session 12, the third change event in EFT, blamer softening, occurs.

Mary: I have been pushy, just at the wrong times, I know. But, I want to be taken at face value. I mean, it's me that has been talking to you. Not some stranger or some boss or someone else.

Therapist: (conjecturing) You're saying, "It's me, hear me, trust me ... I'm someone special, not just anyone, so tune in to me"?

Mary: Yea, exactly, come be with me, listen to me, aren't I important enough for him to listen to? I haven't felt like I could be me or that he wanted me to be me ...

Therapist: (evoking) What's that like, Mary, on the inside of you, to wonder if he wanted you to be you?

Mary: It hurts, it's painful. I know I haven't always made it easy on him, but I started losing hope that he wanted me to be me anymore.

Therapist: (conjecturing) And, losing hope ... that's a hard place to be? Sad too?

Mary: Yes, sad too.

Therapist: (evoking) Sad that you were losing hope? Sad that you wondered if you could be you; if he wanted you to be you? If you were loved for you?

Mary: All of that ... really sad to wonder if he loved me anymore (starts to cry).

Therapist: (reflecting, conjecturing) So, underneath all those questions and lists you were throwing his way, underneath all that pushing you were doing, you were really wondering if you are loved? If he still loves you? You were getting scared that you weren't important to him anymore?

Mary: Yea, I've been really scared he stopped loving me (cries more). I really need him to love me. I love him so much ...

Therapist: (validating, evoking) You really need him—that's new for you to say. You've gotten so self-sufficient over these deployments, but you really need him and haven't known how to tell him? You really get scared that he doesn't love you, and you really need him to be there for you, love you, watch your back, so you know you're not alone?

Mary: Yes, yea, I do really need him. I have felt really alone. I've been so sad feeling this alone.

Therapist: (evoking) What would it be like to tell him how much you need him? How alone you've felt and how sad it has been for you to feel this alone?

Mary: He'll think I'm too needy if I tell him how much I need him. I've tried to cover up my loneliness—he said he married me because I was self-sufficient and independent, so I don't really want to tell him how alone I've been and how much I need him. He'll think I'm weak.

Therapist: (conjecturing, heightening) It's risky, isn't it, to let him see this part of you. You fear he'll see you as needy and not strong, self-sufficient, independent. It's scary to tell him about how important he is to you? How much you long to be close to him?

Mary: I don't think he'll like this part of me ...

Therapist: (to Scott, evoking) What's it like for you to hear Mary being so real, so vulnerable, so open, even when it feels risky to her?

Scott: I like knowing I'm needed. I want to be there for her. I do see her as strong. Mary, I do see you as strong—you are strong—but I need to know you

need me too. I need to know you'll let me come close and be there for you. I've felt really alone too and thought I was the only one who felt alone. But, we've both been feeling alone for too long now.

Therapist: (to Mary, evoking) Can you hear him, Mary? Can you let his words touch you? He's being so earnest.

Mary: Yea, kind of. I can kind of let his words touch me. (to husband) You won't think I'm weak? You won't think less of me?

Scott: No, no, not at all. I want your softer side—I can come closer to your softer side. I need to know that I'm needed.

Therapist: (to Mary, enactment) Can you tell him how much you need him, Mary? He's right here, loving you, waiting to catch you. Can you let him in on how sad and alone you've been?

Mary: (to husband) I really have been missing you, missing us. I tried getting more self-sufficient, but that didn't work. I try staying strong, holding steady, but I couldn't keep it going. I do need you ... I've missed having you so much (crying) ... I can't do this without you.

At this point in therapy, the two change events have helped Mary and Scott restructure their interactional pattern. Each of them now expresses their underlying emotion more openly and more directly to each other, which strengthens their connection. As Scott said, "I don't do it perfectly each time, but I also don't withdraw either."

Treatment Process: Late Phase

In sessions 13–15 (Stage 3: Consolidation/Integration), Scott and Mary continued to share their underlying emotions as they started solving old relationship issues that, previously, had seemed so unresolvable (step 8). Together, they were able to talk through their needs when it comes to parenting their teens and deciding whether he should retire from the navy. Before therapy, these specific issues felt threatening to each of them and fueled arguments and distance between them. They also consolidated their new positions in their relationship's dance (step 9). Scott, the previously withdrawn partner, was now verbalizing his feelings, sharing his experiences, and interacting with Mary regularly. Mary, previously the pursuer, was much softer and more open to Scott, which gave him the space he needed to stay emotionally engaged with her. Mary was able to talk about her needs and fears in a nonreactive way, and he was able to ask for comforting and talk about his moments of helplessness. Both were able to talk about how it used to be, and how it had changed, and they were interacting differently. Both felt that, for the first time in a long time, they could go to each other and openly connect.

A month after therapy, Mary called the therapist to share that they had experienced three big issues since the termination session. She said that she was able to share her vulnerabilities and he was able to talk about what he was going through. She reported that they were "delighted" with their connection. She contrasted how they started therapy (as having a "terrible marriage") to now feeling like she had a "wonderful husband and marriage."

Conclusion

Therapist's Reflection/Commentary on the Case

Challenges

Before the initial session, Mary called the therapist to say that her husband did not think he could change and was throwing up many blocks to attending the session. She told the therapist that the therapist had her work cut out for her. In the first session, the therapist worked hard to validate and normalize the husband's defenses. He was guarded for good reason, and the therapist let him know that she understood his need to be guarded. The therapist's ability to validate his defenses in the first few sessions and not push him into his emotions was the beginning of the therapist building an alliance with him and normalizing his experience.

There were times in the early sessions where he would use his "radio chatter" voice to communicate both to his wife and to the therapist. The therapist evoked what was happening moment to moment with him right in the session, which was pivotal. Eventually, he was able to describe being "tight," and this "tightening up" was framed as a coping strategy. This was his way of withdrawing, getting distance from his intense internal experience, in these in-session moments. Helping him talk about his internal experience in these "tight" moments was a key in order for the grip of tightness to loosen. Starting with his physiological arousal (stiffening, jaw clenching), he was able to name and touch his internal feelings of frustration and helplessness.

What Worked

What worked was holding this couple's distress in an attachment frame supported both partners, which allowed the changes to occur. As the therapist put their distress and the resulting cycle in attachment terms, their behaviors started making sense to them. No longer was Mary just overreacting, and no longer was Scott just leaving home. Each partner was able to see their own, as well as their partner's, behaviors in context. Validating both of their defenses and holding a nonpathological perspective was vital for Scott to engage and for Mary to soften.

Implications for Training and Supervision

Brief Suggestions for Therapists and Trainees

EFT is an empirically supported therapy with a rich body of literature to aid therapists. The following are a few simple suggestions.

- Find empathy for both clients. The therapist's ability to empathetically attune to each partner is imperative. All interventions in EFT start with empathetic attunement.
- Be curious and tentative. Being curious about clients' experiences leads to more empathetic, relevant, evocative responses. The EFT therapist wants

the clients to discover their leading edges and what is just below their awareness. The therapist uses tentative conjecture to help bring the focus to their implicit experiences.

- Remember that both emotions and the resulting behavioral responses and strategies make sense and are logical in their context. Sometimes that context is rooted in both current partner and previous relational history, including childhood attachment relationships.
- Focus on creating experiential change events in session. Change does not come from simply having a new insight. Partners must experience each other differently. If they won't do it in session, they are not going to do it outside of session.
- There are a variety of ways of learning to be an effective emotionally focused couple therapist, including reading the treatment manual (Johnson, 2004), doing exercises in the EFT workbook (Johnson et al., 2005), viewing EFT training tapes, and participating in EFT externships (4-day intensive trainings), EFT core skills trainings (for those who have completed a certified EFT externship), receiving supervision from an EFT-certified supervisor, and becoming an EFT-certified therapist and viewing training videos (see www.ICEEFT.com).

PE: Web address is good.

Brief Suggestions for Supervisors

For supervisors working from an EFT perspective, there is an empirically based model of EFT supervision (Palmer-Olsen, Gold, & Woolley, in press) and a process of training and certifying EFT supervisors (see www.ICEEFT.com). The EFT supervision model involves four primary goals:

1. Cocreate and maintain a secure supervisory alliance.
2. Ensure supervisees' theoretical grounding in EFT stages and steps and in attachment theory.
3. Ensure supervisees' ability to deepen and regulate clients' emotions and facilitate bonding processes.
4. Ensure supervisees' ability to regulate and use their own emotional processes in therapy (Palmer-Olsen et al., in press).

EFT supervision emphasizes helping supervisees gain in-depth competence in the conceptual, perceptual, and executive aspects of effective EFT.

EFT supervision is isomorphic to the practice of EFT. Therefore it emphasizes providing a secure learning environment and experiential learning. The experiential learning often takes the form of role plays of therapist/client interactional sequences, and doing video-based and live supervision. Certified EFT supervisors often use the Internet to provide live, real-time supervision remotely, sometimes from opposite sides of the world.

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