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Attachment Theory

A Guide for Couple Therapy

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The application of attachment theory to adult relationships, which did not occur until the late 1980s (Hazan & Shaver, 1987; Johnson, 1986), was a revolutionary event for the modality of couple therapy. For the first time, a theory of close relationships offered the couple therapist a coherent, relevant, widely applicable, and well-researched framework for understanding the complex phenomenon of the adult love relationship. This is a phenomenon that has preoccupied and perplexed human beings throughout history. Couple therapy, as a modality, has generally been missing a comprehensive theory of relatedness to guide intervention. Over the years a number of general ideas have arisen that have guided the practice of couple therapy—for example, that adult love relationships mirror past relationships with parents, and that we even actively re-create the negative elements of these relationships to resolve inner conflicts; that problems in relationships are due to developmental delays that cause partners to enmesh rather than differentiate; or that partners lack skills, either communication skills or the negotiation skills, with which to create good rational quid pro quo contracts with spouses. There have been many problems with these conceptualizations. For example, the concept of enmeshment confuses caring and coercion (Green & Werner, 1996), and quid pro quo contracts are not generally found in happy couples but only in those who are very distressed (Murstein, Cerreto, & McDonald, 1977). In general, then, as a modality, couple therapy has largely been a set of techniques in search of a coherent

theory of relatedness to help direct its interventions. As Anderson (2000) noted in her address at the millennium conference of the American Association of Marriage and Family Therapy, we have set out on a vast and troubled ocean in a very small theoretical boat.

The application of attachment theory to adult love relationships is part of, and consonant with, a larger revolution that has seen adult love relationships and problems in such relationships addressed in scientific inquiry. As Berscheid notes (1999, p. 260), science has at last begun to address the "core mysteries of human relationships." Attachment theory, and the associated research on adult attachment relationships, fits very well with the burgeoning recent research on the nature of relationship distress (Gottman, 1994), and on the impact close relationships have on mental and physical health (Kiecolt-Glasser et al., 1993; Anderson, Beach, & Kaslow, 1999). It is also easily integrated with key perspectives in the couple therapy modality, namely, systems theory and the feminist perspective (Johnson, 2002; Johnson & Best, 2002).

There is nothing so practical as a good theory, and attachment theory helps the couple therapist see into and through the complex, multidimensional drama that is a close relationship in crisis. It helps direct the therapist to the defining features of such relationships, set treatment goals that are relevant and meaningful, and map out the best ways to intervene. A map that outlines the nature of the terrain makes the difference between a glorious adventure and getting lost in the woods and reaching a dead end. If we consider a typical North American distressed couple who arrive in a therapist's office, what does attachment theory tell us about them and their problems?

THE ATTACHMENT PERSPECTIVE ON DISTRESSED RELATIONSHIPS

First, this theory tells us that most significant relationship problems will be about the security of the bond between the partners, about their struggle to define the relationship as a safe haven and a secure base (Bowlby, 1969; Cassidy & Shaver, 1999). Contact with intimate others is the primary way humans have evolved to deal with anxiety and fear. Proximity to an attachment figure tames fear and offers an antidote to feelings of helplessness and meaninglessness. The key issue in distressed relationships is each partner's accessibility and responsiveness to emotional cues. As a distressed woman remarked to her spouse, "It's not the fights that really matter. I could handle disagreements—if I felt like you were there for me. But I can never find you when I need you. I feel alone in this relationship." The spouse becomes the primary attachment figure for the majority of adults, and as such their main source of security and comfort. The attachment to one's partner may

be especially crucial at a time and in a culture where there has been a loss of "social capital" (Twenge, 2000). Many people now live in a "community of two," not in the bosom of their extended family or village, and they have no one else to count on for emotional support beside their spouse. Attachment theory also suggests that a therapist may help couples improve their communication skills or gain insight into their past and present relationships, but may be less than effective if he or she does not specifically address the need for comfort and the promotion of the safe emotional engagement and responsiveness that is the basis of a secure bond. This perspective parallels the recent empirical research that stresses the pivotal importance of soothing and supportive responses in defining close relationships and the absolute requirement for safe emotional engagement (Gottman, 1994: Gottman, Coan, Carrere, & Swanson, 1998; Pasch & Bradbury, 1998).

Second, isolation, separation, or disconnection from an attachment figure is inherently traumatizing. Distressed partners who are emotionally disconnected tend to become immersed in fear and insecurity, and to adopt the stances of fight, flight, or freeze that characterize responses to traumatic stress. The more distressed and hopeless the relationship, the more automatic, rigid, and self-reinforcing the emotional responses and the interactional dance between partners will be.

Third, consonant with the current collaborative, nonpathologizing trend in couple and family therapy (Anderson, 1997), attachment theory depathologizes dependency needs (Bowlby, 1988). Bowlby suggests there is no such thing as overdependency or true independence; there is only effective or ineffective dependence (Weinfield, Sroufe, Egeland, & Carlson, 1999). The more effectively dependent a person can be, the more confidently separate and autonomous he or she can be. In general, Western societies have denigrated dependency needs in adults and exalted the image of the separate, self-sufficient individual. Feminist authors remind us that women are often pathologized for their focus on closeness to others (Vatcher & Bogo, 2001). Bowlby also emphasizes that no attachment strategy is dysfunctional in itself. A strategy such as extreme avoidance can be functional in that it can maximize the stability and safety of a specific attachment relationship by minimizing the demands made on an attachment figure. It is when such strategies become rigid and globally applied in new contexts that problems arise. This perspective helps the therapist take a validating, respectful, egalitarian stance toward his or her clients.

Fourth, from an attachment perspective, the patterns of distress in couple relationships are quite finite and predictable and reflect the process of separation distress. Most often, one partner will pursue for emotional connection, but often in an angry critical manner, while the other will placate or withdraw to "keep the peace" or to protect him- or herself from criticism. Each partner's steps then call forth and maintain the others' in a reciprocally determining feedback loop. Gottman (1994) found in his re-

search on relationship distress that negative cycles such as critical complaining and defensive distance predicted the continued deterioration of a relationship. Bowlby (1969) painted a picture of separation distress as naturally proceeding through angry protest, clinging and seeking, depression and despair, and, finally, detachment from the relationship. Occasionally, couples will come for therapy when the pursuing spouse has given up and is beginning to withdraw as a prelude to detachment. This perspective helps the therapist to see the pattern of interactions in a distressed relationship and also to "see beyond" it to the desperation and longing underlying coercive demands and protests and the anxieties and hopelessness underlying stonewalling and withdrawal.

Fifth, depression and anxiety naturally accompany relationship distress (Whisman, 1999), with its attendant loss of security and connection and debilitating sense of isolation, and such distress is likely to maintain these emotional problems. Such distress will also feed into and maintain stress that arises from other sources, for example, posttraumatic stress from violent assault or the echoes of childhood sexual abuse (Johnson & Williams-Keeler, 1998). The resilience fostered by the safe haven and secure base offered in a secure attachment relationship is not to be found. The couple therapist often deals with psychological disorders such as depression as well as with relationship distress per se. Attachment theory suggests specific links between relationship distress and mental disorders, which most clients describe in terms of loss, aloneness, and a sense of helplessness. It thus offers the therapist a clear perspective from which to intervene. It also supports the view of couple therapy as a modality that directly addresses and has an impact on individual functioning and growth.

Sixth, attachment theory directs the therapist's attention to the regulation, processing, and integration of the key emotional responses within a couple relationship (Johnson, 1996). Many models of couple therapy have marginalized emotion, seeing it as a tag-on to cognition or as part of the problem. *Emotion*, which comes from the Latin word meaning "to move," has often been viewed as an intrapersonal, nonsystemic variable. In fact, it is perfectly consistent with systems theory to view emotion and emotional expression as a key link between self and system and as a leading element, an organizer, of the interactional cycles that systems theory has highlighted for couple therapists. Attachment theory emphasizes the importance of emotion as a prime motivator for and organizer of attachment responses. Emotional responses also assign meaning to relationship cues, which are often by nature quite ambiguous, and are a prime means of communicating with others. As Bowlby states (1991, p. 294), "The principal function of emotion is one of communication—namely, the communication to the self and the other of the current motivational state of the individual." Research into the nature of relationship distress also echoes the importance of emo-

tional signals. Facial expressions of emotion are powerful predictors of divorce (Gottman, 1994). Attachment theory suggests that we should pay exquisite attention to the emotions clients bring to couple therapy, which mostly involve anger, sadness and longing, shame, and fear. The therapist can help partners regulate reactive emotions that fuel negative cycles such as attack/defend, and access and articulate marginalized emotions that can be used to move partners into new forms of emotional engagement. For example, expressing desperation pulls a partner closer and cues his or her compassion.

Seventh, the need for secure emotional connection with a few key others is considered to be hard-wired by evolution, and there are a finite number of ways to deal with the loss of such a connection. Thus, there are only a few engagement styles or strategies that the therapist has to take account of. These involve, first, hyperactivating the attachment system and so becoming preoccupied with the relationship, monitoring it constantly, and becoming coercive and aggressive; second, attempting to deactivate the attachment system by "numbing out" and "shutting down" to care less and protect the self; and, third, trying both of the above in sequence. The last strategy is used particularly by trauma survivors who have been violated in close relationships and who, simultaneously, both desperately need and seek, and also desperately fear and avoid, closeness (Johnson, 2002). The considerable research on these engagement strategies helps the couple therapist understand, validate, and begin to deconstruct them in the therapy session (Johnson & Whiffen, 1999: Johnson & Best, 2002).

Eighth, as in other systemic perspectives, attachment focuses on how the self is defined in the context of recurring interpersonal interactions. Bowlby stressed how models of self and models of other, particularly concerning the lovableness of self and the trustworthiness of others, arise from and then guide interactions with others. These models tend to become stable, not simply because they are in place and influence ongoing information processing, but because they tend to be continually confirmed in interactions with significant others. Working models guide people's responses to others and so set up interactions that then pull for confirming feedback (Shaver & Hazan, 1993). The attachment perspective helps the therapist grasp and deal with typical shifts in levels of interaction from explicit content issues (e.g., "You never help with chores.") to more implicit relationship definition/attachment issues (e.g., "Don't speak to me in that tone of voice—like I am nothing to you.") and implicit identity issues (e.g., "You are impossible, you are just too hard to live with."). The therapist can also actively use new positive interactions to challenge negative views of self and other and to promote the construction of a more positive sense of self. Those who feel securely attached to their partners tend to have a more elaborated, articulated, coherent, and positive sense of self (Mikulincer,

1995). The more safely connected I am to those I love, the more I can be myself. Attachment theory helps the therapist conceptualize and therefore address the links between self and system.

Ninth, and finally, attachment theory tells us what the defining moments in a relationship are likely to be, both in terms of the wounds and specific injuries (Johnson, Makinen, & Millikin, 2001) that define the bond as insecure and in terms of the key shifts and change events in therapy that can redefine the relationship as secure and satisfying. Change events in emotionally focused couple therapy (EFT; Johnson, 1996) are associated with specific bonding events called "softenings." In a softening, a newly vulnerable spouse reaches out to a now accessible and engaged partner and asks for his or her attachment needs to be met (Johnson & Talitman, 1997). These pivotal moments appear to offer an antidote to the cycle of negative interactions that have imprisoned the couple for so long. Once such change events are defined and the interventions that lead to them specified (Bradley, 2001), the whole endeavor of therapy is expedited. Pivotal moments where the relationship is defined as unsafe and insecure are also able to be identified. This is crucial in that, if unaddressed, such moments will tend to block change and create impasses in the therapy process. These events, which may be considered relationship traumas, will be discussed in more detail later in this chapter. Attachment theory deepens our understanding of everyday relationship events that have generally been considered to be crucial to relationship satisfaction, such as sexuality. Adult attachment is considered to be reciprocal. It is also representational, in the sense that to know that one is held in the mind of the other, or to hold the other in mind, is often comforting and a source of support. Adult attachment is also sexual (Hazan & Zeifman, 1994). For many partners sexual encounters may be the only time they are held, reassured, and able to connect with their softer feelings and dependency needs.

THE ATTACHMENT PERSPECTIVE ON A POSITIVE RELATIONSHIP

The research on secure attachment offers the couple therapist a clear empirically validated model of healthy connectedness, and thus a specific picture of what couples should, in the best case scenario, be able to do at the end of therapy. The picture of secure attachment that emerges from the research on childhood shows securely attached children being able to regulate their distress on separation from an attachment figure, to send clear assertive signals as to their needs when reunited, to trust and accept comfort and reassurance, and then, confident about their connection with their loved one, to turn to tasks and the exploration of the environment. This picture seems to be equally relevant and applicable to adult partners. More specifically, in terms of affect regulation, securely attached partners should be better able

to contain their reactive, negative emotions and to access and articulate their marginalized or numbed-out emotions. So if a secure attachment can be established, the "aggressive blamer" can modify his or her anger and express other emotions such as sadness and longing, and the "stonewalling spouse" can touch and share the helplessness and uncertainty that cues this stance. Securely attached people in general are more able to access and acknowledge their distress in an open congruent way that elicits responsiveness.

As relationships become safer and more secure in the therapy process, partners are able to find exits from negative cycles. Secure attachment is associated with greater self-disclosure (Mikulincer & Nachshon, 1991). Secure partners have greater access to their underlying emotions and can choose to share these emotions and so change the "music" of their relationship "dance." They can also reflect on the process of interaction, and so metacommunicate about the dance. Research suggests that, indeed, secure bonds are characterized by this ability to metacommunicate and so change the direction of an interaction (Kobak & Cole, 1991). In terms of processing information, secure partners are confident enough to engage in cognitive exploration and remain cognitively flexible, even under stress (Mikulincer, 1997). They are more open to new evidence and deal with ambiguity better. In essence, a secure style facilitates the ability to learn from new experience and update models of self and other as necessary. This research parallels the results of the first outcome study on EFT (Johnson & Greenberg, 1985), where partners who were no longer dangling their feet over the cliff of attachment insecurity could, by the end of therapy, tolerate differences, negotiate, and problem solve. In this study, distressed partners who received EFT and increased the security of their bond were as good at problem solving in final sessions as those who had received specific training in this skill as part of the study. Secure partners are also able to reflect on their experience and create integrated coherent narratives about their attachment relationships (Main, Kaplan, & Cassidy, 1985). Insecurity acts to constrict and narrow how cognitions and emotions are processed and dealt with, and so the ability to create such narratives.

The communication of secure partners tends to be more open and direct than that of insecure partners. They tend to disclose more and be more attuned to the communication of others. They are confident enough to assert themselves but tend to offer more empathic support and use rejection less (Feeney, Noller, & Callan, 1994). It is in watershed events when one partner is distressed and the other either provides or fails to provide closeness and comfort that the quality of communication matters most (Simpson & Rholes, 1994). Then the ability to disclose and confide in a direct way about needs and fears and to tune in to the other's experience is crucial if partners are to define or redefine the relationship as a safe haven and a secure base.

COUPLE THERAPY BASED ON ATTACHMENT AS A THEORY OF RELATEDNESS

A model of intervention based on this theory, such as EFT (Johnson, 1996), should then be characterized by the following:

- A focus on and validation of attachment needs and fears and the promotion of safe emotional engagement, comfort, and support.
- A privileging of emotional responses and communication and direct addressing of attachment vulnerabilities and fears so as to foster emotional attunement and responsiveness.
- The creation of a respectful collaborative alliance, so that the therapy session itself may be a safe haven and a secure base.
- An explicit shaping of responsiveness and accessibility. Withdrawn partners will be reengaged and blaming partners will be supported to soften so that bonding events can occur that offer an antidote to negative cycles and insecurity.
- A focus on how the self is defined and can be redefined in emotional communication with attachment figures.
- An explicit shaping of pivotal attachment responses that redefine a relationship and an addressing of injuries that block relationship repair.

THE EFFECTIVENESS OF INTERVENTIONS BASED ON ATTACHMENT THEORY

A relevant, coherent, and well-developed theory should give rise to specific interventions that prove to be effective in clinical practice. Attachment theory forms the theoretical basis of EFT, and indeed the literature supports the effectiveness of this intervention (Johnson, Hunsley, Greenberg, & Schindler, 1999). This approach has been found to be more effective than skill-building cognitive-behavioral approaches (Johnson & Greenberg, 1985), and, at present, obtains the best results of any couple intervention in the literature. Studies on EFT have found that 70–75% of couples recover from relationship distress after 10–12 sessions and that 90% rate themselves as significantly improved. The effectiveness of EFT is also apparently not as heavily influenced by initial distress levels as other approaches. Specifically, initial distress was found to account for only 4% of the variance in satisfaction at follow-up compared to an estimated 46% in the behavioral approaches (Whisman & Jacobson, 1990).

In terms of evidence as to the value of the theory, there are two other interesting points that emerge from the outcome research on EFT. First, as

in psychotherapy research in general, the quality of the therapeutic alliance appears to predict outcome in EFT. However, it appears to be the task-relevance aspect of this alliance that is the most powerful predictor of outcome, rather than the bond with the therapist or a sense of shared goals. This suggests that couples found the focus on attachment relevant and compelling. Second, EFT does not seem to have the same problem with relapse as other approaches. There is evidence that results are stable, even in very stressed, high-risk relationships where couples would be expected to relapse (Clothier, Manion, Gordon-Walker, & Johnson, 2002), and that there is a trend to continuing improvement after therapy ends (Johnson et al., 1999). If interventions reach to the heart of the matter, they are more likely to create lasting change.

THE CREATION OF SECURE ATTACHMENT: THE EFT MODEL IN PRACTICE

EFT follows the principles outlined above for interventions based on attachment theory. The process of change in EFT occurs in three stages (Johnson, 1996). These stages involve:

1. The deescalation of negative cycles, such as attack–withdraw, that maintain attachment insecurity and block safe emotional engagement and responsiveness. The naming of these cycles and discussion of their impact helps the couple to see these cycles, rather than each other, as the enemy.
2. The shaping of new cycles of responsiveness and accessibility, where initially withdrawn partners take a more involved and active stance and state their needs and fears. Critical, pursuing partners can then begin to ask for their needs to be met in ways that foster compassion and contact. Powerful bonding events can then occur that offer a new emotional experience of connection.
3. The consolidation of gains and the integration of the process of change into the couple's model of the relationship and each partner's sense of self.

A snapshot of an EFT session would capture the therapist constantly involved in two tasks. First, the therapist will be reflecting present patterns in the process of interaction and exploring and expanding the processing of attachment-oriented emotions. The therapist will also explore the cognitive images of self and other that are cued by such emotions. Second, the therapist will be setting interactional tasks, either to enact (and so clarify) present interactional positions or to begin to shape new, more attuned, and

more engaged interactions. So, the therapist might ask partners to explore their experience, as in, "What just happened there, as you, Celia, asked him to explain and then [turning to the other spouse] you, Michael, began to give reasons but suddenly looked at Celia's face and threw up your hands and became silent? Was that one of those times you spoke about when the ground opens up at your feet?" The therapist will then help this partner express the emotional reality behind the throwing up of the hands to his spouse, as in, "I see in your face that I will never do it right—I have failed before I begin. So I despair and shut down and then we are stuck." The therapist then helps the other spouse process this message.

In general terms, anxiety and insecurity tend to constrain the way both inner experience and interactional responses are constructed, shaped, and given meaning. The EFT therapist then deconstructs such experience or response, taking the sudden silence of the client Michael above and noting the hopelessness inherent in his response, the sense of self as a failure implied by it, the underlying attachment fears, and the part this response plays in the couple's pattern of interacting. This moment is then reconstructed and expanded and used to prime new interactions. As the therapist helps this spouse tell his wife about his hopelessness and despair, a new level of emotional engagement is initiated and begins to have an impact on how Celia views her husband. Change occurs by the construction of new emotional experience that changes the nature of the attachment bond between spouses.

CORE INTERVENTIONS

The following sections describe the interventions used by the EFT therapist. Some interventions may be used more than others at various stages in therapy.

Reflecting Emotional Experience

To address and reformulate key emotions, the therapist tracks and attunes to each client's relational experience and reflects the essential elements in this experience. For example: "Could you help me to understand? I think you're saying that you become so what you call 'tight' in these situations that you want to hold onto everything, keep everything under control? And then you get very curt with your husband when he begins to 'rock the boat' and talk about what is missing in the relationship. Is that right?"

Main functions: Focusing the therapy process; building and maintaining the alliance; clarifying emotional responses associated with underlying attachment issues and interactional positions.

Validation

Validation is the most basic intervention in EFT. It invites people to engage with their experience and frames their experience as legitimate and acceptable. For example: "It's so hard for you to even hear what he is saying? You just cannot believe that he might want to be close to you—when you feel so small, so needy. You don't feel entitled to be held and comforted right now, is that it?"

Main functions: Legitimizing responses, especially attachment needs and fears; supporting clients to continue to explore how they construct their experience and their interactions; strengthening the alliance.

Evocative Responding

Evocative responding expands by open questions the stimulus, bodily response, associated desires and meanings, or action tendencies implicit in emotions. For example: "What's happening right now, as you say that?" "What's that like for you?" "So when this happens some part of you wants to reach out, but another part of you is screaming out that it is too dangerous?"

Main functions: Expanding elements of experience to facilitate the reorganization of that experience; formulating unclear or marginalized elements of experience; encouraging exploration and emotional engagement.

Heightening

Using repetition, images, metaphors, or enactments, the therapist heightens and elucidates the nature of the clients' experience and how they construct that experience. For example: "So could you say that again directly please, 'I do turn away, I do shut you out,' " or, "This is so difficult for you, you feel lost, like there is no ground under your feet," or, "Can you turn and tell her, 'It's too hard to tell you about my longing?' "

Main functions: Highlighting key experiences that organize responses to the partner and new formulations of experience that will reorganize the interaction.

Empathic Conjecture or Interpretation

In this intervention, the therapist goes one step further in formulating the clients' experience than the clients themselves have done. For example: "You try to protect that raw, sensitive part of you by keeping a 'barrier' between you and the world, but then it gets a little lonely behind there, is that it?"

Main functions: Clarifying and formulating new meanings, especially

regarding interactional positions and strategies of engagement that prevent emotional engagement with the partner and definitions of self. These conjectures are always explicitly open to correction and modification by the client.

Tracking, Reflecting, and Replaying Interactions

As the title of this intervention suggests, the therapist holds a mirror up to specific interactions and patterns so that they can be seen more clearly. For example: "Can I stop you for a moment? What just happened here? You smiled at him when he said he loved you, but then you turned your head and said 'Is that right' and began to recount that time he let you down and you decided to be 'separate and strong.' "

Main functions: Slows down and clarifies steps in the interactional dance; replays key interactional sequences so they can be restructured.

Reframing in the Context of the Cycle and Attachment Processes

In this intervention the therapist places specific experience in the context of the interactional patterns and each partner's attachment needs and fears. For example: "You go still and tight because you feel like you're right on the edge of losing her, yes?" "You go still because she matters so much to you, not because you don't care?"

Main functions: Shifts the meaning of specific responses and fosters more positive perceptions of the partner.

Restructuring and Shaping Interactions

The therapist supports the clients to enact present positions and so clarify those positions, as well as enacting new behaviors based upon new emotional responses. The therapist also choreographs specific change events, such as softenings. For example: (1) "Can you tell him, 'I won't, I won't . . . I'm never going to put myself in your hands again?' " (2) "You have just spoken about being sad. Could you tell him right now about that sadness?" (3) "Can you ask him for what you need right now?"

Main functions: Clarifies and expands negative interaction patterns, creates new kinds of dialogue and new interactional steps/positions, leading to positive cycles of accessibility and responsiveness.

These interventions are discussed in more detail elsewhere, together with markers or cues as to when specific interventions are used, and descriptions of the process partners engage in as a result of each intervention (Johnson, 1996, 1999; Johnson & Denton, 2002).

A GOOD MAP LEADS TO NEW DISCOVERIES AND TERRITORIES: NEW DIRECTIONS IN EFT

Recent developments in EFT illustrate how an attachment perspective can help the therapist treat complex forms of relationship insecurity and distress, such as those found in the relationships of trauma survivors (Johnson, 2002) and address specific kinds of impasses in therapy, such as the recently formulated *attachment injury* (Johnson et al., 2001).

The delineation of attachment injuries illustrates how a relationship theory can clarify impasses in the change process and expedite effective intervention. Attachment theorists have pointed out that incidents in which one partner responds or fails to respond at times of urgent need seem to disproportionately influence the quality of an attachment relationship (Simpson & Rholes, 1994). Such incidents either shatter or confirm each partner's assumptions about attachment relationships and the dependability of the other. Negative attachment-related events, particularly abandonments and betrayals, often then cause seemingly irreparable damage to close relationships. Many partners enter therapy not only in general distress, but also with the goal of bringing closure to such events and so restoring lost intimacy and trust. During the therapy process, these events, even if they are long past, often reemerge in an alive and intensely emotional manner, much like a traumatic flashback, and overwhelm the injured partner, creating an impasse and hindering the process of change. These incidents, usually occurring in the context of life transitions, loss, physical danger, or uncertainty, when attachment needs are most salient and compelling, can be considered relationship traumas. Attachment theory offers an explanation of why certain painful events, such as specific abandonments, become pivotal in a relationship, as well as an understanding of what the key features of such events will be, how they will impact a particular couple's relationship, and how such events can be optimally resolved. Indeed these injuries *must* be resolved if a couple are to repair their bond and create lasting change in their relationship. The resolution of such an injury is presented as part of the case illustration below.

EFT has also been used for many years in a hospital clinic to improve the relationships of clients with relationship distress that is exacerbated by complex posttraumatic stress disorder (Herman, 1992). This disorder, where others are experienced simultaneously as the source of and the only respite from terror, is usually the result of abuse by attachment figures in childhood. It often leads to the adoption of a fearful–avoidant engagement strategy in adult relationships (Shaver & Clarke, 1994). This strategy is characterized by extreme neediness and extreme fear of closeness and exposure. Attachment theory also helps link specific qualities in a primary relationship to individual problems such as depression and posttraumatic stress disorder. If couple therapists can help traumatized partners create a more

secure bond, they can also create a potent healing environment where such trauma can be addressed and trust in self and others restored (Johnson, 2002). The map provided by attachment theory has proved invaluable in adapting EFT to these relationships. If the treatment of trauma is essentially about the taming of fear, attachment theory offers the couple therapist the possibility of helping the couple create the "primary protection against feelings of helplessness and meaninglessness" (McFarlane & van der Kolk, 1996, p. 24), a secure connection with a loved one.

CASE PRESENTATION: NO-MAN'S-LAND

Louise and Jim had been married for 14 years. She was a professional artist and he was a successful lawyer. They had met in their early 20s and had had a long-distance relationship for 5 years before they finally married. They had no children and were comfortable with this choice. They came in with a long story of alienation from each other and recounted their previous experience in couple therapy which had ended 9 months earlier and had been negative. In particular, it had contained one session that Louise had experienced as "catastrophic" and which she refused to talk about.

The way they described their everyday interactions was that they were both distant and withdrawn. However, they stated that up until 2 years ago they fought quite regularly. These fights would be about how Louise was pursuing Jim for closeness, while he remained reserved and, in her terms, "cold." In the last 2 years, after a family crisis where her mother had a heart attack and died, Louise had "shut down" and stopped pursuing and began to avoid any kind of physical contact with Jim. Louise said, "We are distant friends. It's a case of going through the motions. Like a no-man's-land. I think maybe we shouldn't be married at all." Louise also spoke of long-term problems with anxiety attacks and bouts of depression and had had individual therapy at various times in her life. She felt that the problem had been that she had grown up alone; she had been "close to no one—except Jim—at first—maybe." Jim also spoke of having no model for "whatever she means by closeness" and coming from a very "reserved" family. He had understood for years that Louise had been disappointed by the relationship and had "hunkered down and just avoided confrontation." He spoke of missing sexual contact and being confused about what his wife wanted from him. He asked, "I do need space sometimes. Do I have to give myself up to stop her from leaving me?" When pressed, Jim agreed that he too was lonely. He added, " I think we're stuck. She talks about divorce. We chill out so much—where are the feelings for each other?"

What were the key moments/episodes in Louise and Jim's journey toward secure attachment? After a few sessions, I began to understand that the "catastrophic" past therapy session had involved an attachment injury

for Louise. She stated that the therapist and Jim had agreed in that session that she was too needy, immature, and "dependent," and that she had to learn to give Jim the space he needed. She said that "something had snapped," and she had "switched off." She was not now willing to take risks and to pursue Jim, as in the past. Jim expressed anger at this point, and said he was fed up with walking on eggshells and trying to meet Louise's expectations. Louise then commented that the only emotion she ever saw from him was anger. This couple was easy to work with, except for the fact that Louise needed time and reassurance to feel safe in the alliance with me after her previous experience. Jim seemed to have generally used avoidant, "cool your jets" strategies, while Louise described herself as lonely and preoccupied and as using an "upping the ante" strategy, before she had moved to a more fearful–avoidant stance.

Deescalation of this couple's negative cycle of defensive withdrawal was a relatively easy process. We began to talk about the cycle they were caught in, and both were able to state that they did not want to lose the marriage. Using an attachment perspective and fostering the exploration of underlying feelings, Louise was able to begin to express her anger at Jim's inaccessibility and how he had labeled her the "big, bad, needy one" and discounted her distress. Jim, while at first very intellectual and reserved, began to be able to talk about how he did have feelings, even though his natural style was to be "detached." In fact, with the therapist's help, he began to name his sense of being "flooded and exhausted" from the effort of being "so careful" in the relationship. They began to be more open and sympathetic with each other in the sessions, and both agreed that secure emotional connectedness was a "foreign country" for them, neither being able to remember such a bond in their childhood. They began to share more and to speak of each other as friends, as well as to express some hope for their relationship.

In the second stage of therapy, it seemed imperative to encourage Jim to emotionally engage and become more responsive, and then to try to foster Louise's trust and heal her attachment injury. I began to reflect and heighten Jim's feelings and prompt him to confide in his spouse. He began to access feelings of helplessness and frustration at "not knowing what to do—how to give her what she wants." With support, he was able, even though Louise often sat silent and tight-mouthed, to express his pain and fear of disappointing and so losing his wife.

THERAPIST: What is happening right now, Jim? Your voice sounds very calm, but you are talking slower and more and more "carefully," and you are rubbing your hands together all the time.

JIM: Am I? Well, maybe I'm learning, but I can't talk on an emotional level all the time you know. I can't be made over instantly into what I am not. I am who I am.

THERAPIST: And you are worried that this may not be acceptable to Louise? (*He nods and his eyes fill with tears.*) Can you tell her about that? (*He shakes his head.*) That would be too hard? To tell her how—well—overwhelming it is—this fear of losing her and how it paralyzes you and makes it even harder to try to open up—is that OK? (*He nods in assent.*) Can you tell her, it's so hard to let you see my fear and confusion?

He does this and she responds relatively sympathetically. After this session and the kind of process encapsulated above, Jim began to emerge from his shell and to talk about his sense of rejection. He was able to talk about how Louise could help him by validating his attempts at sharing and being more tolerant of his "fumblings to be personal." He stated that he too wanted the connection they had glimpsed in the beginning of their relationship. As he became more engaged, Louise began to hold her mouth in a tight-closed line and to speak of being "bored."

The task now was to support Jim to stay engaged and to bring Louise, step by step, into a softening where she would risk emotional engagement with Jim. Louise would swing between cool distance, angry remarks, and brief allusions to fear and sadness. After a week where Jim had been very "busy," she remarked, "If you won't carry the relationship, I'm dropping it." I asked her to tell him, "I won't expose myself again and reach for you. My hurt, my aloneness, weren't important to you." He was able to tell her that it was the sense that he was being tested and was failing that terrified him. We framed his dilemma as one where she was *so important* to him that, ironically, he would "freeze up" and be unable to respond. Louise replied, "If you really wanted me I wouldn't have had to fight so hard to get here." We focused on her anger and her determination not to be hurt again. She did admit, however, that they now were able to cuddle and perhaps "things were shifting." We then moved more intensely into Louise's hurt in the relationship and how hard it was now to risk with Jim after being "shut out" all those years. He validated her struggles and her hurt, told her that he found her coolness "scary," and poignantly asked her not to give up on him and the relationship. But just as I thought she was going to reach for him, she then stepped back and became immersed in the trauma of the previous catastrophic therapy session. She became alternately shaky and then distant. I encouraged her to focus on this experience and after saying there was no point and what was happening now was "too little, too late," she began to speak of her sense of isolation and violation in that past session. The attachment injury frame helped me to clarify her experience into a sense of abandonment (Jim had joined with the previous therapist in discounting her) helplessness (she saw that her pain did not matter to him), and despair (she said, "It was the final blow").

The process then evolved in the steps we have identified as typical of

attachment injury resolution, leading into a softening and a bonding event. We can summarize these as:

- Louise accesses and articulates the injury and it's attachment significance: "I didn't matter. You shut me out. You both talked about me like I was a mental case, a nonperson. After all my struggles." I helped her articulate and express her grief and then her determination to protect herself and her ensuing stance of "never again."
- With the support of the therapist, Jim was able to acknowledge her hurt and to admit that he had let her down and shut her out. He elaborated on how terrified he had been in that session and how he had responded to the therapist's suggestion that Louise had to " mature" and change with relief, since it assuaged his own fears of failure. He explained his stance in the incident and I framed it in terms of his fears of losing her, rather than in terms of his callousness or indifference.
- Louise, supported by my validation and structuring of the experience, was then able to articulate the depth of her grief and her sense of isolation. As the only person she had ever felt connected to had turned away from her, her "desperation" had been overwhelming and she had given up on the hope of comfort and closeness. As she put it, "I wanted to die. I couldn't tell you but I was suicidal for days." She wept as she spoke of the sense that she was "disintegrating" as her need for closeness had been disqualified by Jim, as it had in her family relationships.
- Jim moved his chair close and intensely expressed his remorse and regret. He acknowledged again that he had let her down and had not understood her need. He wept with her.
- I asked Louise if she could let Jim comfort her. She refused to do this. We explored this "refusal to be taken in by hope." Jim helped by telling her that he was "desperate" for her forgiveness. Gradually, with my reflecting the process and heightening Jim's messages, she began to hear his remorse and his message that she was important to him. She was then able to tell him how afraid she felt to let the longing for him come up again. I supported her to state this directly and fully to Jim.
- Jim comforted Louise. She began to talk about "trying to find a way back to him" and they begin to piece together a narrative of how they had lost each other and now perhaps had found each other again. They both were able to speak of needing reassurance and comfort. Louise articulated that it was crucial that Jim had acknowledged that she had the right to feel angry and hurt about the session where the injury occurred and the lack of intimacy in the relationship.

Once this injury was resolved, Louise was able to take small steps toward Jim and the trust between them began to grow. She was able to ask

for her needs to be met in specific ways that he did not find overwhelming, and he was able to respond to her vulnerability as in a classic EFT softening event. In this event she was able to fully experience and disclose her fear of depending on Jim again and he was able to reassure and comfort her. The couple were then able to move into the consolidation phase of therapy, where the relationship becomes defined as a safe haven and a secure base. The differences between them were now less significant. Louise said, "My needs are really not that huge. If he shows me he needs me too." And Jim said, "I do want to be close—but I have to feel safe enough to learn how to do it." Louise was able to state, "I think I am finding feelings—I forgot I had them—it's tentatively love." We talked of ways that they could reassure each other and keep connected on a daily basis and of how they had worked to restore and renew their relationship. They were also able to formulate, with the therapist's help, a coherent narrative of how their relationship had become distressed and how they had repaired it. As a last comment, Jim remarked, "We have both been so lonely, but now no-man's-land seems to be turning into a field of daisies." He smiled.

CONCLUSIONS

Attachment theory, as it has been developed and related to adult relationships, is a transactional systemic theory that offers the expanding field of couple therapy a much-needed comprehensive theory of adult love and connectedness (Johnson & Best, 2002). It offers the therapist an answer to key questions, such as what to focus on and what elements to target for change in the complex drama of relationship distress. It guides the therapist to the heart of the matter and offers a compelling and empirically supported model of relationship health and dysfunction. It informs the therapist as to the pivotal processes and watershed events that define the nature of a close relationship. All of this is essential to the task that now faces couple therapy as a modality (Johnson & Lebow, 2000). This task is to articulate efficient and effective interventions that can help couples construct stable, long-term, satisfying bonds, interventions that can also address key individual symptoms by changing the nature of an individual's most immediate context. As Gurman (2001) suggests, primary relationships have great healing power, and for change to endure it must be supported in a person's natural environment. This theory has great breadth, but it is also specific enough that it can focus on the agreed priority for most clinicians (Beutler, Williams, & Wakefield, 1993), namely, that of delineating the therapist and client behaviors leading to important moments of change. It is an essential part of the coming of age of couple therapy as a modality and indeed makes couple therapy a glorious adventure.

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