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Attachment Theory and Emotionally Focused Therapy for Individuals and Couples

Perfect Partners

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Experiential therapies, such as emotionally focused therapy (EFT; Greenberg, Rice, & Elliott, 1993; Johnson, 2004), share with John Bowlby's (1969/1982, 1988) attachment theory a focus on the way we deal with basic emotions, engage with others on the basis of these emotions, and continually construct a sense of self from the drama of repeated emotionally laden interactions with attachment figures. The relevance of attachment theory to understanding change in adult psychotherapy, whether individual or couple therapy, has become clearer because of the enormous amount of research applying attachment theory to adults in the last two decades (Cassidy & Shaver, 2008). Attachment theory is now used explicitly to inform interventions in individual therapy (Fosha, 2000; Holmes, 1996), and it forms the basis of one of the best-validated and most effective couple interventions—EFT for couples (Johnson, 2004; Johnson, Hunsley, Greenberg, & Schindler, 1999). This chapter considers how the attachment perspective helps the humanistic experiential therapist address individual problems such as anxiety and depression, as well as the relationship distress that accompanies and maintains these problems. The current humanistic experiential model of individual psychotherapy is perhaps best represented by the systematic and evidence-based interventions of the EFT school (Greenberg et al., 1993). This approach has received considerable empirical validation both for

anxiety/trauma-related problems and for depression in individuals (Elliott, Greenberg, & Lietaer, 2004).

POINTS OF CONTACT

The theoretical points of contact between experiential therapies such as EFT and attachment theory are many. Both take a transactional view of personality: Internal aspects of a person, such as affect regulation abilities, interact with the quality and nature of present close relationships in a dynamic and reciprocal manner. Both link dancer and dance, self and system, in a holistic evolving process (Johnson & Best, 2002). More specifically, in both models the responsiveness and acceptance offered by key others are crucial in facilitating the effective processing and ordering of experience into coherent meaning frames. These frames then guide adaptive action. For the individual to be emotionally accessible and flexibly responsive to self and others is the hallmark of health in both approaches.

In general, the concepts of health and dysfunction seem very consistent across the two perspectives. Attachment research (Mikulincer, 1995) and theory predict that securely attached adults will have a more organized, coherent or articulated, and positive sense of self. Others are seen as basically trustworthy, and the self is viewed as lovable and competent. Rogers (1961), the founding father of the humanistic experiential model of therapy, also focused on how safe emotional connection with others builds a positive and empowered sense of self. This connection not only maximizes flexibility and adaptability, but promotes resilience in the face of stress and trauma. A secure orientation (and the coherent positive sense of self associated with it), seems to promote cognitive exploration and flexibility, helps people stay open to new information, and helps them deal with ambiguity (Mikulincer, 1997; Mikulincer & Shaver, 2003). In brief, it promotes the ability to learn and adapt. As Rogers (1961) pointed out, the presence of an attuned empathic other who offers acceptance enhances exploration and self-actualization. A secure orientation also allows an adult to consider alternative perspectives and engage in metacognition (Kobak & Cole, 1991; see also Jurist & Meehan, Chapter 4, this volume). The ability to reflect on, discuss, and so revise realities is enhanced. The experience of felt security with another is associated with more open, direct communication styles, as well as with more ability to self-disclose and assert one's needs. In general, a secure attachment style allows for the continued expansion of a positive sense of self and the ability to respond to one's environment, whereas insecurity is associated with constriction of experience and a lack of responsiveness.

In EFT, health is described as the ability to fully listen to and engage inner experience (particularly emotional experience), to trust this experience, and to create meanings that can then direct behavioral responses. As

Greenberg et al. (1993, p. 28) state, when this therapy works, clients learn to “trust their own experience and to accept their own feelings. They learn that they are able to be themselves in relation to one another. They are confirmed in their existence as worthwhile people.” Rogers (1961) believed that the growth tendency propelling people toward health is innate, as did Bowlby (1988, p. 152), who stated that “the human psyche, like human bones, is strongly inclined towards self-healing.” Rogers saw this tendency as a genetic blueprint; however, a safe, validating environment enables this tendency. Greenberg (1996) also points out that although Rogers spoke of dysfunction in terms of the conflict between experience and one’s self-concept, this formulation has waned in importance, whereas blocks to listening to emotions and fully processing key experiences have become key to understanding dysfunction. Health, then, is being able to fully engage in current moment-to-moment experience and use this experience to make active choices in how to define the self and relate to others. Key experiences are explored, integrated, and used to expand the range of an individual’s responses, rather than being denied or distorted. The value of being authentic—trusting one’s experience and being true to oneself—is implicit in this model and intricately linked to intimate connection to others. Humanistic therapists view themselves as helping people make active choices, understand how they actively construct their experience of self and of others, and listen to their emotional experiences and needs. Therefore, the views of health set out both in attachment theory and in experiential writings seem to me to be complementary and to share a common view of people’s basic needs—for acceptance, connection, and the safety that leads to exploration and growth. Both look within and between individuals, and at how intra- and interindividual realities reflect and create each other. Both perspectives suggest that when these needs are not met, the processing of experience and engagement with others becomes distorted or constricted. John Bowlby would surely have agreed with Rogers’s comment that therapy should lead someone from “defensiveness and rigidity” to “openness to experience” (1961, p. 115).

In terms of how clients are seen, both attachment and experiential perspectives are inherently nonpathologizing. Bowlby stressed that if we understand the relational environment in which a person learned to relate and adapt, then we would appreciate that the person’s behavior is a “tolerably accurate reflection” of what actually happened to him or her. This parallels the emphasis experiential therapy places on the therapist’s unconditional acceptance of a client’s experience and empathic understanding of the client. In both perspectives, strategies or ways of dealing with emotions that land people in trouble are seen as having originated as defensive maneuvers to maintain connections with loved ones or ward off a sense of the self as unlovable and helpless. Both models speak of coherence, or the ability to integrate different experiences or parts of self, as being an ongoing process aimed at health. The integration of implicit, overlooked, or silenced aspects

of self, spoken of in the experiential literature (Elliott, Watson, Goldman, & Greenberg, 2004) parallels the focus in attachment theory on the secure person's ability to create coherent integrative narratives of key attachment experiences and tell these stories congruently (Hesse, 1999; Main, Kaplan, & Cassidy, 1985).

Both attachment and experiential viewpoints privilege emotion. Bowlby (1991) noted that the main function of emotion is to communicate one's needs, motives, and priorities to both oneself and others. I believe he would have endorsed the EFT concept that being tuned out of emotional experience is like navigating through life without an internal compass. Both perspectives see emotion as essentially adaptive and compelling—as organizing core cognitions and responses to others. Both perspectives also include the view that affect regulation is the core issue underlying the constricted responses that bring people into therapy. Bowlby stated, “The psychology and psychopathology of emotion is ... in large part the psychology and pathology of affectional bonds” (1979, p. 130). The processing of emotional experience is viewed as the vital organizing element in how the self and others are experienced and how models of self are constructed (Bowlby, 1988; Elliott, Watson, et al., 2004). Both experiential therapists and attachment theorists view emotion as the vital element in guiding perception, cueing internal models of self and other and interactional responses. Indeed, research suggests that affect may function as the “glue” that binds information within mental representations (Niedenthal, Halberstadt, & Setterlund, 1999).

The concept of emotion has become more differentiated, and its role in therapy more clearly articulated, than was the case when attachment theory was originally formulated. It is perhaps easier to use emotion in therapy when, for example, we understand clearly that there are six or seven main universal emotional responses (Frijda, 1986; Izard, 1991; Tomkins, 1962–1992). Attachment theorists talk mostly of insight into emotion as a primary change mechanism in therapy, whereas experiential therapists attempt to create new corrective emotional experiences rather than insight per se.

The focus on moment-to-moment emotional processing—which is so fundamental to experiential therapies such as EFT, where the therapist literally tracks and aids in the moment-to-moment construction of an individual's experience—has a parallel in the basic observational technique used in developing attachment theory: the coding of emotional responses and behavior in the Strange Situation (Ainsworth, Blehar, Waters, & Wall, 1978). Both an experiential therapist and an attachment theorist focus on bottom-up processing. Just as an experiential therapist focuses on what happens in a key emotional situation, so Bowlby and Ainsworth focused on what happens in key moments when a vulnerable child is left by an attachment figure in a strange context. Both the attachment theorist-researcher and the experiential therapist in a therapy session note how emotion arises and is dealt with in key situations when vulnerability is present and compelling. Both then focus on how an individual responds and either protects the

self (perhaps by shutting down or becoming overemotional) or reaches out into the environment to get needs met. Both will examine the consequences of that choice for the sense of self and for interactions with others. Both note how an individual pulls others close or drives them away and sends out congruent or conflictual signals. Both ask this question: Can people integrate emotions and move confidently into the world trusting themselves and their own realities, or not? The focus on emotional processing and how it creates patterns of interpersonal responses and models of self is the same. This concern with process is also reflected in the work of Mary Main and colleagues (e.g., Main et al., 1985), who interview people about their past and present attachments. The focus in this work is not on the content of these memories, but on how they are formulated—specifically, on the openness and coherence with which they are retrieved and articulated.

The goals of therapy also seem to be similar. Both the attachment theorist and the EFT therapist expect a client at the end of a therapy process to be more open to his or her experience, more able to engage with strong emotion, and more able to create a coherent and meaningful frame and narrative about the self and key relationships. EFT therapists want to help clients create change in emotional reactions that define key relationships. They want to help clients regulate their emotions and not become stuck in strategies such as avoidance that lead to disorientation and incongruence (Greenberg & Paivio, 1997). They want to help clients connect with, reflect on, and integrate traumatic experience and create positive meaning frames that promote resilience. Attachment-oriented therapists such as Fosha (2000) and Holmes (1996) would endorse all of these goals.

Since both perspectives stress attunement, responsiveness, and emotional engagement—that is, since both contend that genuine connection is the key to growth and adaptation—many of the general conditions of therapy will then be similar. Both models suggest, using slightly different language, that the therapy session should be a safe haven. Empathy and emotional connection have to be key parts of the therapeutic alliance and necessary conditions for change. The need for validation, support, and caring from the therapist is stressed in both perspectives. To depend on others is seen as part of the human condition—not as an immature or dysfunctional response to be ameliorated. In general, the therapist in EFT sounds very much like the security-promoting attachment figure of attachment theory. The therapist is emotionally present and genuine, attuned, accepting, and responsive. The therapist responds to the client's pain and helps the client struggle with that pain; what is sharable becomes bearable (Siegel, 1999). The EFT therapist is a process consultant who stands with clients as they encounter and organize their experience. This role parallels that of the loving parent who provides safety and a secure base as a child reaches out to life. The therapist's validation and presence provide a safe haven, and the therapist's responsiveness creates a secure base from which the client can explore the edges and depth of his or her experience and make sense of it.

Although attachment theory has become well integrated into EFT for couples (Johnson, 2003, 2008), it has not been explicitly used in EFT for individuals, at least as described in the literature. How then does attachment theory hone and refine the experiential approach to change in individual EFT?

ATTACHMENT-INFORMED EFT

Although Bowlby did not focus a great deal on the implications of his theory for the practice of psychotherapy, he sometimes described cases in ways that very closely parallel experiential interventions. For example, he described a case where a therapist offered suggestions as to how a young mother at risk for abusing her baby felt frightened, angry, and helpless as a child and longed for secure connection. The young mother was then able to express these emotions herself and so to make progress in therapy (Bowlby, 1988, p. 155). However, most of the time Bowlby and other attachment theorists, while noting the primacy of affect, seemed to suggest a more analytic, insight-oriented approach to change (Holmes, 1996). The humanistic perspective that forms the basis of EFT is essentially a theory of intervention, whereas attachment theory is a theory of personality and development. How can EFT therapists use current attachment theory and research to hone and refine their work with individual clients?

First, the attachment perspective emphasizes the crucial part played by the therapeutic alliance in the change process. EFT has always stressed the importance of accurate empathy, attunement to the client, and genuine engagement. The focus in therapy is on the person rather than the problem. The therapist strives to be authentic with the client, honoring and processing the client's ongoing experience as a collaborative consultant. The existentialists, who were part of the development of humanistic models, stressed that authentic dialogue and genuine encounter allow for the emergence of the client's authentic self (Cain, 2002). The attachment perspective stresses the need for the alliance also to provide a safe haven and a secure base—that is, an explicit source of comfort, reassurance, and validation. Bowlby (1979, p. 94) spoke of a therapist's sympathizing with a grieving widow's "unrealism and unfairness" in such a way that the therapist became her champion and supporter, rather than telling her to be more realistic. Acceptance, validation, and the offering of comfort at times of great pain become vital parts of the therapy process. For example, when a client cries, ashamed of her "pathetic weakness" and vulnerability, and says that she prefers to "numb out" (something that actually happened in the case of Alexis and Keith, described in more detail later), I would make my voice softer and slower and reflect her pain. I think of my response as holding her with my voice and also letting her know that her pain is seen and respected. "Feeling felt" and attuned to by another is a vital element in the creation of safe

connection in attachment theory. It enables the ability to distill, trust, and “own” one’s emerging experience. I also provide validation—saying in this case, for example, that of course Alexis would choose to “shut down,” since for her in her family it would have been dangerous to allow these feelings to emerge. The ability to numb out had, in effect, saved her life, allowing her to stay connected with those she depended upon. In the safety of the interaction with me, she could then allow herself to weep for all the times she dared not connect with that vulnerability. The creation of a safe haven in therapy allows for new levels of engagement with key emotional experiences—the experiences that define the self.

In cases of extreme trauma or lack of any kind of secure attachment, the therapist may become a surrogate attachment figure; this gives the client a glimpse of another world where others are responsive and accessible, and where safe engagement with inner experience and with others is possible. The therapist also helps contain overwhelming affect at certain times, as a supportive attachment figure does in normal life. The EFT therapist may use grounding techniques during a traumatic flashback (see the example in Johnson & Williams-Keeler, 1998), or may directly use engagement with the therapist as an active experiment in connection. The therapist might say, for example, “What is it like to say these things right now with me here? How is it for you that I am here—seeing your vulnerability? You say you are sure that I must be feeling contempt for you listening to this; can you look at my face and see if that is what you see?” The alliance then becomes a safe platform for exploration, and is also used in and of itself as a tool to explore the client’s habitual sensitivities and ways of engaging others. However, in EFT the focus is not so much on using the therapist as a surrogate attachment figure per se and working on forms of transference from the client; it is on using the alliance as a platform for the tasks of distilling primary or core emotions and processing these emotions, so that they move the client toward new responses to self and other.

Attachment theory also offers a guide to primary emotional experience. Attachment theorists (e.g., Fosha, 2000; Siegel, 1999) and experiential writers (Greenberg & Paivio, 1997; Johnson, 2004) both stress that emotion involves an initial orientation (“Pay attention—this is important. It is good or bad, threatening or safe”), a body response, a process of meaning creation, and an action tendency. The word *emotion* comes from the Latin *emovere* to move—“to motivate.” When an emotion is reprocessed and expanded (e.g., when reactive irritation melts into sorrow), the action tendency and the meanings associated with the emotional experience change. Emotions communicate to the self and others what a person needs and is motivated to move toward (Bowlby, 1991). It organizes experience and interaction. Emotion theorists tell us that six emotions are universal across all cultures: joy, anger, surprise, shame, sadness/anguish, and fear (e.g., Ekman, 1992). Attachment theory gives us an encompassing metaframework in which to place these emotions.

In the context of attachment, our most basic human need is for safe emotional engagement with precious others on whom we can depend and to whom we matter. In the deeper, more primary emotional experiences that emerge in a therapy session, there are a number of primary attachment themes. Fear of isolation and abandonment, or the inability to deal with the threat of disconnection from others, and the longing for a safe-haven relationship form the underlying “music” of many problems that bring people into therapy. Themes of deprivation and violation by attachment figures—which result in either the deactivation or hyperactivation of the attachment system (Mikulincer & Shaver, 2003) and the emotions that go with either of these, especially anxiety and anger—are common. Bowlby saw these themes as key sources of problems in adult life. Studies of the phenomenology of emotional hurt stress the power of abandonment or rejection and the lack of self-valuing implicit in most problematic issues (Feeney, 2004). Problems of depression, if placed in an attachment frame, are seen in terms of loss of connection with and trust in others, or loss of the sense of self as worthy of love and connection. The working models of self outlined in attachment theory focus the therapist on the client’s need to experience others as trustworthy and as a source of safety, and to view the self as competent and lovable. Attachment theory offers a map to key needs and to key emotional responses and the meanings associated with them. It explains and clarifies the power of emotion to shape cognitive models, to bring out our most compelling needs and fears, and to define our interactions with others. It supports the EFT therapist’s stance that emotion has *control precedence* and so is the most powerful route to change.

Attachment theory also offers a guide to new, transforming emotional experiences. In EFT for couples, these key change events involve partners’ taking new risks with each other in order for each to give clear attachment signals that move the other to become responsive and engaged (Johnson, 2004). In individual EFT, the overall task is the reprocessing of primary emotional experience, but the therapist can engage the client in many task experiments that lead to corrective emotional experiences. These experiences always involve a deepening engagement with primary emotions, and these most often concern (i.e., are paths into) attachment issues. This engagement also then creates a new awareness of needs and so a new readiness for action. For example, one task outlined in the EFT literature involves integration of conflicting elements in emotional experience by helping the client give voice to and engage with two opposing parts of the self (“I want to take risks, but I am afraid, so I hide out”). Another task is to confront blocks in experiencing or contacting emotions, which prevent movement into adaptive action and therefore keep the client frozen or paralyzed. These tasks help to uncover the client’s internal working models of self and the affect regulation strategies learned in attachment contexts. They also promote the construction of a coherent narrative that offers a framework for dealing

with emotions, as set out in the work of Main and colleagues (summarized by Hesse, 1999).

Some of the tasks of individual EFT are more clearly interpersonal and involve new ways of engaging others or dealing with inner representations of others. The therapist will help a client deal with painful unfinished issues with an attachment figure by having the client imagine that the person is sitting in an empty chair in the therapy room and engage in an imaginary dialogue with that person. In my experience, it is also extremely useful to evoke attachment figures to help a client confront a block in experiencing emotions. For example, a depressed client who came to me for therapy could not empathize with his own pain, and so could not stand up to his wife and ask for a separation even after decades of an extremely disengaged relationship. In a key change event, I asked him to connect with the attachment figure who most loved him and might understand his pain. I then asked that he express his pain to this figure (his mother) while visualizing her with his eyes closed. I encouraged him to “hear” and articulate his mother’s loving empathic response. He was able, in his mother’s voice, to reassure himself that he had been a good partner and must now listen to his own pain. He then gave himself permission to move into an assertive stance with his wife. This significantly affected his depression. Attachment research also supports the benefits of purposely evoking secure representations; this often leads to increased empathy and positive affect (Mikulincer, Gillath, et al., 2001; Mikulincer, Hirschberger, Nachmias, & Gillath, 2001).

From an attachment standpoint, transforming change events in therapy include the discovery, distillation, and disclosing of core emotions, which allow for better regulation of these emotions and enhanced emotional intelligence (Salovey & Mayer, 1990). These events also modify core models of self and others. New appraisals of behavior arise, and old constricting expectations are challenged. New behaviors can then be explored, and new risks can be taken in relation to basic needs for connection with others and a valued sense of self. Clients can then achieve a *working distance* (Gendlin, 1996) from emotion and so use it as a compass to guide their adaptive responses.

In summary, attachment theory offers a compelling rationale for many aspects of EFT practice:

- Attachment theory supports and validates the concern for a safe, collaborative validating alliance with the therapist as a prerequisite for engagement in the change process. Each therapy session becomes a safe haven and a secure base from which to explore and move into new experiences.
- Attachment theory offers deeper understanding and support for the phenomenology of hurts, fears, and longings that EFT therapists focus on and explore. The themes of abandonment, traumatic isolation, rejection, helplessness, and anxiety, and the ways these are dealt

with (by shutting down and restricting experience, or becoming reactive and so creating more of the same), are placed in an existential context and clarified by the attachment perspective. The EFT therapist then has a clearer map of common human misery and human motivation.

- Attachment theory supports the primacy of emotional experience and the necessity of engaging emotion in the change process. Emotion organizes inner and outer realities. Corrective emotional experiences are able to change representational models of self and others and to cue new responses.
- Attachment research also promotes a focus on the moment-to-moment processing of present experience and how it is constructed, rather than a coaching or “let’s get somewhere else” model. As Main (1991) stresses, the coherence and congruence of experience and its integration into coherent narratives and meanings are the keys to adaptive, flexible coping, rather than the nature or content of that experience.
- Lastly, the change events of EFT—where a client more deeply engages in his or her inner world, with the therapist acting as an emotionally present process consultant and support—are inherent in attachment theory, even if Bowlby did not stipulate specific change processes (such as how to explore and expand working models).

TYPES OF INTERVENTIONS

How does an EFT therapist who explicitly uses an attachment frame intervene? Given the creation of a safe-haven/secure-base alliance in couple or in individual therapy, the two main foci of therapy are the accessing and reprocessing of emotion and the use of new emotional experiences to restructure behavioral responses to self and others. The main types of interventions can be described as follows:

1. Empathetically attuning to the client, the therapist tracks and reflects the client’s experience, with a clear focus on emotions and key emotional responses to attachment figures. Reflection serves many purposes. It structures the session by slowing dialogue down and focusing it on emotional responses. It invites a deeper engagement with the key issues and emotions. It also creates safety and a positive alliance, affirming the client’s sense of self. A good reflection organizes and distills experience, letting the superfluous aspects drop away and bringing the central aspects into the light. Reflection, when repeated, also allows the client to savor, revisit, and so further integrate complex emotional experience.

2. The EFT therapist validates emotion and the defenses we all use against overwhelming emotion or feared responses from key others. Attach-

ment theory helps with this validation by giving the “reasons” behind many responses. For example, the fearful clinging and hostile defensiveness of many clients labeled as having borderline personality disorder is easier to connect with if it is seen as fearful-avoidant attachment, based on experiences in which key others have been both a source of safety and a source of violation. Such a client has experienced being left in an impossible, paradoxical position and is still caught in the mode of “Come here, I so need you—but go away, I can’t trust you.” However, in EFT the focus is not primarily on using the therapist as a surrogate attachment figure per se and working on forms of transference. It is on using the alliance as a platform for the tasks of distilling primary or core emotions and processing these emotions so that they move the client toward new responses to self and other.

3. The therapist evokes deeper engagement in the session by tracking, reflecting, and replaying moment-by-moment interpersonal process—whether between client and therapist, between partners, or within the emotional and representational world of an individual. Evocative questions are the main tools here, as well as replays of key moments. So the therapist might offer the following questions:

”What happens to you when you speak of this? How does it feel—in your body—when you say this to me? You seem very agitated as we speak of this. What do you want to do right now? What do you say to yourself when these emotions come up? Do you say, ‘I shouldn’t feel this way—it’s pathetic’? What happens to you when I say you have a right to feel this way—can you tell me? What happens when you hear your father’s voice in your head saying you must grow up? What is it like to tell Peter, who has just told you he loves you right here in this session, that you are afraid? How do you ‘numb out’ as you say it and then shut Peter out?”

With such questions the therapist will validate secondary reactive emotions, such as anger at an attachment figure, and evoke the more primary underlying emotions, such as fear of abandonment and rejection.

4. The EFT therapist follows the attachment model by addressing deactivating and hyperactivating strategies. To contain the emotional extremes of each strategy, he or she will reflect and help to better organize expressed emotions, placing them in a specific context, or will use grounding, externalization, or the therapeutic alliance to soothe the client. As an example of grounding, a therapist might say,

“Can you just slow down a little and listen to your breath? We are talking about something very difficult here. Can you feel your feet on the ground? You are here with me, and we are working this out. This fear comes up precisely when . . . and that makes sense. We can hold it for a

little bit and look at it—then we will put it away and deal with it some more when you are ready.”

However, most of the time, the EFT therapist will heighten emotion. This is achieved through repetition, through the use of images, and through a focus on somatic responses. Key emotional events or moments are identified and replayed, and the elements of emotion, cues, initial responses, body reactions, meaning appraisals, and action tendencies are reviewed. The interpersonal context and attachment significance are evoked. The therapist uses nonverbal cues and slow, simple speech (Johnson, 2004) to make the implicit explicit, the vague specific, and the muted vivid. So the therapist might say,

“Can we go back a moment? You just said that your partner’s anger ‘swept you away.’ What happens to you as you say that? That is a very powerful image—to feel swept away. That is like ‘overwhelmed,’ and it sounds dangerous—yes?”

5. The therapist uses interpretation or conjecture in EFT. This is not the cognitive, insight-oriented intervention usually associated with the word *interpretation*. As the therapist discovers the client’s experience with him or her and goes to the leading edge of that experience, where it is unformulated or difficult to access, the therapist may go one step beyond the client’s words and offer a conjecture. For example, an EFT therapist working with a couple might say,

“So you’re getting very ‘uncomfortable’ right now as we are discussing what happens when you reach for Harry and he does not respond. I wonder—this uncomfortable feeling—is that the scary part? For most of us, it is very hard to take the risk of asking our lover for a response and our partner possibly being unable to respond. We often feel even more alone then. But maybe that does not fit for you?”

Within the explanatory framework of attachment theory, emotions do not appear haphazard or difficult to understand. As a result, conjectures become easier to make, and when made they are more relevant to the client.

6. The therapist reframes certain emotions and responses in ways that lead to positive possibilities. Attachment theory is a rich source of such reframes. For example, trauma symptoms can be externalized and framed as a dragon that comes for the client and pushes the client against a wall of helplessness, rather than as an inner set of symptoms the client should be able to cope with. The angry protest that is part of distress in unhappy couples can be reframed as a sign of love and the importance of the other partner, rather than as hostility and contempt.

7. The therapist sets up enactment experiments. *Enactments* are struc-

tured experiences that can occur between two opposing parts of the self or two conflicting attachment strategies (e.g., the avoidant part of self that does not wish to risk depending on others, and the part that longs for connection); between self and the representation of an attachment figure (e.g., a depressed woman who obsesses about her distant, unresponsive mother but cannot confront her); or between partners in couple therapy. Before such an enactment, relevant emotional experience is heightened and distilled. The enactment is then set up, as in “Can you talk to that numb part of you—that little girl part of you—and tell her . . .” or “So, Mary, can you please tell Jim directly: ‘It is too hard for me to reach out for you, to tell you how much I need you.’” The therapist helps the person(s) stay focused and move through the enactment, dealing with the emotions as they arise. Next, the therapist helps the client or the couple process what happened in the enactment and make sense of it. In couple therapy, this last step most often involves placing the event in an attachment frame and integrating the attachment meanings that arise.

Let us now look at two moments of change—one in an individual and one in a couple EFT session—that demonstrate different types of interventions.

BURNED OR ALONE: NOTES FROM AN INDIVIDUAL SESSION

Leslie was a factory worker in her early 40s, referred by her family doctor. She had many symptoms of posttraumatic stress, which had developed following an extremely violent marriage where she was repeatedly assaulted and raped. When she left the marriage, she was then stalked by her ex-husband for 4 years, but in her words, “no one cared.” Her family, especially her mother, did not support or protect her. She deliberately chose night shift work in a large factory so that she would not have to be with people, and she lived with a small cat that she idolized. Chris, the only man she had allowed to come close to her in recent years, had become depressed, felt rejected by her, and left the country 2 years earlier. In addition, Leslie had recently discovered she could no longer work in the factory, due to serious somatic complaints brought on by the factory environment. Her only family relationships (with her mother and sister) were very tenuous, and her few friendships were distant. She came to see me because she could not sleep, had massive headaches, could not make the decisions necessary for this life transition, and was obsessed with the fear that something might happen to her cat. If her cat died, then life was “not worth the trouble.” The following is a transcript from the 10th session. My goal in this session was to help Leslie begin to step past her bitterness and defensive hostility, and access her vulnerabilities and needs. Seeing Leslie as a person with

a fearful-avoidant attachment style and as a trauma survivor helped me attune to her.

LESLIE: I'm calling the factory and going back on shift. What difference does it make, anyway? It was my birthday yesterday, and no one bothered to call—why bother? At least when I am running that huge machine, I am somebody. That is the biggest machine in the place. Even the men would look at me and say I could handle it well.

THERAPIST: I'm hearing a lot here. Part of you wants to go back—back to the sense of running the huge machine—that gave you a sense of being someone being special, especially since the alternative seems to be feeling vulnerable. All these headaches, and your family isn't there for you even when you are not working nights and more available. You are still alone and you feel like nobody. They didn't recognize your birthday. So part of you says, "Why struggle? What is it all for? Is that it?"

LESLIE: Right. With my mum, it's always my brother—(*sarcastic simpering voice*) "Oh, poor Terry. We must help him." I'm mad at the whole world. And you said last time that my cat was not all there was. Well, aren't we the clever therapist!

THERAPIST: Hm. Your cat never lets you down.

LESLIE: (*Nods.*)

THERAPIST: I guess I am included in the world you are mad at.

LESLIE: (*Smiles affirmatively.*)

THERAPIST: Okay. I think I did ask if your cat was enough for you last time. Maybe that wasn't so clever, because I know that you count on your cat—she anchors and comforts you—

LESLIE: (*Nods.*)

THERAPIST: —especially when you feel you have lost the one thing that made you feel like somebody—gave you a sense of control, and you feel nobody sees you—is there for you, remembers your birthday. It's like you came out of the factory and no one was waiting for you. That is hard.

LESLIE: (*Looks down and away from me.*)

THERAPIST: So you get mad—at all of us?

LESLIE: (*Nods.*)

THERAPIST: But you don't look mad right now. How are you feeling at this minute?

LESLIE: Like telling everyone to screw off. I had to go for a test—the medical test I told you about—didn't want to go by myself, but everyone was busy. So screw off.

THERAPIST: So no one was there on your birthday, and no one would come

with you for the test? So you say “Screw off” to all of us, but your face tells me that it’s hard to not have someone say “Happy birthday” or come to a test with you. That is so hard.

LESLIE: (*Becomes tearful.*)

THERAPIST: What happens for you as I say this?

LESLIE: I guess it’s hard. (*Looks away out the window.*)

THERAPIST: Hard to not be able to count on someone to come to the test with you, hard to have people miss your birthday, hard to have lost the sense of running that huge machine. That was important to you, wasn’t it? You felt in control there. And your body is hurting. This is such a struggle.

LESLIE: I was good at running that machine. And at night in that place, it was me that was running it. I knew how to run it. It was my kingdom, and no one else was there.

THERAPIST: Yes. You mattered. You knew how to run the big machine well. You felt strong, confident, and safe there. But you made the choice. You knew that that aloneness and that life was killing you. It was safe but deadly, no?

LESLIE: My cat is the only good thing in my life, No one loves me like her, so I get scared if she looks sick. I just don’t trust people.

THERAPIST: Yes. And you have good reasons for that. It’s amazing that you have the courage to come here and risk talking about all these things with me.

LESLIE: You challenge me sometimes, but you don’t scare me.

THERAPIST: But other people do, don’t they, Leslie? They really scare you. There isn’t much room for trust, or even giving people a chance. Did you tell people it was your birthday?

LESLIE: (*Looks away.*)

THERAPIST: What is happening as I ask this?

LESLIE: Nothing. Well, I did tell Mary, my neighbor down the road. And, well, she asked me to come over. She invited me for supper, but I didn’t go. What was the point?

THERAPIST: Could you help me? How do you feel as you say that? You refused her offer. She is the one you like, yes?

LESLIE: (*Nods.*)

THERAPIST: And she reached and you refused. You were important enough for her to ask you to come to be with her, but you pushed her away, kept the door shut tight. How do you feel right now?

LESLIE: (*Very quietly*) I feel angry. (*Looks at me, and I raise my eyebrows*)

and smile.). All right. I don't know. I feel sad, I guess (*Tearfully*). It's a bit like Chris.

THERAPIST: Yes. It's like you said last time. You decide it's safer to be alone, but the longing is still there, isn't it?

LESLIE: (*Sheds tears.*)

THERAPIST: You wanted your mom to remember your birthday—and part of you wanted to go to your neighbor's supper—and wanted to let Chris in. It's sad to want that and not be able to risk it?

LESLIE: If you let people in, you get burned. My mum says to me, "You are better off alone."

THERAPIST: Other people are too scary. They burn you. And you feel so vulnerable, and you have been so burned. You were burned by your dad—we talked of that. You so wanted his approval, but he just gave orders and demands. And then you trusted your husband, and he burned you. So now you tell yourself, and your mother tells you, "It's better—the only way to stay safe, Leslie—to be closed off." Your tears tell me that being closed off and shutting everyone out isn't such a safe place, either. You would like to have been able to let Chris in a little, to take your neighbor up on her offer, but ...

LESLIE: I cry all the time. If I let them in, I'll be a doormat.

THERAPIST: If you listen to the sadness and the longing and how much the aloneness hurts and risk, you will be burned, helpless again.

LESLIE: (*Weeps.*)

THERAPIST: And you promised yourself "Never again." You fought for your life in that abusive relationship. You took control. But now, with leaving the factory, you have lost that. You feel more alone, but too scared to let anyone in?

LESLIE: (*Nods.*)

THERAPIST: All this fear and sadness. And if someone sees that, you would be so easily burned. A doormat?

LESLIE: No one knows how sad I am, but I don't need love, don't let people see me. I don't want love. It's shit.

THERAPIST: So when I see you right now? How is it for you? You do let me in?

LESLIE: It's scary. But I can walk away from here. My mother says she loves me. That is shit.

THERAPIST: (*In a soft, slow voice.*) So can you see your mum if you close your eyes? Can you see her telling you, "I love you, Leslie"?

LESLIE: (*Closes eyes and weeps.*)

THERAPIST: That brings up sadness, hurt in you? Yes? 'Cause she isn't there

when you need her, and you are so alone and vulnerable. She even tells you it's better to be alone, but it hurts.

LESLIE: (*Nods.*)

THERAPIST: Can you tell her?

LESLIE: It's not better. It's not better. (*Long pause*) But it's too scary. Can't open the door. (*Weeps.*) I couldn't even go to the neighbors. They are nice. They like me.

THERAPIST: So you're telling your mother, "It's not better to be alone with no one to count on, to feel you matter, to trust. But it's so hard to risk letting anyone in." Can you tell her?

LESLIE: How can you tell me it's better to be alone? I never had the choice. I was alone or I was burned, and you were never there, and I can't live like this any more.

THERAPIST: Can you say that again, Leslie?

LESLIE: I can't live like this. It's too hard. You let me down. But I can't be angry all the time and not letting anyone in.

THERAPIST: What is that like to say that? "I got hurt, abandoned, let down, but it's too hard to live with all the doors closed." To never risk is to be closed in behind those doors, maybe? But it was your way of fighting to survive.

LESLIE: Yes. I could never trust you, and then so much hurt. So I closed the door. Had to do it to stay alive. But now I wanted to go to the dinner. I wanted to let Chris in. I'd give anything to have him back. With him, I felt I was good for something. I mattered, but then he let me down, so I cut him off.

THERAPIST: So can you tell her, "You are wrong. I got mad and shut everyone out to stay alive. But it's cost me and I am so sad and scared and alone. It's too hard just to have Smiley [her cat]. I can cut everyone off, but then I am so sad. I cry all the time."

LESLIE: Yes. Like she said. (*Points to me and laughs.*) It's stupid, but it feels good to say this.

THERAPIST: It makes sense to me. You are a fighter. You fought in one way that got you out of a furnace, but then it got you stuck, and it's hard to turn around and start to risk and trust. But you are in here taking risks with me. What did you say last week? Maybe you didn't want to live all encased in barbed wire, feeling like you were good for nothing.

LESLIE: (*Relaxes and smiles.*) Yes, that's right. But I trust you a little 'cause you are just a silly therapist. (*We both laugh.*)

I then summarized the process above with Leslie, and we agreed that she would write it down in a journal when she got home. Journaling enabled

her to make a more coherent narrative out of the intense emotions she had experienced. Being able to impose order on experience and still be engaged with it is part of functional living and secure attachment. Leslie also volunteered that she was going to go see her neighbor and tell her that it had been too hard to accept her invitation for the birthday supper. The huge number of issues—loss, deprivation, trauma, a model of self as “nothing” and of others as “dangerous,” and a major life transition that confronted Leslie with all her vulnerabilities (difficult life adjustments and health problems)—complicated the therapy process. However, staying with the thread of primary emotions and attachment themes helped me stay focused and present with Leslie. In this session, she had already come a long way from her initial statements of “I hate people” and “I want to change my life—but without being with people.”

No Touch: Notes from a Couple Session

Alexis and Keith were a highly intellectual professional couple; they had been married for 15 years, and had two children ages 8 and 6. Ten years ago, they had emigrated to Canada and left all their family and friends in another country. They were extremely easy to create a positive alliance with. They arrived for the first session displaying a dance of mutual withdrawal after a recent fight. During the fight, Keith had insisted that Alexis change her hair before they left for a party together, but she refused. He then told her that if she did not change her hair, she did not love him, and they should separate. The tiff made them realize how alienated from each other they had become, and this scared them.

Among couples, the content of fights is typically irrelevant; the strong emotions embedded in attachment themes are the heart of the matter. Such was the case with Keith. Keith reported that he had lost his wife when the first child was born. He withdrew into his work, felt more and more rejected by Alexis, and as a result asked for less and less connection. Similarly, Alexis had felt rebuffed and isolated by Keith’s “irritability.” To cope, she “built a wall” around herself, dealing with every issue by staying “in control” and analyzing everything in her head. The couple had not made love in 2 years and described their lives as “empty routine.” After seven sessions, during which their negative cycle of angry withdrawal by Keith followed by numbing and distancing by Alexis had been articulated and framed as the enemy that kept each partner isolated and anguished, Keith began to open up and express his “loss” of Alexis to motherhood. He was able to express his hurt, his fear of asking for connection, and his “automatic shutdown” that occurred whenever he felt shut out by her. He experienced his wife as “behind glass,” and expressed his “loneliness” and his need for reassurance. Alexis was quite responsive to Keith’s frankness, and soon after, the partners resumed their sexual relationship and began to confide in each other. Keith

shared that he felt “abandoned” by her in favor of the children, and that this paralleled his experience with his distant parents. He also felt “judged” by her. As a result of these disclosures, he became more accessible and responsive and was able to share his needs with Alexis.

The goal was now to help Alexis experience and be moved by her attachment emotions, and to engage more intimately with her partner. She articulated that she had had an unpredictable and verbally abusive home life as a child and wanted harmony at whatever price. She found negative emotions very disturbing, and to cope she habitually “numbed them out.” As in many other couples, her habitual way of dealing with key emotions in childhood specifically shaped the way she engaged with her spouse, especially in the context of closeness and vulnerability. Let us take a small segment of her key responses and examine how I attempted to work with them to produce a *softening* change event in EFT. In a softening event, a previously distant or critical spouse risks engaging with his or her newly responsive partner (who has already reengaged) from a position of vulnerability, and asking for his or her attachment needs to be met in a way that elicits a positive response from the partner. This event results in mutual accessibility and responsiveness, and in moments of secure bonding that transform the relationship.

Again and again Alexis returned to the incident of the fight about how she wore her hair to the party, so we stayed there and mined the moment. As I helped her focus on her feelings, the process flowed as follows:

ALEXIS: I am numb, barren as a desert. I have just put my feelings aside. Under control. I was the pillar in my family. I kept everyone together. But that night it felt awful. I felt so vulnerable. There was no sense of being desired. He didn’t think I was beautiful. He could just turn away. (*Weeps.*)

THERAPIST: In that moment you could not numb out. You were so vulnerable, and what you heard was that he did not want you, need you. He turned away.

ALEXIS: (*Nods.*)

THERAPIST: You were not desired—have not felt desired—but rejected—alone.

ALEXIS: I am so lonely, and I am inhibited. It is hard for me to show myself.

THERAPIST: Ah-ha. Hard to show that soft side. That vulnerability, that longing to be desired. Can you ask, Alexis? Can you ever ask Keith for reassurance, attention, touch? Can you ask for a hug?

ALEXIS: (*Recoils in chair, shakes head, and cries.*)

THERAPIST: I see the answer is no—no? That would be too hard, too risky?

ALEXIS: (*Nods.*)

THERAPIST: It’s too scary to reach out and ask?

ALEXIS: I have built a wall. It is scary. I can't touch him. We didn't touch for months and months.

THERAPIST: It is too hard to feel all that longing to be desired, to feel so lonely, so vulnerable. And to reach, to ask, to show him you and your need?

ALEXIS: Yes. I can't do it. (*Puts face in hands.*) So I just numb out. Go in my head and try to stay calm.

THERAPIST: Yes. It's overwhelming to feel this vulnerable, so you shut down, and Keith then feels shut out.

KEITH: (*Nods in agreement.*)

THERAPIST: And he gets angrier and more distant. And you feel more rejected and put up more of a wall. This is the dance that took over your relationship and has left you both alone. Keith, how do you feel as your wife talks about this? How scary it is for her to even protest your distance, to call out for you, to reach for you?

KEITH: It is so sad. It's sad. We got so caught in that. I want her to be able to reach for me.

ALEXIS: But you are so silent. And we do not touch. I cannot.

THERAPIST: What does the silence say to you, Alexis?

ALEXIS: That he does not even like me. And the only safety is in me—to stay in my head so I have ... silence is so awful. (*Turns to Keith.*) You shut me out too.

KEITH: I did shut you out. In those fights we had years ago, I heard that you despised me. Like we talked about here. I heard that I had failed, felt I had lost you to the kids, felt left out. But we are here now.

THERAPIST: What you are saying, Keith, is that you both went behind walls, and now you want to reach out and get Alexis to risk, to trust, to let you in, to ask for the love she needs?

KEITH: (*Stares at Alexis intently, leans forward.*) Yes, yes.

THERAPIST: Can you tell her, please? (*Here I am setting up an enactment where the attuned and responsive partner reaches out and encourages the more fragile partner to risk connecting with attachment needs and sending clear attachment signals.*)

KEITH: I want you to risk with me. I don't want you to be lonely. I don't want to be lonely. I want you to trust me, to support you. I don't want to lose you. I want you to be able to ask. I will be there. So you can ask for a hug, maybe?

ALEXIS: That is terrifying. To ask for a hug, to ask to be held. I can't do that. Being that open in my family ... well ... (*Throws up her arms.*)

THERAPIST: That was suicide in your family, yes? The only safety was in shut-

ting down. It would be like being naked to ask—exposed. What happens to you when Keith asks you to risk? Can you look at him?

ALEXIS: (*Looks at Keith.*)

THERAPIST: What happens when he says, “Risk with me, trust me, ask me”?

ALEXIS: (*Long silence*) I hear it a long way off. (*Cries.*) I do need him. (*Turns to Keith.*) I want to let you in, but it’s so scary. We have to go slow. It’s sad that I just can’t ask.

THERAPIST: Yes. All those lonely years—in your family and with Keith. What was the word you used a few weeks ago? All that “lonely anguish.” Maybe even doubting that you were entitled, deserved, had a right to ask for his touch, his love? (*Alexis weeps and nods.*) So can you tell him, “I want to let you in, but it is so scary”?

ALEXIS: Yes. (*Turns to Keith and says in a very soft voice:*) I do need you, but it’s so hard to say it.

KEITH: (*Stands up and holds her.*)

I then replayed and helped the couple process this event, distilling meanings and validating attachment needs.

The responsiveness in this kind of softening event offers an antidote to negative cycles of interaction that foster insecurity and alienation. As emotions—the music of the attachment dance—change, so do the dance and the dances. Individual and interpersonal change occurs in such events, and the events themselves are associated with positive outcomes and recovery from distress in EFT. They are so powerful that they appear to revise models of self and other and to create new ways of dealing with attachment needs. Understood this way, softening events may explain the low rates of relapse in EFT even among at-risk couples (Clothier, Manion, Gordon-Walker, & Johnson, 2002). The therapist uses the attachment figure, attachment emotions, and needs as they arise to help each person reach past his or her habitual ways of dealing with emotion and engaging others. Perhaps couple therapy can be so powerful precisely because the main attachment figure is present in the room; the dramas of attachment and self-definition are immediate. This is in contrast to more analytic or even psychodynamic interventions, where much time must be spent in engaging emotions and eliciting key habitual responses.

CONCLUSIONS

Integrating an attachment perspective with EFT interventions seems to be a powerful combination for change. John Bowlby developed a brilliant theory of human functioning and development. It seems to me that the attachment perspective streamlines and extends the experiential perspective on

change, and that EFT, as a specific model of change, shares much common conceptual ground with attachment theory. EFT also involves a systematic set of interventions that extends attachment theory into the realm of clinical practice. Bowlby always made it clear that emotion and emotion regulation are the primary issues in health and dysfunction, but interventions based on attachment have focused mostly on therapeutic techniques that depend on cognitive insight to create change. Even when attachment theorists expressly embrace a focus on emotion as a change agent—for example, when Holmes (1996, p. 33) states that the royal route to change is when “previously warded off or repressed affect is evoked, focused on, turned into narrative, experimented with and finally mastered”—the systematic techniques, process maps, and interventions to work with emotion are missing. The stated goal of attachment-informed therapy has often been to change internal working models. EFT assumes that the fastest way to change such models is through new corrective emotional experiences that are placed in the context of and used to transform attachment responses. I believe and hope that Bowlby would have shared my view that EFT is a model of change easily bonded to attachment theory, and that it is almost tailor-made to be attachment theory’s clinical arm.

RECOMMENDATIONS FOR FURTHER READING

- Ekman, P. (2003). *Emotions revealed: Recognizing faces and feelings to improve communication and emotional life*. New York: Times Books.—A book that summarizes some of the most fascinating research on emotion.
- Goleman, D. (2006). *Social intelligence: The new science of human relationships*. New York: Bantam Books.—A book that presents and integrates a mosaic of the new threads of this science.
- Karen, R. (1994). *Becoming attached: First relationships and how they shape our capacity to love*. New York: Oxford University Press.—The fascinating story of attachment theory.
- Johnson, S. (2008). *Hold me tight: Seven conversations for a lifetime of love*. New York: Little, Brown.—An easy-to-read version of attachment theory and how it revolutionizes our view of couple relationships.
- Mikulincer, M., & Shaver, P. R. (2007). *Attachment in adulthood: Structure, dynamics, and change*. New York: Guilford Press.—A fine synthesis of the last 15 years of thinking and research on adult attachment.

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