
The Path to a Secure Bond: Emotionally Focused Couple Therapy



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Emotionally focused therapy (EFT) for couples combines experiential and systemic techniques to expand emotional responses and cycles of interaction. This approach has also been used to treat depression, chronic illness, and anxiety disorders. EFT appears to translate well across culture and class, focusing on universal key emotions and attachment needs. From the EFT perspective, adult love is a hardwired, adaptive attachment response. The therapist's in-session focus is on the processing of emotions and key interactional patterns as they occur in the present, because emotional experiences are the primary instruments of change in this approach. The therapist is a relationship consultant who offers a safe platform whereby each partner can distill, expand, and transform experience and find new ways to connect with the other. The case presented here illustrates the three stages of EFT: deescalation, restructuring interactions, and consolidation. © 2006 Wiley Periodicals, Inc. *J Clin Psychol: In Session* 62: 597–609, 2006.

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An observer watching an emotionally focused therapy (EFT) session with a couple would see the therapist continually engaged in three tasks: actively monitoring and creating a safe alliance with both partners, focusing on and expanding emotional responses, and linking these responses recursively to the interactional patterns that lead the couple into

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therapy. The therapist explicates and expands these patterns to include safe, emotionally engaged interactions (Johnson, 2004).

So, in a beginning session, the EFT therapist might note that a husband speaks of needing to “tell” or “push” his wife and that she seems to “give up” or “move away.” The therapist would encourage the couple to consider this negative “dance” and its consequences for the connection between them. The therapist would then support one partner to expand on an emotional response, perhaps by accessing the husband’s “irritation” and helping him link it to an underlying “desperation” about not being able to connect with his wife. The therapist would help the husband express his reactionary irritation directly rather than simply blaming his spouse and would also support the husband as he connects with his underlying desperation and shares it with his wife. Next, the therapist would work with the wife to discover how she hears and responds to this communication. The expression of deep, attachment-oriented emotions, such as the desperation noted previously, has the potential to change both interactional patterns and each partner’s construction of the emotional reality of the relationship. EFT therapists thus move between a focus on people’s construction of their inner emotional experience and a focus on each partner’s creation of key attachment interactions—for better or for worse.

More specifically, EFT therapists work with emotion by reflecting emotional responses and key moves in the interactional dance, validating and normalizing responses, asking evocative questions, and replaying key moments. They often heighten the process with images or interpretations. The therapist works with interactions by reflecting patterns and reframing them in terms of attachment and “stuck” cycles that are the “enemy” in the couple’s relationship. EFT therapists create enactments in which couples make their patterns explicit and slowly try out new ways of connecting and bonding.

EFT: Theoretical Underpinnings.

The theoretical basis for treatment in this couple therapy is experiential and systemic (Minuchin & Fishman, 1981; Rogers, 1951). The theoretical basis for understanding adult love is adult attachment theory (Bowlby, 1969; Hazan & Shaver, 1987).

Theories of Treatment

As in other humanistic therapies, in EFT the therapist collaborates with clients in the ongoing reprocessing and reconstruction of each partner’s experience and helps to generate new meaning in their experience that can then empower them and facilitate growth. EFT is a systemic therapy in that problems are seen as the result of constricted or rigid ways of responding to context cues and interacting with others. From a systemic viewpoint, emotion is a “leading” or defining element that organizes the pattern of interactions that constitute a relational system. The therapist’s empathic response is to the client as “the translator is to the text” (Elliot, Watson, Goldman, & Greenberg, 2004, p. 113). From this perspective, the distilling of new meanings offers new choices and opens up implicit automatic responses for review.

The therapist’s stance is that the client’s responses are valid and understandable given a particular context and that the client can grow—given a safe validating environment. This depathologizing focus is on ways people become “stuck” in patterns of emotional processing and engaging with others and then cannot adapt to new contexts (Bowlby, 1969).

Focusing on emotion is, as the name suggests, a key feature of EFT. The EFT therapist focuses on the core emotions identified as universal: anger, fear, surprise, shame, joy, sadness, hurt/anguish, and surprise (Tomkins, 1991). Each emotion has a cue, a general instantaneous appraisal (negative/positive, safe/unsafe), physiological arousal in the body, reappraisal in which meaning is assigned, and a compelling action tendency that “moves” a person into a particular response. In this way, emotions are the principal organizers of behavior, especially in close relationships in which emotional signals are the music of the dance between partners.

Theory of Love Relationships

The theory of relationships that informs EFT is attachment theory. This theory is systemic (Johnson & Best, 2003) and postulates that intra- and interpersonal realities create each other in a circular feedback fashion. Patterns of interaction with loved ones are the arenas in which individuals experience and define themselves. The couple therapist uses a theory of relatedness to guide goal setting and treatment. Attachment theory offers an image of adult love that reflects current research on distress and satisfaction in marriage (Gottman, 1994; Huston, Caughlin, Houts, Smith, & George, 2001). This research suggests that emotional engagement and emotional responsiveness (the two determinants of a secure bond put forward by attachment theory) are the main predictors of satisfaction in marriage, and that soothing responses are generally crucial elements of this process. Negative cycles of criticism and complaints infused with anger, followed by distancing and defensiveness, are the death knell of love relationships precisely because they make safe emotional engagement impossible.

The basic tenet of attachment theory is that a safe emotional connection to a few loved ones is a fundamental survival need wired in by millions of years of evolution. “Can I count on you to be there for me?” “Will you come when I call?” and “Are you within reach?” are the crucial questions that all spouses ask. From the attachment perspective, the fear of isolation and the helplessness that accompanies it are in every human heart. Effective or secure dependence exists when there is confidence in a positive, loving answer to these questions. This theory contradicts the popular idea of self-sufficiency and the focus on differentiation from others.

When partners experience disconnection, a predictable process of separation anxiety unfolds. People begin with protest, which usually takes the form of coercive anger, followed by clinging and seeking. If the attachment figure does not respond, then depression and despair set in. From this point of view, it is not surprising that clinical depression is so often part of marital distress. In secure relationships, partners recognize, accept, and respond to protest. If they do not (as often happens in distressed relationships), then two emotion-regulation strategies usually ensue. One is to demonstrate hypoactivated attachment: avoiding emotions through distraction or immersion in tasks and denying attachment needs. The other strategy involves hyperactivated attachment: People become highly anxious and cling to the attachment figure in an effort to coerce responsiveness, often through critical remarks. These responses then become habitual emotion regulation tactics and default options in interactions with loved ones. The more one partner clings, the more the other avoids. This picture is clear from the research on marital distress and from the clinical experience of couple therapists. Traumatized individuals tend to combine these strategies into a “Come here; I need you—but you are dangerous—go away” strategy that unfortunately makes it exceedingly difficult for their partner to respond to them consistently.

The Steps and Stages of EFT

Experiential theory, systemic approaches, and attachment theory are integrated into a theoretical whole in EFT and provide a guide for treatment. The stages and steps of EFT are as follows.

Stage 1: Cycle Deescalation

- Step 1. Assessment: Creating an alliance and explicating the core issues in the marital conflict by using an attachment perspective.
- Step 2. Identifying the problem interactional cycle that maintains attachment insecurity and marital distress.
- Step 3. Accessing the unacknowledged emotions underlying interactional positions.
- Step 4. Reframing the problem in terms of the cycle, the underlying emotions, and attachment needs.

Stage 2: Restructuring Interactional Positions

- Step 5. Promoting identification with disowned needs and aspects of self and integrating these into relationship interactions.
- Step 6. Promoting acceptance of the partner's new construction of the relationship and new interactional behavior.
- Step 7. Facilitating the expression of specific needs and wants and creating emotional engagement. The key change events, withdrawer reengagement and blamer softening, evolve here. The events are completed in step 7. When both partners complete step 7, a prototypical bonding event usually occurs, either in the session or at home.

Stage 3: Consolidation/Integration

- Step 8. Facilitating the emergence of new solutions to old relationship problems.
- Step 9. Consolidating new positions and new cycles of attachment behavior. In all of these steps, the therapist moves between first helping partners crystallize their emotional experience in the present by tracking, reflecting, and expanding this experience; then he or she sets interactional tasks that add new elements to and reorganize the cycle of partner responses. The following case illustrates this process. The second author was the therapist for the case and the first author was his clinical supervisor.

Case Illustration

Presenting Problem and Description of Clients

John and Mary were in their mid-30s and had been married for 12 years. Their lives were hectic and stressful: John ran a consulting firm whose clientele consisted of high-profile companies in the computer technology industry. He had a history of depression, and his score on the Symptom Checklist-90-R (SCL-90-R), a standardized measure of psychological distress, confirmed that he was depressed at the time of the couple's initial

consultation. Mary was a nurse in a local hospital. They both worked over 60 hours a week and they had two children under the age of 10, who were having behavior problems in school and difficulty in getting along with each other and with their parents at home. The couple sought help to rectify what they termed a cycle of “closeness vs. coldness” that had been present in their relationship for 10 years.

During the initial assessment, Mary mentioned becoming “terrified” on the numerous occasions when she experienced John as unavailable. She had begun to criticize him angrily when this would happen, and to distance herself from him when she sensed that her efforts to procure his attention and support were in vain. Mary also said that she now doubted John’s love for and commitment to her because, according to her, John would lash out in anger against her when she would approach him with her concerns or when the climate in the home became stressful. Mary described a difficult childhood in which her parents were unavailable emotionally but were excessively critical of what they identified as her laziness.

Frustration with Mary dominated John’s presentation at the beginning of therapy, but the couple assessment revealed feelings of long-standing depression and worthlessness. John said that he often felt that he was a failure and that this feeling led him to defensive expressions of anger toward his wife and family at times, but that for the most part he would withdraw from Mary when she would try to engage him in an aggressive manner. Similarly to Mary, John characterized his perceptions of Mary’s unavailability when she criticized him as “unnerving.” He added that the most pleasant times in his relationship with Mary were those in which he felt safe enough to talk and express himself more openly and that he would like to feel that way more often. John also pointed out during the assessment that his parents discouraged the expression of strong emotions while he was growing up.

Case Formulation

On the basis of the information gathered during an initial intake interview, during individual sessions with each partner, and through John and Mary’s scores on the Dyadic Adjustment Scale (DAS), a standardized measure of couple distress, the therapist established that Mary and John were caught in a cycle of *pursue-withdraw*, which is also known as *criticize-defend*. Their stressful work schedules and concerns about their children’s behavior problems in school seemed to have aggravated this pattern, in which Mary generally expressed anger and resentment toward John, who pulled away from her both literally and figuratively and also lashed out at her. Both partners were dealing with elevated fear, anger, guilt, and frustration. Attempts at managing these negative emotions by withdrawing from (John) or angrily engaging (Mary) the other led to further tension and misunderstandings, during which John’s fears of failure and Mary’s concerns about John’s unavailability were confirmed. John scored in the nondistressed range on the DAS, but Mary scored in the range typical of divorcing partners. This disparity suggests that Mary was much more distressed about the state of the couple relationship than John was at the beginning of therapy. However, both partners demonstrated in the early sessions and in their responses on the DAS that they were committed to each other and to working on their relationship.

In accordance with the experiential focus of EFT, the therapist paid special attention to Mary and John’s interactions during the initial sessions. These interactions reflected their problematic cycle. Mary would speak about John in a critical manner, and he would cast his gaze downward and move his chair farther away from her. John would then talk

in an intellectual, rational way about his contributions to the couple and family life and express his anger at feeling attacked. When queried about his reaction to Mary's statements and the way in which they were delivered, John said that he did not know what to do other than back away.

Course of Treatment

Stage 1: Cycle Deescalation. The therapist's goals in the initial sessions were to establish a strong therapeutic alliance with John and Mary; to explore each partner's emotional experience in the relationship and his or her attempts to satisfy attachment needs for safety, security, and comfort; and to gauge the effect of their habitual way of regulating their emotional experience in their interactional dance.

The following excerpt is from a stage 1 session with John and Mary, in which the focus was mainly on John's experience and behavior in the couple's negative cycle:

JOHN: Mary gets fed up with me all of the time. Sometimes I might already be feeling down, or beaten, you know, like the universe hates me, and then she's there getting fed up.

THERAPIST: Down, beaten, the whole universe against you, hating you (*heightening emotion*) . . . and what is it, what does Mary do that says to you, "She's fed up with me"? (*tracking emotional cues*)

JOHN: Well, she exhales a lot (*John demonstrates an irritated sigh*).

THERAPIST: Uh-huh. And what's that like for you as you see Mary exhaling, exhaling, and you're feeling down and beaten (*evocative question*)?

JOHN: Well, sometimes I come home with an idea and I want to explore it and I tell Mary about it, and she exhales and rolls her eyes. It's as if she's saying with her body, "I've listened to 15 years of your harebrained ideas that never go anywhere and I'm tired of it!"

THERAPIST: What does that feel like as you speak about it right now, John, this image of Mary exhaling, rolling her eyes (*evocative question*)?

JOHN: It's deflating. It sometimes feels like being hit with reality. I have lots of ideas, but nothing ever comes of them. I'm a failure.

THERAPIST: Hit with the reality that *you* are a failure, when you see Mary exhale and roll her eyes. It sounds like you carry that sense of being no good, of being a failure, of the whole universe hating you; you carry that around with you and then you see Mary roll her eyes, which kind of confirms that it's all true. (*John nods in agreement.*) So what do you do? What do you do when you're feeling down, and beaten, and no good to anybody, like the whole universe hates you, and then you see Mary roll her eyes or exhale and that just confirms those feelings for you (*gauging client's habitual manner of regulating emotion*)?

JOHN: I don't tell her about it. I ask for space or go play my drums or something.

THERAPIST: (*slowly*) So when you're feeling beaten, sad, and no good, and then you see Mary do this, you have this tendency to go inside yourself, to turn away from Mary.

JOHN: That's right. But I wish it could be different. I long for it to be different . . . to feel whole and complete.

THERAPIST: I see. When you're feeling sad and beaten, you keep those feelings inside and you turn away from Mary; you don't want her to see you. But deep inside you're also longing, longing for this place where you feel complete and whole. But you withdraw; you go inside yourself with those feelings, too.

At that point in the session, the therapist explored Mary's reactions to John's tendency to withdraw. Mary talked about her distress when she sensed John was absent, and she mentioned that she would raise her voice, criticize, and complain in order to capture John's attention. John's withdrawal thus contributes to his wife's emotional distress, which she regulates by pursuing him aggressively.

Stage 2: Changing Interactional Positions. The steps in stage 2 are the busiest for the EFT therapist, as he or she builds upon the couple's ability to unite against their negative cycle and to conceptualize their problems in terms of attachment needs and emotions, and their corresponding actions (e.g., withdraw when sad; criticize when afraid). The therapist now actively restructures the couple's in-session interactions in order to help them become more accessible and responsive to each other; that leads to the formation of a more secure emotional bond.

The following exchange illustrates John and Mary's initial movement into stage 2, as they began to discuss more openly and spontaneously the impact of their individual emotional experience on their behavior in the couple. Note how the therapist often refers to or repeats key themes that the clients themselves use to describe their feelings and interactions:

THERAPIST: (*slowly*) As I listen to you I'm putting this together in my mind and seeing you, John, tired, failing, afraid, sad, and beaten, but longing, longing for that place where everything will be all right, but you turn away. You turn away from Mary. Can you turn to Mary and tell her about this stuff (*setting up enactment to restructure interactions*)? Tell her about how you feel beaten and afraid, but you long for something different, for her.

JOHN: (*turns chair to face Mary*) There are times when I feel very, very small, insignificant, incapable, not well liked, like a failure, like my life's a list of failures. And, uh, it feels very depressing.

THERAPIST: (*softly, slowly in order to heighten John's emotional experience*) It's sad.

JOHN: It's definitely sad and bleak. And I kind of like to be by myself when I feel this way, but it's always mixed with a desire . . .

THERAPIST: A longing . . .

JOHN: A longing . . .

THERAPIST: But you turn away.

MARY: (*surprised*) A longing?

JOHN: Yes, a strong, physical desire to feel different. And I guess I don't reach out in those moments because I don't want to be touched. . . . I feel like there's no help for me; nothing can be done to stop the pain. It's within me, (*the idea*) that I can't be helped, that this longing is irrational.

THERAPIST: So you're longing, on the one hand, longing for the pain to go away, feeling helpless . . .

JOHN: Longing for wholeness and completeness.

THERAPIST: Yeah, wholeness, completeness . . . so what was it like for you, Mary, just now, to have John look at you and tell you that he's (*slows down, drops voice*) hurting, and sad, and longing for something that he doesn't even think is attainable?

MARY: It might sound funny to say that it feels good, but it feels good.

John reacts with a facial expression of extreme surprise and turns his head toward Mary in disbelief.

THERAPIST: What just happened there, John (*moment-by-moment tracking of client experience*)? When Mary said that it felt good, right there, you did this (*mimics John's facial expression and head movement*).

JOHN: I was kind of *surprised*.

THERAPIST: Surprised to hear that it felt *good* for Mary to hear you talk about these things . . . continue please, Mary.

MARY: (*looking at John*) Well, it's also sad, but I feel a lot of compassion, too. It's almost like a kind of electricity, kind of like butterflies in my stomach. I feel touched, close, intimate . . .

THERAPIST: So when John opened himself up to you, you felt excited, touched, close (*concretizing the interactional shift that occurs when John accesses and expresses his vulnerability*). Uh-huh. (*to John*) And you're not used to this. You're used to feeling hurt and pain, feeling beaten. You run and hide from Mary then because you don't think she would want to see you that way. But when you express those feelings to Mary, you see that it feels good for her, and you do a double take. She's telling you that . . . actually, you tell him, Mary. Tell John what you just told me.

MARY: (*to John*) When you talk about feeling sad or afraid, I feel like I can see you; you're there with me, not off somewhere else. And then I don't feel so afraid.

THERAPIST: Mmm. So it's scary when it feels like John's not there.

MARY: Yeah, it's scary and then I have to run after him . . . like running after a speeding car. Trying to keep everything going.

THERAPIST: Yeah. When John doesn't let you see what's going on, it seems like he's not there for you, and then you run after him. How would you do that?

MARY: Well, I feel like I have to scream at him, to yell into his face, "Hello!" just to be seen or heard.

THERAPIST: It sounds like John is so important to you, and you need him so much, and when he withdraws it's frightening. But we just saw that it can be different when he talks about what he's feeling inside. Can you help him, Mary? Can you help him see how he gives you a gift when he lets you in like this?

Mary then expressed to John the sense of closeness she felt when he exposed his vulnerability to her. It took several sessions, however, for John to be able to receive and act upon that input from Mary. John was so ashamed of his depression and his litany of perceived failures that it was a challenge to put him in contact with his sadness and fear; it was easier for him to speak about things intellectually, to withdraw from Mary, or in many instances to become angry or frustrated with her. However, his withdrawal and anger only heightened Mary's sense of fear and abandonment and led to her pursuit of John in a critical, sometimes aggressive way.

In this next excerpt from a later session of EFT, Mary reiterates her desire for closeness to John, who moves beyond engaging with and expressing his emotions and their impact on his behavior in the couple into expressing his needs for support and security more explicitly. This helps Mary identify with and take ownership of her role in the couple's negative cycle:

MARY: I do criticize or get short with John, especially when I feel stressed and overwhelmed. I was always taught that it's not OK to be lazy or inactive, so I always tried to fix everything and everybody. But when I can't, I get frustrated and scared.

THERAPIST: Overwhelmed, stressed, scared. Hmm. And it's like you're running, running after that speeding car but can't keep up (*therapist uses image from an earlier session*).

MARY: Yeah. And when I don't succeed, when I look around and see all of the problems that my family is having, I feel so ashamed. I feel like I'm messed up and it's all my fault. And John gets so mad. Either he gets mad or just goes away.

THERAPIST: You're there, feeling overwhelmed, and stressed, and having a hard time keeping everything running at home, and you're saying that John gets angry or snaps at you?

MARY: Yes. And then I just feel even more ashamed, ashamed and alone.

THERAPIST: It sounds to me like sometimes things get so hectic and stressful in the family, and you're there, Mary, working so hard and feeling all this pressure to keep everything running. But it's tough. And it doesn't always work, which makes you feel ashamed. And it sounds like when you're feeling all of this you really need John, need to know that he's there. But you experience him as angry or distant, and this makes you feel even more ashamed, and alone, all by yourself. So then you run after him, pound on the door. It's hard to feel so alone, alone and scared (*heightening emotion; Mary nods and starts to cry*). Can you turn to him and tell him that?

MARY: (*to John*) I do criticize you or come after you sometimes. But inside I'm feeling so afraid, so alone. And then you're not there or you're angry; there's this big anger *thing* lurking around the house, and I feel even lonelier.

THERAPIST: Mary, what is it like for you to tell John this?

MARY: It's scary. I don't usually show this. But maybe then he sees how I get so upset. I'm trying to find him. I need him.

THERAPIST: Can you tell John what you would need from him, Mary, when you're feeling stressed, overwhelmed, afraid, and ashamed like this?

MARY: (*to John*) I just need you to be there. To be present. With me.

At this point, the therapist worked with John to help him hear and accept his wife's stated need for his presence. The therapist framed this as evidence of John's great importance to Mary and directed her to express that to her husband. At first, John's understanding was that Mary was still criticizing him, but he then began to identify with her feelings of shame and inadequacy, which she did not usually express:

JOHN: I feel that way too: thinking that I'm a failure, that people are judging me, that I don't fit and people will see that I'm an idiot.

THERAPIST: So what would help you, then? What would help you when you feel like you don't belong, that the world will see through you and see what a failure you are?

JOHN: Having people around, I guess. Being taken care of.

THERAPIST: Tell Mary that, John. Tell her how much you need her when you feel sad in this way.

JOHN: (*to Mary*) When I'm down and depressed, I need to feel cared for. I always thought you wanted me to march on with the banner held high, but lately you've been saying that you want to hear about what it's like when I'm feeling depressed.

THERAPIST: Sounds like you would like to feel as though Mary loves you even when you don't feel like you can "march on with the banner held high."

JOHN: (*to Mary*) Yeah, I need to feel like you love me, like you'll be there even when I feel depressed and sad like this.

THERAPIST: What happens, Mary, when John says this to you?

MARY: I didn't mean to, but I guess I did give John the idea that it's not OK to be sad. I mean (*weeps softly*), it was always so scary when I was a kid and my mom would get depressed. She was never there for me then. I just learned to feel like she was dead.

THERAPIST: So it's hard for you when John gets depressed and then shuts down and shuts you out. It's like he's "dead." You've lost him. But now he's saying that he needs you when he feels down. What happens to you now when you hear John say how sad he is and how much he needs you when he feels depressed?

MARY: It's hard but it feels good at the same time. It feels like John's really here and being present with me.

THERAPIST: Sounds like you want to see that part of John, even though it's hard. Sounds like you're saying that you really do love him, even when he can't "march on with the banner held high," and you want him to share that because then you feel as though John's present, that he's there with you and that feels safer than when he's not.

MARY: That's right. I want him to let me in, not to go off into the depression.

As instructed by the therapist, Mary did indeed express to John a sincere, heartfelt desire to comfort him when he was expressing sadness or being down; that was when he would withdraw or become angry with her. The following excerpt demonstrates the challenge the therapist had in achieving withdrawer reengagement from John in the wake of Mary's softer, more accepting stance:

THERAPIST: John, can you hear Mary when she says, "I want to see you when you're feeling sad; I want you to turn to me"?

JOHN: I can hear her, but I can't see it. It's a voice off in the distance.

THERAPIST: A voice, eh, off in the distance . . . so how is it, right here, right now, John, to hear Mary say that she wants to see your vulnerability and wants to be there for you, rather than having you withdraw or become impatient with her?

JOHN: I feel stuck. Stuck in this spot. I don't have any confidence in that. If you told me you wanted to take a trip to Paris, I'd form images in my head of the Eiffel Tower, cafes on the street, and berets. But when you and Mary say this, I have no idea what that would be like or look like.

THERAPIST: It's like uncharted territory. So it would be a real risk if you were to reach out to Mary.

JOHN: Yeah, I just don't believe that it would be possible.

THERAPIST: A hopeless place, by yourself, with nowhere to turn, feeling lonely, never knowing what that could possibly be like.

JOHN: I might be a little afraid, too.

THERAPIST: Fear, eh? Can you contact that fear? Where do you feel it?

JOHN: In the pit of my stomach. It's like a big ball of snotty phlegm.

THERAPIST: What's that big ball of snotty phlegm telling you? What's your sense of it?

JOHN: I feel like I might cry.

THERAPIST: Oh, it's like you get afraid when you come into contact with your feelings of sadness.

JOHN: Yeah, it reminds me of a time when I was a kid and I felt so sad and nervous at a family reunion that I just kept myself from going there or feeling that; otherwise I would have crumbled into a pile of dust; limbs would have literally fallen off.

THERAPIST: Cutting yourself off from these feelings before you crumble, so there's fear, fear that "if I let myself go, I'll crumble, I'll die. Mary will reject me; she'll see my baggage." (*using client phrases from previous sessions in order to heighten experience*)

JOHN: So I stop it; I don't let it get that far.

THERAPIST: You learned that, in order not to disintegrate, you had to cut yourself off (*from your feelings*), so when Mary says that she *wants* to see you, you hear her but

can't really respond because you've cut off that sadness. You're talking about a fear, about being afraid that if you show Mary your sadness or gloominess, you'll crumble, limbs will come off. Is that it? Can you tell Mary that, John?

JOHN: (*to Mary*) I'm scared to get in touch with those deeper feelings because there was a time when I physically felt that if I did, I would crumble. But I know that by withdrawing I'm getting further from those feelings and from you and just exacerbating the problem.

THERAPIST: (*to Mary*) What's it like to hear John talk about how afraid he is like this?

MARY: (*looking at John*) I'm thinking that there must be something to help him learn to do that. I mean, it's so important to be able to have your feelings and have them heard.

THERAPIST: You're saying that it makes you sad and that you want to help him access his feelings, that it's important to you. Tell him that, Mary.

MARY: (*to John*) I want to hear your voice.

THERAPIST: (*observes John's appearing visibly moved*) What's happening, John, as Mary says "I want to hear your voice"?

JOHN: Hope. I suddenly have hope that it might be possible. I feel less stuck. I think I can find words to express how I feel and I think it might help to share them with Mary. I feel like I could believe.

The therapist then validated the risks the couple had taken and encouraged John to ask for what he needed, what might comfort him and help him stay more engaged with Mary. John thus moved through step 5 into step 7 of EFT: He accessed his emotional experience (sadness and a fear of failure), acknowledged its effect on his behavior toward Mary and her subsequent negative feelings as a result of it, asked for Mary to hear him and help him when he felt sad and afraid, and Mary responded. Similarly, Mary expressed to John her experience of anxiety and stress in the couple, her recognition of its influence on her behavior with him and the way in which her behavior contributed to his sadness and withdrawal, her need for John's presence to feel less alone, and John responded. John's reengagement in the couple and Mary's softening thus created a safer, more secure environment for each partner and helped them reestablish a sense of closeness and connectedness that they said had been missing in their relationship for a long time.

It is important to note that movement through stage 2 of EFT is not linear but recursive: "The reduction in hostility of the critical partner invites the other's approach; the reduction in the distance of the withdrawn partner encourages the other to risk and ask for what he or she needs" (Johnson, 2004, p. 166). Thus, the more John would risk telling Mary about how afraid he was instead of withdrawing from or becoming angry with her, the more she would approach him and tell him about her own vulnerabilities. Both of them needed support and encouragement from the therapist at various junctures in order to help them move forward.

Outcome and Prognosis

Stage 3: Consolidation and Integration. At the time of writing, John and Mary are getting ready to move into stage 3 of EFT. Mary is deepening her engagement and exploring the closeness she experiences as she moves into asking John for specific reassurances (e.g., "I need to know that you love me even when I'm not feeling capable"). Each partner is beginning to talk openly about keen insight into the couple's negative cycle, as well as his or her role in perpetuating it. At the same time, they are also expressing greater awareness of the new pattern that has emerged between them, in which each feels safe

and secure enough with the other to seek comfort in times of vulnerability. The therapist's goal in stage 3 is to help the couple nurture and maintain this secure bond that has developed during the course of therapy. This involves helping them continue to explore and reap the benefits of their openness with each other about their fears and desires. A key aim is for the therapist to specify the gains the couple has made by creating a coherent narrative of the couple's journey from distance to connection.

Clinical Summary and Treatment Implications.

After an initial couple session, there was one individual session each with John and Mary, followed by 20 more conjoint sessions over a period of 6 months. We anticipate that 5–10 additional sessions will be necessary to help guide John and Mary through stage 3 of EFT. There were no treatment adjuncts (e.g., medications, workshops, self-help resources), although John discussed the possibility of receiving treatment for depression. Because therapy is ongoing at the time of writing, final outcome measures (DAS, SCL-90-R) are not currently available.

The preceding case presents the typical clinical process in EFT. The couple demonstrated a dysfunctional interaction pattern of critical demanding by one partner followed by withdrawal or bursts of temper by the other, the female partner struggled with abandonment and isolation, and the male partner displayed defensive withdrawal and a sense of hopeless rejection. Most often women enter therapy complaining of being alone and "shut out" and men speak of a sense of failure and being "shut down." The process of the couple through the nine steps of EFT was also quite typical.

There were also atypical aspects to this case. For example, the most common impasse in EFT occurs when the blaming spouse, in this case Mary, moves into step 7 but does not arrive at a position of vulnerability and ask for attachment needs to be met. The couple cannot then meet in the mutual accessibility and responsiveness of secure bonding. However, with this couple, although Mary appeared to be very angry and reactive in the few sessions, she moved with relative ease through the steps of therapy and into the risks necessary to complete step 7. Instead, the greatest difficulty was with helping the withdrawn partner, John, to reengage. For many sessions he would struggle to connect with his emotions and become caught in intellectualizing. He was also reluctant to engage in the enactments that the therapist set up. When asked to turn and express a heightened attachment emotion to his partner, he might change the subject or talk about his emotions in a detached way. The therapist then had to reflect this process and slice the risk finer. So the therapist would recognize that it appeared to be hard for John to turn and share an emotion with Mary and ask John instead to explore that difficulty and share it with Mary. He might then be able to say to her, "Yes, it is too hard to tell you how sad I am . . . maybe it's scary too. . . . I know I will look into your eyes and see what a failure I am." This kind of enactment helped advance the process of John's engagement with his wife.

This case also corroborates our clinical experience and our research studies that indicate that EFT works well with depressed partners. According to attachment theory, depression is one of the signs of separation protest in insecure attachment. Loss, lack of connection with others, a sense of unworthiness, and helplessness are key aspects of depression, marital distress, and insecure attachment. In EFT, depressive responses are placed in the context of negative interactional cycles and unmet attachment needs. The therapist helps partners team up against these cycles and the depression associated with them. Changing key interactions with a loved one can then be a powerful and efficient way to alter intrapsychic symptoms such as depression. EFT is also used in a similar way with partners who are struggling with anxiety symptoms as the result of trauma.

This case was also the first couple therapy case ever conducted by the second author. The therapist received clinical supervision from the first author; however, the smooth and effective way in which this case progressed speaks to the transportability of EFT. This model is now well articulated in terms of theory and practice and can be systematically taught and adopted by therapists with varying levels of experience. The process of change and treatment methods are described in depth. Training materials such as training tapes and a workbook also help the beginning therapist to address the complex multilevel drama of a distressed relationship using the map offered in EFT. This transportability to different contexts and settings is also apparent in current applications of EFT, for example, in an ongoing research project with martially distressed breast cancer patients, and in the use of EFT in different cultures such as those in China, Finland, and Korea. More information about the process of EFT, research on this approach, and training opportunities can be found on the EFT Web site (www.eft.ca).

Finally, EFT is based on emotional presence and engagement in a process of discovery with every client. EFT therapists are encouraged to learn from each client, just as the client learns from them. In this case, the second author discovered through his work with John and Mary the power and intensity of both positive and negative emotions in the change of the couple's interactional dance. He observed his clients' struggle to connect with their emotions, work tirelessly to integrate those new connections into their interactions, and reap the benefits of a more secure relationship. At the same time, he learned to admire and appreciate the Herculean effort that they were willing to dedicate to the change and nurturance of their attachment bond.

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