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CREATING HEALING RELATIONSHIPS FOR COUPLES DEALING WITH TRAUMA: THE USE OF EMOTIONALLY FOCUSED MARITAL THERAPY

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Emotionally focused marital therapy (EFT), a marital therapy that particularly focuses on the creation of secure attachment, has proven in empirical studies to be effective for distressed couples. This paper discusses the application of EFT in couples where one or both of the partners have experienced significant trauma. EFT, in this context of trauma, incorporates the nine steps of conventional EFT and also encompasses the three stages of the "constructivist" self development theory of trauma treatment. This paper illustrates how the integration of EFT and trauma treatment can prove effective in treating not only relationship distress but also the individual symptoms of posttraumatic stress disorder (PTSD).

THE CONFLUENCE OF TRAUMA AND MARITAL THERAPY

Distressed and unstable relationships are a significant part of the aftereffects of trauma and posttraumatic stress disorder (PTSD). The experience of trauma intensifies the need for protective attachments (Herman, 1992). At the same time, it destroys the trust and security that are the main building blocks for such attachments. Trauma, particularly trauma inflicted by one person on another, constitutes a "violation of human connection" (Herman, 1992, p. 54). It can render such connection problematic, no matter how much it is needed, and define it as a source of danger. It is not surprising that traumatized partners seek out marital therapy to help them deal with the relationship distress that has been generated, maintained, or exacerbated by the effects of trauma.

To a certain extent, partners in distressed relationships where one has been traumatized have the same symptoms as other maritally distressed couples. They are often struggling with overwhelming negative affect: anger, sadness, shame, and fear. They tend to feel

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hopeless and helpless in their relationship and so focus on personal safety and on protecting themselves rather than on connecting with the other. They become stuck in constricted, self-reinforcing relationship cycles, such as pursue/withdraw and attack/defend, that make positive emotional engagement almost impossible. However, for both trauma victims and their partners, who can be viewed as being "vicariously traumatized" (McCann & Pearlman, 1990; Nelson & Wright, 1996), the aftereffects of trauma can prime, intensify, and exacerbate marital distress. In many cases, the effects of trauma and couples' struggles to cope with these effects are so pervasive that they engulf and erode even the most positive relationships.

The results of trauma are multifaceted and affect many varied aspects of functioning. The symptoms of PTSD are arranged as three symptom clusters or "criteria" in the revised *Diagnostic and Statistical Manual (DSM-IV)* (APA, 1994). These three symptom clusters include: re-experiencing symptoms (including spontaneous and triggered intrusive thoughts, nightmares, flashbacks, and physiological reactivity to reminders of the trauma); symptoms characterized by avoidance and numbing of emotional responses (including avoidance of people, places, conversations, activities either formerly pursued or connected with the trauma itself, absence of feelings of love and joy or restricted affect, a sense of foreboding about the future, and overall emotional withdrawal or numbness); and symptoms identified with an ongoing sense of being hyperaware (including hypervigilance, an exaggerated startle response, expressions of anger, sleep disorders, and difficulty concentrating). These symptoms or some subset of them typically follow exposure to a traumatic stressor that was perceived as threatening to the physical integrity of the self and responded to with feelings of terror, horror, and/or helplessness (Criterion A of *DSM-IV* [APA, 1994]).

These symptoms of PTSD all add to the intensity of marital conflict or alienation. The loss of the ability to regulate affective states (van der Kolk et al., 1996) is accepted in the literature as a primary, if not the core, issue in adaptation to trauma (Figley, 1989). In the marriages of trauma victims, negative affect, especially fear evoked by becoming vulnerable to another, tends to be more intense and compelling than in other couples. The interactions of these couples are often characterized by extreme hypervigilance and reactivity and by more extreme flight, fight, or freeze responses.

Often relationship activities that have the potential to soothe and calm other distressed couples, such as confiding and lovemaking, become at minimum a source of threat and at worst a source of retraumatization in the partnerships of trauma victims. These and any other situations where one feels vulnerable become studiously avoided. Emotional engagement, one of the prime predictors of marital satisfaction and stability (Gottman & Levenson, 1986), becomes tentative, if not avoided completely, and alienation and isolation pervade the relationship. Solomon et al. (1992) highlight this alienation and suggest that in combat veterans' relationships, veterans' withdrawal and immersion in traumatic memories leaves their partners extremely lonely and vulnerable to a variety of psychological and somatic complaints. Withdrawal, which has been found to be aversive and detrimental in distressed marriages in general, tends to be particularly problematic in traumatized relationships. Shame also tends to be a powerful factor in traumatized couples because shame often elicits or reinforces the avoidance of contact and emotional engagement. The nature of shame is to "hide and divide" (Pierce, 1994), and traumatized partners tend to see themselves as particularly unlovable and unworthy of care.

Trauma victims' marriages are, therefore, more likely to become distressed and, once distressed, tend to become stuck in particularly intense self-perpetuating cycles of distance, defense, and distrust. In addition, marital distress tends to evoke, maintain, and exacerbate

trauma symptoms. A vicious cycle is then set in motion that is often totally debilitating both to the relationship and to individual partners' ability to cope with the effects of the trauma. Therefore, it is not surprising that marital therapy has been identified as an important and often necessary part of treatment for trauma survivors (Carroll et al., 1985; Reid, Wampler, & Taylor, 1996).

THE MARITAL RELATIONSHIP AS RECOVERY ENVIRONMENT

The marital relationship can be considered one of the most important elements of the recovery environment. The research of van der Kolk and his colleagues (van der Kolk, Perry, & Herman, 1991) suggests that the ability to derive comfort from another human being predicts more powerfully than trauma history itself whether symptoms improve and whether self-destructive behavior can be regulated. Expectations associated with attachment, concerning how accessible and responsive others will be if they are needed, have been explicitly linked to how individuals cope with and adjust to trauma (Mikulincer, Florian, & Weller, 1993). Marital therapy that focuses on attachment processes can then be a natural arena in which to foster the development of constructive strategies to deal with and detoxify traumatic stress.

There appears to be a clear consensus in the research and clinical literature that the main effect of trauma is the loss of ability to regulate affective states (van der Kolk & McFarlane, 1996). A supportive relationship can help survivors to regulate negative affect and manage symptoms such as the re-experiencing constellation of symptoms (Criterion B of PTSD in *DSM-IV* [APA, 1994]), which includes disturbing nightmares and flashbacks, intrusive thoughts, and physiological reactivity. If a trauma survivor can turn to her spouse for support at the beginning of a flashback, she may be less likely to dissociate or engage in self-injurious behavior. At such moments, the security of the relationship can also help survivors to regulate or modulate overwhelming negative affects, such as shame and anger, and so improve adjustment to the alarming symptoms of a trauma response and curtail withdrawal and avoidance (Criterion C of PTSD in *DSM-IV* [APA, 1994]).

The experience of connection and caring, as choreographed and experienced in marital therapy, can foster new learning that mitigates the effects of trauma and also provides a corrective emotional experience. For example, partners can learn that not all close relationships have to involve betrayal and can, in fact, be a source of comfort and a "secure base" (Bowlby, 1969). Such a sense of safety can promote the continued reprocessing and integration of the trauma without outbursts of rage or an ongoing residual irritability (Criterion D of PTSD in *DSM-IV* [APA, 1994]). The numbing of responsiveness (Criterion C) often associated with the trauma response can then begin to wane. As safe emotional engagement with a partner becomes possible, the trauma survivor is able to be more "present" and more open to positive healing experiences and less immersed in the past and the trauma to which the symptoms of PTSD are irretrievably connected.

As McCann and Pearlman (1990) suggest, trauma victims need to develop certain "self-capacities," specifically the ability to maintain a sense of self as benign and positive—in effect, feeling comfortable and comforted in one's own skin. Marital therapy can help to foster such capacities and redefine the marital relationship as a context in which the victim learns some mastery over the effects of trauma and is defined as worthy of acceptance and support from a caring other.

In the safety of marital therapy, the reprocessing of traumatic experiences can build a powerful bond between partners. For example, when responded to with empathy, the process of sharing not just the facts of the trauma but the emotional experience of grief or shame tends to create emotional engagement and to forge a strong bond between partners. This bond can then become a protective factor against retraumatization or further traumatic impact on the relationship.

Currently, there are very few published empirical studies of marital therapy for trauma survivors and their partners. Sheehan (1994) reports improvement in clients' intimacy after therapy that focused upon the fear of intimacy in traumatized couples. Rabin and Nardi (1991) report that an educational group program for Israeli combat veterans and their wives resulted in 68% of the couples reporting improvement in their relationship; however, the trauma survivors did not report a significant decrease in their PTSD symptoms. This may have been due to the fact that these symptoms and the affect associated with them were not sufficiently addressed in this instructional treatment format.

A small number of unpublished studies suggest that marital therapy that strengthens communication and support-giving is helpful to these couples (Cahoon, 1984; Sweany, 1988). Most authors who recommend marital therapy for trauma survivors stress that a psychoeducational component concerning the nature of trauma must be included in therapy (Rosenheck & Thomson, 1986) and that the potential for violence or substance abuse should also be assessed and addressed (Geib & Simon, 1994; Matsakis, 1994). It is also necessary to help the couple frame traumatic events in ways that do not continue to damage the relationship (Figley, 1989)—for example, helping couples to frame benign theories of why the trauma happened and why both people have reacted as they have. Many authors suggest that it is important to help trauma victims share traumatic memories with their partner so that a mutually held perspective can be established (Johnson, Feldman, & Lubin, 1995).

It is important to point out that many trauma survivors for whom marital therapy is recommended will have also experienced or concurrently be involved in individual therapy. Individual interventions for PTSD are numerous and often include the integration of behavioral, cognitive, and psychodynamic approaches, as well as various "exposure" therapies such as eye-movement desensitization and reprocessing (EMDR) (van der Kolk, McFarlane, & van der Hart, 1996). Marital therapy is not in any way recommended here as being in-and-of-itself sufficient effective treatment for trauma. However, marital therapy has the potential to play a significant role in the recovery environment and be a vital part of the overall treatment plan. In addition, marital therapy may be particularly crucial when individuals are dealing with trauma that has been inflicted by human design or constitutes betrayal in an attachment relationship.

TRAUMA AND EMOTIONALLY FOCUSED MARITAL THERAPY

What kind of marital therapy should be used to treat trauma survivors in relationships and to help mitigate the effects of trauma? At the moment, the two best specified and empirically validated forms of marital therapy (Alexander, Holtzworth-Munroe, & Jameson, 1994) are behavioral marital therapy (BMT) and emotionally focused couples therapy (EFT). EFT, which helps partners to reprocess their emotional responses to each other and thereby change their interaction patterns to foster more secure attachment, seems to be particularly appropriate for trauma couples because it pays explicit attention to how affect is processed, regulated, and integrated in the relationship (Johnson & Greenberg, 1994). EFT also fo-

cuses explicitly on the creation of trust and secure attachment, providing an antidote to the isolation and alienation associated with traumatic experiences, and increasing the sense of emotional connection that trauma therapists suggest is "the primary protection against feelings of helplessness and meaninglessness" (McFarlane & van der Kolk, 1996, p. 24).

EFT has been used for couples dealing with trauma, couples whose relationship has been hijacked and redefined by traumatic experience. Specifically, it has been used for couples if one or both partners are victims of past sexual and physical abuse (Johnson, 1989), violent crime, natural disasters, and chronic and terminal illness, as well as for a small number of combat veterans.

EFT AND COUPLES DEALING WITH TRAUMA

EFT is a short-term (12–20 sessions) approach to marital therapy (Johnson, in press), which focuses on reprocessing the emotional responses that organize attachment behaviors (Johnson, 1996). In empirical studies, it compares favorably with other approaches (Dunn & Schwebel, 1995; Johnson & Greenberg, 1985) and has been found to be effective with diverse populations, including depressed women (Dessaulles, 1991) and populations characterized by chronic family stress, such as the parents of chronically ill children (Walker, Johnson, Manion, & Cloutier, 1996). Key change events in EFT have been identified, as well as the kinds of clients who are particularly suited to this form of treatment (Johnson & Talitman, 1996).

The EFT therapist works on both intrapsychic and interpersonal levels. On the intrapsychic level the therapist uses experiential techniques, such as empathic reflection and validation, and expands emotional experience by heightening and conjecture. On the interpersonal/systematic level, the therapist reflects and reframes the patterns and cycles in the interaction and directly choreographs new interactions and specific change events (Johnson, 1996). The EFT therapist attempts to take clients to the leading edge of their experience as it occurs in the session and helps them to formulate this experience in new ways that evoke new responses both to and from their partner. Typically, one might see the EFT therapist engaged in two tasks. The first task involves accessing and reprocessing affect—for example, helping a partner to access the despair and hopelessness that underlies a withdrawal/avoidance position, or the grief and desperation that underlies an attacking/pursuing position. The second task involves the shaping of new interactions. Here the therapist uses expanded emotional experience to create a new dialogue with the partner, a dialogue that encourages contact and compassion. So a therapist might help a partner to access and formulate the terror that arises when he or she needs comfort and to tell his or her spouse, "I want to run. I can't risk being hurt again, so I disappear."

EFT has been delineated in nine steps that parallel the three stages of trauma treatment articulated by McCann and Pearlman (1990). These three stages are stabilization, the building of self and relationship capacities, and integration. The first four steps of EFT can be viewed as stabilization; in these steps, after the initial assessment (step 1), relationship cycles and patterns and underlying feelings are identified (steps 2 and 3) and negative patterns of interaction are then framed as the problem (step 4). For trauma victims and their partners this involves not just understanding the cycles of their relationship and how their ways of coping with affect feed those cycles, but also understanding the nature of trauma and how it has affected each of the partners and defined the relationship. The middle steps of EFT (steps 5–7) can be viewed as building self and relationship capacities. In EFT, these

steps involve owning the longings and fears that arise in the relationship (step 5), the acceptance of these by the partner (step 6), followed by asking for needs to be met in a way that evokes empathic responsiveness from this partner (step 7). In this middle stage, the therapist empowers partners to actively create the relationship as a safe haven where fears can be confronted and soothed, grief shared, shame modified, and anger reprocessed. This process builds trust and gives each partner a sense of efficacy. In the last two steps of EFT (8 and 9), new positive ways of coping with the problems related to the trauma and new interactional positions are integrated into the relationship, paralleling the integration phase of trauma treatment.

These three stages can be viewed in terms of the trauma symptoms that arise in the relationship, the EFT therapist's tasks and interventions used, and the effects of these interventions on both the relationship and the trauma experience. However, it should be noted that no form of effective treatment rigidly adheres to a step-by-step process. Rather, all the stages or steps may be continuously active and can be referred to or experienced by both the couple and the therapist in an ongoing, dynamic therapeutic relationship. Since the process of EFT with normal distressed couples is well documented elsewhere (Johnson, 1996), this discussion focuses on aspects specific to couples dealing with trauma. Following this discussion, a transcript of a key EFT change event with such a couple is presented.

STAGES OF TREATMENT IN MARITAL THERAPY

Stabilization (Steps 1–4 of EFT)

As the therapist helps the couple to articulate and identify the negative cycles in their interactions, such as critical pursuit followed by withdrawal and avoidance, the experience of trauma is incorporated into the description of such cycles. The discussion and recognition of both the legacy of the trauma and these cycles are parts of the early rapport-building and "roundtable discussions" suggested by Figley for use in the early stages of family therapy if one parent has suffered trauma (Figley, 1989). These cycles, often primed by affect cues associated with the trauma, are then framed from a metaperspective as victimizing both partners. This brings partners together against the common enemies—the negative cycles and the traumatic experiences—that have hijacked their relationship. This is similar to the naming of abuse as a third person in a relationship, described by Geib and Simon (1994).

The beginnings of what Figley (1989) calls a "healing theory" may also emerge here as the therapist describes and validates the couple's struggle to cope with the effects of trauma and how this struggle inadvertently creates the cycles that continue to distress them. Specific responses, such as fits of rage, are placed in the context of a response to the traumatic experience and the ongoing cycles in the relationship. A strong alliance with the therapist facilitates this process. Partners begin to learn how each of them suffers the aftershocks of exposure to the original trauma. They begin to develop empathy for their own and their partner's attempts to cope with the residual pain inherent in the original trauma. Partners also develop an understanding of how these attempts to cope with pain can sabotage positive emotional engagement between them.

Survivors also begin to explore how their emotional experience of the relationship evokes traumatic cues. Specific trauma symptoms, especially symptoms associated with re-experiencing the trauma such as flashbacks and intrusive thoughts, as well as numbing and avoidance of particular cues, arise and are clarified as the partners describe their interactions or interact in the session. The therapist reflects and validates each partner's emo-

tional experience—for example, the shame and fear that arises with sexual contact and the desire to distance and withdraw. The therapist helps the survivor to formulate his or her experience in a way that evokes understanding and compassion in the partner, rather than anger or a sense of rejection.

The non-traumatized partner also has the opportunity to share how he or she has been affected by the trauma and how the traumatic experience and symptoms of PTSD have constrained the relationship. Partners of survivors often have no clear sense of how the trauma colors relationship cues, and even less of a sense of how to respond. Often spouses have only a very sketchy idea of the trauma itself and may be unable to understand their partner's responses without the help of the therapist. In the midst of their own frustration and distress, partners may also minimize or discount the trauma experienced by the other; this response is often wounding to the traumatized partner and damaging to the relationship.

The EFT therapist frames the relationship as a potential safe haven that can provide protection, comfort, and a secure base in a dangerous world. The therapist, using an attachment perspective, frames the non-traumatized partner as the safe, irreplaceable other who can help the survivor to cope more positively with trauma symptoms and so become more available for an intimate relationship. This frame provides relief to the non-traumatized partner, who now sees the trauma survivor as in pain or afraid rather than rejecting or indifferent, and as needing the non-traumatized partner's active help to begin the process of healing.

The symptoms of marital distress and the trauma responses arising in the relationship then begin to de-escalate. The couple begins to nurture hope and to view their relationship as potentially a safer place where they can help each other deal with trauma-related responses. The therapist may also help the couple to formulate "safety rules" and to clearly state personal limits and boundaries so that the relationship can become safer and more predictable for both partners. For example, sexual cues and wishes may be made explicit so that physical touch can be tolerated and not associated with feared sexual activities.

For the individual, this process affects trauma symptoms in many ways: it modifies the relationship cues that evoke the traumatic experience and begins to frame the other partner as an ally in dealing with the trauma, rather than an instigator of revisiting the horror, terror, or helplessness inherent in that experience. It also promotes confiding rather than attempts by each partner to hide the effects of the traumatization. Pennebaker (1985) outlines the negative effects of behavioral inhibition and secrecy and stresses the positive effects of confiding in another. These effects are seen in the cognitive reorganization that can occur when an experience is described to another. An individual may then find new meaning in the original traumatic events, particularly when the response of the other provides new information (e.g., "My partner does not despise me for running away, so maybe I can be more accepting of my need to escape and protect myself from the earlier trauma that continues to be part of who I am").

Building Self and Relational Capacities (Steps 5–7 of EFT)

The EFT therapist's concern at this stage of therapy is to help partners cope with the trauma in new ways that actually bring them together and nurture the bond between them by fostering contact and trust, rather than damage this bond by such coping methods as withdrawal. A partner can be framed as part of the solution rather than part of the problem. The focus here is less on helping the couple to tolerate and manage negative affect and more on reprocessing and integrating this affect into the relationship. The therapist also focuses on the model of self that arises for each partner in the affectively intense interactions that

occur in the session. The therapist helps the partners to reframe these models of self in more positive terms and to respond to each other as deserving care.

These processes—reprocessing negative affect, creating new trusting interactions, and redefining the sense of self—all evolve together and prime one another. The EFT therapist helps partners to explore and reprocess the emotional responses that are implicit in their interactions. These responses are then owned and expressed to the partner. Through interventions that heighten and expand emotional experience, survivors access the desperate fear of being hurt that primes reactive rage or numb withdrawal and, with the therapist's help, are able to ask for comfort, reassurance, and acceptance in a way that enables the other to respond positively.

In general, affect is explored and heightened in EFT. However, it is important to note, particularly for trauma survivors, that in EFT negative affect is also contained so that partners can stay coherently engaged with their experience of the interactive process. The therapeutic alliance and the structure of the session keeps affect at manageable levels. Specific interventions such as reflection and validation can also be used to defuse affect that threatens to become overwhelming (Johnson, 1996). The therapist's ability to accept, name, and crystallize problematic elements of a partner's experience, as the partner experiences them, fosters affect tolerance, regulation, and integration.

Reprocessing intense affective responses using experiential interventions has been outlined elsewhere in detail (Greenberg, Rice, & Elliott, 1993; Johnson & Greenberg, 1995). Typical sequences might involve risking vulnerability to ask for help with trauma symptoms (flashbacks, for example), or risking the disclosure of specific fears, hurts, and griefs. For example, the spouse of an incest survivor might emerge from his distant position and validate his wife's need for vigilance in the light of her traumatic experience but also express his own fear of her rage and later demand that she not mistreat him. When his wife is able to hear him, he can then reassure her that he wants to be close and to support her in dealing with her history of trauma. The next sequence might involve the survivor's struggle with her reluctance to trust her partner. This process might involve addressing her fears of abandonment or of being exposed as shameful or of being abused again. This partner also usually touches fears concerning the unlovable nature of the self, tied into self-recrimination: "If this happened to me, I must have deserved it" or "I am now contaminated and unlovable." These fears can be processed in the session where the other partner's acceptance acts as an antidote to the poison inherent in such negative views of the self and helps the survivor to regulate self-loathing. This process encourages more positive coping with the effects of trauma and also strengthens the bond between partners.

A large part of the process described above involves accessing, formulating, and reprocessing specific fears, fears arising from the attachment insecurity in the relationship (which may or may not be the result of trauma) as well as from the traumatic experience. It has been suggested that to reduce fear is the most important treatment goal in the treatment of PTSD (Foa, Hearst-Ikeda, & Perry, 1995). One of the main mechanisms associated with this reduction of fear appears to be that, as the fear response is experienced and reprocessed in a safe environment, new information is made available that is incompatible with the more dysfunctional elements in the fear experience. The survivor is then able to access a new sense of mastery in relation to this traumatogenic fear. In couples therapy this new information may have many facets. A crucial element may be that the survivor is able to risk trusting his or her partner and can access reassurance and comfort, rather than terror

and betrayal. As a result of this new experience, there is less need for emotional numbing, dissociation, and the avoidance of intimate contact. At the same time, new cycles of risking and empathic responding create a context that promotes the continued processing and reorganization of traumatic experience.

Integration (Steps 8–9 of EFT)

At this point in therapy, newly processed emotional experiences and a new sense of self are affirmed, specified, and integrated into the survivor's model of self ("I have been wounded but I can learn to trust again"), new kinds of interactions are integrated into the definition of the relationship ("This is the kind of relationship where I can ask and receive comfort"), and new ways of coping with the trauma are integrated into self and system ("I can lean on you when the ghosts of trauma come for me").

Optimally, new positive patterns of interaction become self-reinforcing (trust and confiding beget more trust and confiding) and continue to provide the partners with a secure base from which they can develop a less stressful perspective on their relationship foibles and also continue to cope with the effects of the trauma. Studies of anxiety disorders (PTSD is considered an anxiety disorder in *DSM-IV*) suggest that the specific reactions of close family members are the most powerful variables in the maintenance or loss of treatment benefits (Craske & Zoellner, 1995; Steketee, 1987). From this standpoint, marital therapy may be useful in terms of helping to consolidate and maintain the gains made in individual therapy.

As the couple complete the EFT process they are able to find collaborative solutions to ongoing trauma issues, such as anniversary dates and other reminders, and to relationship sensitivities that may take many years to alleviate, such as incest or assault victims' need to restrict some sexual activities. Interactions that at first can occur only in the session with the direction of the therapist, such as asking for reassurance, now begin to occur outside of the session. The relationship is no longer defined and organized in terms of the trauma but has a present and future life of its own.

To illustrate the use of this model with traumatized couples, a transcript of a key change event in EFT follows.

A CHANGE EVENT IN EFT WITH A TRAUMATIZED PARTNER

Session 12

The wife was an incest survivor who had begun to experience severe flashbacks three years before and had a history of serious self-mutilation. The couple presented a classic critical pursue/defend withdraw pattern, with the husband taking the withdrawn position. They had three children and had been married for 12 years. They were a professional couple, and the wife was referred to marital therapy by her individual therapist, who reported that marital problems appeared to be helping to maintain this client's self-destructive behavior, lack of trust in others, and negative view of self. The EFT therapist was the first author.

This excerpt is intended as an example both of how changing the relationship affects the symptoms and consequences of trauma and how changing the way the trauma is dealt with can change the relationship. This session focused on intrusive re-experiencing symptoms that blocked emotional engagement between the partners and shows how such symptoms can be addressed within the relationship in a way that creates compassion and contact.

The therapist structures a softening event where Julie, the wife, can ask for contact and comfort from her spouse.

A softening is a change event in EFT (step 7) in which a hostile or pursuing partner accesses attachment needs and fears and asks for them to be met in a vulnerable manner that primes a positive response from the other partner. This other partner has already become available and re-engaged in the relationship. The softening change event has been found to be associated with clinically significant change in EFT (Johnson & Greenberg, 1988). This event redefines the bond between partners.

The therapist focuses upon a key incident that reflects how the emotional responses arising from the trauma define the relationship and how the patterns in the relationship maintain the trauma symptoms. In the transcript that follows, specific EFT interventions are identified by italics.

Th.: So Julie, in the middle of the night, while he was sleeping beside you, you got so distressed that you got up and cut yourself, yes? (Julie nods.) And then you called the distress line, without waking him, yes? It was too hard to reach for him, right?

Julie: I can't. . . .

Larry: I'd like her to wake me. I'd try to be accepting.

Julie: No. You'd tell me to smarten up. You'd tell me to snap out of it. You'd be all rational, or . . . (Her face tightens; she stops and looks down.)

Th.: What's happening, Julie? Can you go on? (Leans forward.) It's very scary, the thought of reaching for him?

Julie: It's like climbing a mountain.

Th.: Ah-ha. He'll disapprove of you, maybe. He won't like all that heat, all that emotion, or, or he'll . . . ?

(Reflection)

Julie: Maybe he'll get sexy. (She squirms in her chair and hides her face with her hand.)

Th.: Right, and you already feel so vulnerable you can't bear the thought of touching, of risking any more fear, any more shame, is that right?

(Empathic interpretation)

Julie: (Nods.) So I look after myself. I cut myself.

Larry: (to the therapist) I do try to dampen it, the heat I mean, the emotion. I do. I get scared, too. If she stays in the feelings she'll . . . well, she'll regress. I think she'll self-destruct.

Th.: You get alarmed; you try to shut things down to protect her. . . .

(Reflection, Interpretation)

Larry: Yes, yes. And it's scary for me too, but I don't know what to do.

Th.: You don't know how to help her. So when Julie does tell you her feelings in those situations, when she's desperate, you get alarmed and try to kind of contain them to protect you and her. Is that okay? (He nods.) But, Julie, you experience that as him not being there for you, as him not responding to you, and you feel betrayed and judged. (She nods.) So then you feel that you have to deal with it all alone, one way is to go and cut yourself, and then you feel angry at Larry for days, that he's let you down. (She agrees.) Larry, you get the sense that you have disappointed Julie and you feel even less sure of yourself and more paralysed here, is that it?

(Reflect, Summarize underlying emotions, Relate to negative cycle)

Larry: Yes, that's it. But it's hard for me to know what to do. I'd like her to wake me up.

Th.: You want to learn how to help her, yes? You'd like to be able to comfort her.
(Larry agrees.)

Julie: No. He wants to keep things calm. He wants to know if I need to be babysat. He'd be angry at me waking him.

Th.: It's hard for you to believe that he'd like to be there, that he might be willing to struggle to find out how to do that, to be with you, to stay with you and handle the heat, yes . . . ?
(*Therapist heightens the husband's desire to be engaged.*)

Julie: (Tears. Stops crying, takes on a dead flat voice.) I'm a histrionic bitch anyway. He's right; I should smarten up.
(She exits into self-criticism away from his invitation to engage.)

Th.: Ah-ha, some part of you says that you don't deserve comfort anyway, hum? (She nods.) What happened just before that, what happened when I said, "It's hard for you to believe that he wants to be there," to be there to take care of you?
(*Reflect, Refocus*)

Julie: (Her face goes blank, she curls up in her chair, puts her hand down on her chest and is silent. Long pause.)

Th.: Julie, where are you? What's happening?

Julie: (Long pause. She begins to breath faster. When she speaks, she speaks in a very small high-pitched voice, like that of a little child.) Asked Daddy—sitting on his lap—scared of the dog—asked him—sitting on his lap—scared. (She closes her eyes and weeps.)

Th.: (in a soft voice) You turned to Daddy for comfort and something dreadful happened, something very, very scary, hum?
(*Therapist tracks and reflects her immediate experiencing.*)

Julie: There's touching, touching. (She squirms in her chair, puts her hands over her face. Long pause.) It's wet. There's wet, a stain. There's a stain. He's doing it: he's touching. (She breaks into sobs.)

Th.: Ah-ha. (Long pause.) You're so scared, so small and scared, hum? So vulnerable, you went for comfort and were betrayed and it was overwhelming. Are you hearing me, Julie? (She nods; sobbing slows down.)

Th.: (Long pause.) You asked for comfort and you got abused. (She nods. Her breathing returns to normal.) You went back and touched the experience, the horror of what happened when you reached for comfort. Can you come back here now? (She nods.) Can you feel your feet on the floor, your back against the chair? (She nods.) When you're ready, can you open your eyes? (She does.) Are you okay? What's happening?

Julie: Disgusting.

Th.: Ah-ha, you feel disgusted at what happened, or are you part of that disgust, too?

Julie: Yes, yes, I'm disgusting too. Larry must feel disgusted listening to all this.
(Larry has been leaning forward intently focused on his wife with a look of deep concern on his face all this time.)

Th.: Ah-ha, can you look at him right now, can you raise your head and look at him?
(*Therapist directs interaction.*)

Julie: No, no. He thinks I'm a cry-baby. My dad called me that when I got upset.

Th.: I understand. Can you look up at Larry, just a peek maybe? (She shakes her head.) Start with me—can you look at me? (She does.) What do you see, Julie? (Pause.)

Perhaps you see that I feel a little shaken and sad that you were so hurt, so betrayed. (Julie tears and looks down.) Can you look at Larry, please?

(Therapist provides secure base, directs interaction, fosters risk-taking with partner.)

(Julie turns her head and looks up. As her eyes meet Larry's, he reaches out for her hand and she hesitantly takes it.)

Th.: What do you see in his face?

Julie: I think. I think . . . maybe he feels sad for me. (She sounds surprised.)

Th.: Ah-ha. Is that right, Larry?

Larry: Yes. I feel sad. No wonder you can't reach for me when you're scared, no wonder, and I haven't helped, have I, with all my lectures.

Th.: You can understand a little how afraid Julie is and that she has good reasons for those fears.

(Validation)

Larry: Absolutely. I want to help. I want to be there.

Th.: Ah-ha, can you hear him, Julie? (She nods.) He's asking you to risk reaching for him, to risk trusting him. Can you help him, can you tell him what you need? He needs some help.

(Heightening process/his invitation)

Julie: I'm not a good wife.

(Julie attempts to exit from the process and not respond to the task set by the therapist.)

Th.: Can you help him be with you? Can you tell him what you need?

(Refocus)

Julie: Just be there, look at me like that, let me know that you care, that you're not judging me, just be with me, maybe hold me.

Larry: (Holds her hand tighter.) I'll try. I will. I know I'll make some mistakes sometimes. I can't do it right all the time.

Julie: You just married me cause you're moral and religious. I'm crazy.

(Exit)

Th.: Julie, did you hear him say that he wants to be with you, that he's going to try and sometimes he'll blow it, but he wants to try? (She nods and smiles.) You're trying that on, even though some part of you feels so unlovable sometimes that you dare not hope for that, hum? (She nods again.)

Okay. Larry, how are you? This is hard for you too, hum?

(Heightens process, Empathic summary, Interpretation)

Larry: Yes, sometimes I feel hopeless, like she'll never trust me.

Th.: Can you tell her that? "This is hard for both of us and I want so much that you will try and trust me"—can you tell her?

(Therapist directs interaction.)

(He does.)

After this session the husband continued to actively support and reach for his wife, and the wife began to use the relationship to deal with her symptoms, rather than to self-mutilate. The couple were able to reinstate sexual contact (after four years of abstinence) and to continue to help each other create and sustain a positive sense of self. The negative pursue/withdraw cycle had already diminished and now positive cycles of contact and support began to evolve.

This couple was typical in that the trauma survivor had already accessed traumatic memories and gained some perspective on her trauma-related responses before being referred to marital therapy. EFT has been used in a small number of cases without prior individual therapy, but this is not the norm. In these cases, a relatively mild trauma might have been experienced and the resultant symptoms may be manageable for the individual and yet still have severe repercussions for the couple relationship, usually in areas of intimacy such as sexual interactions. Often the individual partner dealing with the traumatic experience would not meet the criteria for the diagnosis of full PTSD but may be suffering from partial PTSD, exhibiting a subthreshold combination of symptoms listed in the main symptom criteria of *DSM-IV*. Julie, however, displayed many symptoms of PTSD, in addition to the explicit re-experiencing symptoms addressed here. These were dealt with in other sessions and included: hyperarousal (and in particular, anger fits), avoidance of trauma triggers such as being touched, and feelings of being overwhelmed by the mammoth task of living without joy or love in her life. These symptoms had a direct impact on her marriage and on Larry's feelings of despondency and inadequacy in the relationship.

As is typical, Larry often felt overwhelmed himself and he felt unable to respond effectively to his wife's difficulties and terrors. He became depressed and demoralized. In the therapy, which tackled his wife's emotional responses to him and his best efforts, it was a relief for him to develop an understanding of Julie's shifts between alarm or anger and numb unresponsiveness. He also had a safe place in the therapy to discuss his own sense of being traumatized by her expression of her symptoms. It is imperative that the therapist not only support this partner, but also be able to contain his or her own anxiety when trauma-related symptoms arise in the session and so provide a secure base for the couple's exploration of their own feelings.

Therapy sessions are not always as dramatic as the one transcribed here, in which a flashback actually occurred in the session, but to work with trauma survivors the therapist does need to tolerate intense affect and to "stay with" the survivor in his or her suffering (van der Kolk, McFarlane, & van der Hart, 1996). It is also immensely satisfying to work in a context where it is possible to affect many different elements of individual and relationship functioning that create momentum for both individual and relational change. This therapy with Larry and Julie was terminated when the couple were able to "unlatch" from their negative cycle, sustain emotional engagement, and consistently respond to each other's attachment needs. At this point, the partners were comfortable depending on each other rather than on the therapist. The process of the session transcribed is best conceptualized from an EFT perspective not as a form of a catharsis, which is not part of the EFT perspective (Greenberg & Johnson, 1988; Johnson and Greenberg, 1994), but as a reprocessing of trauma-laden emotional responses in a relational context where the partner can ask for comfort. The result of this experience is the expansion and restructuring of the couple's interactions around this basic attachment need.

CONCLUSION

A more secure and intimate relationship with a spouse can help the trauma survivor on many levels; it can help this person to process the traumatic experience more effectively and to re-establish a sense of safe connection with others. It is worth noting that in a study of burn patients (Perry et al., 1992), it was not the extent of injury or facial disfigurement that predicted the development of PTSD, but the amount of perceived social support avail-

able to the victims. Positive attachment can also help to restore self-efficacy. As attachment theorists suggest, "nothing fosters the confidence to utilize our own capabilities to the full more than the knowledge that when we are in a fix we are not alone" (Clulow, 1991).

A marital therapy such as EFT may be especially indicated when trauma has occurred in the context of an attachment relationship, or when other traumatic experiences of interpersonal violence, such as war or criminal attack, significantly affect the survivor's ability to sustain close relationships, with the consequence that marital distress then creates or sustains a negative recovery environment. The treatment process in EFT is able to address both re-experiencing and intrusive symptoms and numbing and avoidant symptoms as they occur in the context of a close relationship. The symptoms of hyperarousal can also be addressed, but there is an important caveat here. If such hyperarousal is expressed in violent behavior toward the spouse, EFT is not recommended. Any ongoing threat of violence is considered a contraindication for EFT (Johnson, 1996). EFT is also of limited usefulness for couples who are in the process of separating. Other factors found to predict success in EFT may also be relevant here (Johnson & Talitman, 1996). For example, the female partner's faith that, despite marital difficulties, her partner still cares for her has been found to be particularly important for success in EFT. Preliminary clinical data suggest that EFT may also be particularly effective when used with the victims of childhood sexual abuse and in traumatic bereavement situations that have given rise to marital conflict, such as the accidental death of a child.

Given the far-reaching effects of trauma, the logic of involving the spouse in treatment seems compelling, particularly since if the relationship between spouses is not part of the healing process, it inevitably becomes part of the problem. The challenges to the marital therapist here are many. The literature stresses the need to be especially alert during assessment to issues of addiction and angry, abusive behavior and to expect crises and "emotional storms" during treatment. McCann and Pearlman (1990) make the point that to work with the emotional turmoil of the survivor's world, the therapist must have a map. In this text, we have suggested that the map that EFT offers to the marital therapist enables that therapist to help the survivor and his or her partner to create a healing relationship—a "safe haven" (Bowlby, 1988) in a dangerous world.

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