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Emotionally Focused Therapy Externship

Alliant University
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Emotionally Focused Therapy for couples was conceptualized and published by Dr. Susan Johnson and Dr. Leslie Greenberg in the 1980’s.

EFT for couples has been developed primarily by Dr. Johnson since that time. The material contained within is based on Dr. Johnson’s training, development and research.

We are deeply grateful to Dr. Johnson for her brilliance, compassion and dedicated service to couples and therapists throughout the world.

Sue Johnson is a clinical psychologist, researcher, professor, author, popular presenter and speaker and one of the leading innovators in the field of couple therapy. She presents and writes on attachment and bonding, the science of love, interventions to repair relationships, trauma couples and forgiveness.

Sue holds professorships at the University of Ottawa in Canada and at Alliant University in San Diego, California. She is one of the originators and the main proponent of Emotionally Focused Couple Therapy (EFT), a powerful, tested intervention to help couples repair rifts and build strong loving bonds. She is also the Director of the Ottawa Couple and Family Institute and the International Centre for Excellence in Emotionally Focused Therapy (ICEEFT) which has numerous affiliated Centres and Communities in North America and Europe.

Sue received her doctorate in Counseling Psychology from the University of British Columbia in 1984. Her professional books are considered to be among the leading texts on couples therapy and she serves on the board of many professional journals. Her 2008 book - *Hold Me Tight, Seven Conversations for a Lifetime of Love*, written for the general public, outlines her last 25 years of research and the new science of adult bonding. This book is the basis for a program for post-deployment military couples created for the U.S. military and a relationship education program, Hold Me Tight: Conversations for Connection.

She has received numerous honors for her work, including the Outstanding Contribution to the Field of Couple and Family Therapy Award from the American Association for Marriage and Family Therapy and the Research in Family Therapy Award from the American Family Therapy Academy. She is an invited Fellow of the American Psychological Association and her work has been noted and elaborated upon in publications such as *The New York Times* (an article on her program for the US military), the *Washington Post*, *USA Today*, and the *Globe and Mail, More* and *Psychology Today* magazines. Sue has an active media presence. For example, her favorite radio interview to date was her conversation about love on CBC’s *Ideas* in November, 2009. Her favorite TV spot is on the CBC talk show *Stephen and Chris*. She blogs on [http://www.holdmetight.com](http://www.holdmetight.com) and [http://www.psychologytoday.com/](http://www.psychologytoday.com/). Video clips of Sue presenting her work are also shown on the holdmetight.com website.
Meet Your Trainers

Scott R. Woolley, Ph. D.

Dr. Scott Woolley is a Distinguished Professor and the System-Wide Director of the Couple and Family Therapy Masters and Doctoral Programs within CSPP (California School of Professional Psychology) at Alliant International University. He is a founder and Director of the San Diego Center for Emotionally Focused Therapy and the Executive Director of the Training and Research Institute for EFT at Alliant (TRI EFT Alliant).

Dr. Woolley has trained therapists in EFT in many areas of the world, including Canada, Chili, Finland, Great Britain, Guam, Hong Kong, Ireland, Japan, Mexico, Norway, Taiwan, The Netherlands, and throughout the U.S., and works closely with Dr. Susan Johnson, founder of EFT.

Dr. Woolley earned a B.S. in Economics and an M.S. in Marriage and Family Therapy from Brigham Young University, and a Ph.D. in Marriage and Family Therapy from Texas Tech University. Dr. Woolley is an AAMFT Clinical Member and Approved Supervisor, and a Certified EFT Therapist, Supervisor, and Trainer.

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Lisa Palmer Olsen, Psy. D. is a licensed marriage and family therapist in San Diego California. She is a Founder and Director of the San Diego Center for Emotionally Focused Couples Therapy. Lisa completed her dissertation research on how to teach and supervise EFT. Dr. Sue Johnson and Dr. Scott Woolley were part of her dissertation committee. Dr. Palmer-Olsen’s primary clinical and research interests are in the areas of couple and family therapy; specifically with those couples and families dealing with severe trauma and attachment disorders. She is an AAMFT clinical member and approved AAMFT supervisor. As a student of Alliant International University, Dr. Palmer-Olsen had the opportunity to train under family therapy founders Dr. Jay Haley and Dr. James Framo. She earned the Bachelor degree of Psychology at Colorado State University, the Master and Doctoral Degrees in Marriage and Family Therapy at Alliant International University.

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Is love a mysterious mixture of sex and sentiment?? If so we cannot understand it, cannot make or keep it, and a science of love is impossible. The answer is No!

Love is:
• An exquisitely logical survival system
• Our foremost and most basic need – from the cradle to the grave
• Our only defense against “emotional starvation”
• A haven of safety, strength, and effective dependency

There is an agreement that romantic love involves a “hurricane of emotion”

After that:
• Sexual desire dressed up – infatuation – a “fever”
• Immature idealization – “perceptual anesthesia”
• Evolutionary reproduction strategy - 4 years
• Brief infatuation - Then a friendship
• An addiction (dopamine)
• Illusion - Invention of medieval troubadours
• A rational deal – negotiated exchange

The couple therapist is in territory of the:
• Understandable
• Predictable
• Explainable
• Changeable

We Know:
• The Territory – The Problem
• The Destination – Goal
• The Map – Key Moves/Moments

Notes:
Love is Good for our Health

Lovers are *hidden regulators* of our body processes and emotional lives.

**Negatives**

- Isolation is dangerous (heart attack / stroke risk doubles) Strength of heart = strength of love relationship
- Relationship distress elevates cortisol levels.
- Conflict depresses immune system – slows healing – nastiness matters
- Rejection / exclusion trigger same circuits as physical pain

**Positives**

- Holding a loved one’s hand calms “jittery neurons”
- “Nurturing solace” protects from disease – shapes resilience
- Confiding in others helps heart – lessens adverse effects of aging
- Those who feel securely connected deal with trauma better – 9/11, prisoners of war, missile attacks

**Primary Roots of EFT**

- Experiential Therapy (Perls)
- Person Centered Therapy (Rogers)
- Systemic Therapy (Minuchin)
- Attachment Theory (Bowlby)

*All Knowledge is experience – everything else is just information.*

*(Albert Einstein)*

Notes:
Basic Overview of EFT

- **EFT** views couple distress as being maintained by absorbing negative affect.
- Absorbing negative affect both reflects and primes rigid, constricted patterns of interaction.
- These patterns make the safe emotional engagement necessary for secure bonding impossible.

**Key Elements in Marital Distress from Empirical Evidence**

1. High levels of negative affect:
   - Absorbing state
   - More compelling than positive affect

2. Negative attributions:
   - Character blame and a vigilant focus on negative
   - Issue → relationship → self-definition

3. Safety-first becomes the rule.
   - Nonverbal signals

**The goals of EFT are to:**

- access, expand and re-organize key emotional responses.
- create a shift in partner’s interactional positions.
- foster the creation of a secure bond between partners through the creation of new interactional events that redefine the relationship.

**Notes:**
EFT Assumptions

1. Accessibility and responsiveness are the building blocks of a secure attachment bond. Consequently, Couples therapy is about the security of the attachment bond, accessibility, and the responsiveness of the partner.

   ARE you there for me?
   - **Accessible** (Can I reach you? Will you open up to me? Do you need me?)
   - **Responsive** (Can I depend on you? Will you come when I call?)
   - **Engaged** (Are you emotionally present? Will you keep me close?)

2. Emotion is a target and agent of change. Emotion:
   - Is a source of information
   - Communicates - organizes social interactions
   - Orient & primes responses
   - Is a vital element in meaning - colors events
   - Has control precedence

3. Emotion frequently leads to adaptive actions. For example:
   - Anger often leads to asserting, defending
   - Sadness often leads to seeking support, withdrawing
   - Surprise/Excitement often leads to attending, exploring
   - Disgust/Shame often leads to hiding, expelling, avoiding
   - Fear often leads to fleeing, freezing, giving up
   - Joy often leads to connecting, engaging

4. Negative emotions occur at two levels: Primary and Secondary.
   - Primary Emotions are the deeper, more vulnerable emotions such as sadness, hurt, fear, shame, and loneliness.
   - Secondary Emotions are the more reactive emotions such as anger, jealousy, resentment, and frustration. They occur as a reaction to the primary emotions.
   - Primary emotions generally draw partners closer. Secondary emotions tend to push partners away.

Notes:
5. In trying to connect, distressed couples get caught in negative repetitive sequences of interaction where partners express secondary emotions rather than primary emotions.

6. Insecure attachment leads to negative interaction cycles and, in return, negative interaction cycles lead to insecure attachment (it is circular).

7. Rigid interactions reflect and create negative absorbing emotional states. Negative absorbing emotional states reflect and create rigid interactions (it is circular).

8. Partners are not sick or developmentally delayed. They are stuck. Most needs and desires are adaptive.

9. Attachment needs are universal, although their expression is culturally defined. The way we seek and obtain support is defined different in various cultures and even in different families and must be understood and respected.

10. Change involves new experiences and new relationship events. Therapy is about creating these new relational experiences.

Attachment Theory Pioneers

**John Bowlby (1907–1990)**

**Mary Ainsworth (Strange Situation)**

**Philip Shaver**

Notes:
Research on EFT Outcomes

1. Effect size of 1.3-90% treated couples better than controls.
2. 70-73% of couples recovered from distress at follow-up (trend- improvement continues after therapy).
3. Two-year follow-up on relationship distress, depression, and parental stress – results stable – 60% maintain gains or continue to improve.
4. Positively impacts depression, intimacy, trust.
5. Studies have been rigorous, with implementation checks and few dropouts.
   (Clinical Psychology: Science & Practice, 1999, 6, 67-79.)
6. EFT alone is as effective as EFT with communication training in improving communication and relationship satisfaction.

EFT Predictors of Success
1. Alliance – especially task aspects.
2. Distress at beginning of treatment only predicted 4% of variance in distress.
3. Traditionality is not predictive.
4. EFT worked well for older and “inexpressive” men.
5. Best pre-therapy predictor – female’s faith that the partner “cared”.
6. Deeper emotional experiencing is related to greater satisfaction with therapy.

Notes:
The Attachment Perspective - this Foundation of the New Science of Love offers us: a map for Positive, Loving, Stable Relationships which outlines:

- The logic of our emotions
- The longings and needs guiding interactions
- A path for repair and renewal
- A language of love
- A guide to the pivotal moments in love relationships

Attachment theory is an interactional theory of love where:

- self and system define and determine each other
- problematic behavior is seen as a response to past and or present threats to secure attachment.

For example:

**Angry criticism** is viewed in EFT as:
- an attempt to modify the other partner’s inaccessibility
- a protest response to isolation and abandonment by the partner.

**Avoidant withdrawal** is seen as:
- an attempt to contain the interaction and regulate fears of rejection
- an attempt to avoid confirming working models that define the self as unlovable

“All of us, from cradle to grave, are happiest when life is organized as a series of excursions, long or short, from the secure base provided by our attachment figure(s).”

*John Bowlby A Secure Base(1988, p. 62)*

Notes:
10 Central Tenets of Attachment Theory

1. Attachment is an innate motivating force throughout the life span.
   • Seeking and maintaining contact with significant others is a primary motivating force that is a part of humans from the cradle to the grave.
   • Dependency is an innate, healthy part of our beings and not something we grow out of (Bowlby, 1988).

2. Secure dependence complements autonomy.
   • We can not be overly dependent or completely independent. Rather, there is only effective or ineffective dependence.
   • Autonomy and secure dependence are two sides of the same coin – they are not dichotomies.
   • The more securely dependent we are, the more separate and independent we can be.

3. Attachment offers a safe haven.
   • The presence of an attachment figure (parents, spouses, lovers etc.) provides comfort and security.
   • The perceived inaccessibility of such a figure creates distress.
   • Positive attachments offer both a buffer against the effects of stress and uncertainty and an optimal context for the ongoing development of the personality.

4. Attachment offers a secure base.
   Secure attachment provides a secure base from which individuals can explore the world and adaptively respond to the environment. A secure base encourages:
   • exploration
   • cognitive openness
   • updating models of the self and others

Notes:
5. Accessibility and responsiveness build secure bonds.
   - Emotional engagement is crucial.
   - Any response, even anger, is better than none. No response or no emotional response sends the message that “You don’t matter, and there is no connection between us.”

6. Fear and uncertainty activate attachment needs. When we are threatened (traumatic events, stress, illness, or an attack on the safety of the attachment bond itself) attachment needs for comfort and connection become very compelling. Attachment behaviors, such as seeking proximity to a loved one, are activated.

7. The process of separation distress is predictable. If attachment seeking behaviors do not evoke comforting contact and responsiveness from an attachment figure, a process of angry protest, clinging, depression, and despair occurs, resulting eventually in detachment. Depression naturally follows loss of connection.

8. A finite number of insecure forms of engagement can be identified. The response, when a partner is perceived as not being dependable can be organized along two dimensions: Anxiety and Avoidance (Fraley & Waller, 1998)

   **Anxiety:** Attachment behaviors become heightened and intense and may include anxious clinging, pursuit, and aggressive attempts to get a response.

“*All of us, from cradle to grave, are happiest when life is organized as a series of excursions, long or short, from the secure base provided by our attachment figure(s).*”

*John Bowlby A Secure Base*(1988, p. 62)

Notes:
9. Attachment involves working models of the self and the other.
   - They are developed through thousands of interactions and become expectations that are carried forward and help form new relationships.
   - They are not just cognitive schemas but involve goals, beliefs, and strategies that are infused with emotions that provides meaning and direction.
   - These models are formed, elaborated, maintained, and most importantly, are changed through emotional communication in attachment relationships.

10. Isolation and loss are inherently traumatizing.
    - Couples often speak of the stress of isolation and loss in terms of trauma.
    - In complex trauma, violations of human connection tend to contaminate current relationships making it difficult to reach out for comfort and safety.
    - The effects of trauma are amplified and maintained because the safe antidote of safe attachment is out of reach.

The people we love are the "hidden regulators" of our bodily processes and our emotional lives – Sue Johnson "Hold Me Tight"

Notes:
1. Healthy sex is a bonding behavior. It involves a feedback loop – love helps shape the nature of sex and visa versa.
2. A secure attachment facilitates “relaxed and confidant engagement” in sex.
3. Secure partners report more and better sex - more satisfaction (both men and women) (Mikulincer & Shaver, 2007).
4. Motive:
   - Secure partners identify closeness and connection as a primary motive
   - Insecure partners report having sex to
     - please
     - avoid rejection
     - gain reassurance
     - self-enhancement
     - fit in
     - brag regarding performance
     - sensation
5. Efficacy – insecurity linked to:
   - Lower sexual self-esteem – physical attractiveness of self
   - More perceptions that sex is controlled by the other or the situation
   - More problems in sexual communication (so less co-ordination of responses)
   - Stronger concerns about sexual performance
   - Less willingness to experiment sexually within a relationship

What is Healthy Sex?
1. Both partners are accessible, responsive and engaged emotionally and physically.
2. INTEGRATED attachment, sex and care giving.
3. Best aphrodisiac / technique is secure attachment between partners.
   Sex as intimate play and connection:
   - A safe adventure – tension/excitement plus comfort, surrender to sensation.
   - Touch arouses and comforts, oxytocin – cuddle hormone released in sexual arousal.
   - Synchrony sex – resonance.

Notes:
Exercise: Attachment Styles

In groups of three, create examples of how a securely attached, anxiously attached and avoidantly attached partner might respond to the following threats:
1. A sexy, ambiguous phone message from the husband’s new secretary.
2. A wife is out late and doesn’t call home.

Exercise: Identify Attachment Language

Attachment language often reflects the following themes:
- Abandonment, loss and aloneness: fears of finding the other unavailable and unresponsive
- Rejection and being unvalued or seen as inadequate by the other: feeling unworthy or unlovable.
- Lack of safety and support: doubting that one would come first, that one can count on one’s partner, and therefore being overwhelmed by stress.
- Feeling that you do not exist in the mind of the other – that one is peripheral and dispensable – and how this impacts one’s sense of self.
- The risks involved in reaching out: fears of asking for attention and admitting need.

Example 1

**Husband:** “You say I just want sex, but it’s not true. I just feel like giving up when you say that, like we are doomed. How can it ever work?”

**Wife:** (in a calm flat voice) “I really don’t know. But if you would just calm down and be less demanding. I just move away to stop the fights. I just think it is better if we don’t get caught in these arguments…the relationship is easier – calmer – that way.”

**Husband:** “How can things be ‘easy’ when we never make love, when you are never close to me? Tell me that. It’s like everything else comes first with you, but my feelings…they never count. You just focus on the event, like all I want is an orgasm. But that is not all I want. I want to feel close to you – desired- like I am important to you. But first comes the kids, then the house, then your job, and then – maybe – if there is time left – maybe us. Sometimes I think if I were dying you would tell me to hold on till you were less busy. You wouldn’t be there for me. I might as well live alone.”

**Wife:** “I just get that whatever I do will never be good enough for you, I am a big disappointment…so I just give up, I just shut down. It just doesn’t feel safe in our house anymore. I am not sexy enough for you, not warm enough – not enough.”
Example 2 (the same couple at the end of session 10 of EFT)

Wife: “I am starting to feel a lot safe here. Like I am not on trial all the time, being tested. I just give up when I feel that, I just shut down and go numb. I am starting to get that we both get scared and insecure and then we don’t know how to reassure each other.” (To spouse) “I do want this relationship and you are important to me – very important. I feel lonely too, you know. I just want to be held sometimes, and talked to, paid attention to – not always asked to make love. Then I just feel like I am just a route to an orgasm, not like you want me.” (She cries) “When we were first together you made me feel like I was so special – so precious. I miss that – I do. But now you seem so mad at me all the time.

Husband: “I know. I get desperate – feel like I am losing you – so I guess I come on all furious and pushy. But really it’s just because I am so unsure of us – of you. And it’s pretty risky to tell you this – guess it’s easier to demand to make love.”

Notes:

The Four P’s of EFT

Experiential
1) Present
2) Primary Affect – Focus Validation
Systemic
3) Process (time)
4) Positions/patterns (structure)

“The EFT Therapist is a Process Consultant”
Overview of EFT for Couples

Stage 1
Develop an alliance, identify cycle, identify and access underlying emotions, and work to deescalate (Steps 1–4)

The Nine Steps of Emotionally Focused Couples Therapy

Stage 2
Engage the withdrawer (Steps 5–7)
Soften the pursuer/blamer (Steps 5–7)
Create new emotional bonding events and new cycles of interaction (Step 7)

Stage 3
Consolidate new cycles of trust, connection and safety, and apply them to old problems that may still be relevant (Steps 8–9)

Notes:
Stage 1, Steps 1 – 4 —————————————————————————-
Assessment and Cycle De-escalation

1. **Alliance and assessment:** Creating an alliance and delineating conflict issues in the core attachment struggle.
   (What are they fighting about and how are they related to core attachment issues?)

2. **Identify the negative interaction cycle, and each partner’s position in that cycle.**
   
   Cycle levels include:
   - Action tendencies (behaviors)
   - Perceptions
   - Secondary Emotions
   - Primary Emotions
   - Unmet Attachment Needs

   The goal is for the therapist to see the cycle in action and then identify and describe it to the couple and work toward stopping it.

   ![The Cycle Diagram]

   **Pursuer**  
   - Behavior
   - Perceptions/Attributions
   - Secondary Emotion
   - Primary Emotion
   - Unmet Attachment Needs

   **Withdrawer**  
   - Behavior
   - Perceptions/Attributions
   - Secondary Emotion
   - Primary Emotion
   - Unmet Attachment Needs

   Notes:
3. **Access unacknowledged emotions underlying interactional positions.**
The goal is to help each member of the couple to access and accept their unacknowledged feelings that are influencing their behavior in the relationship. Both partners are to "reprocess and crystallize their own experience in the relationship" so that they can become emotionally open to the other person.

4. **Reframe the problem in terms of underlying feelings, attachment needs, and negative cycles.**
The cycle is framed as the common enemy and the source of the partners’ emotional deprivation and distress.

**Stage 2, Steps 5 – 7 ————————————————————————————————————**

**Changing Interactional Positions / Creating New Bonding Events**

5. **Promote identification with disowned attachment emotions, needs and aspects of self, and integrate these into relationship interactions.**
Help the couple redefine their experiences in terms of their unacknowledged emotional needs. "I nag because I feel abandoned and I want to be loved." "I withdraw because I feel invaded and rejected and I need to feel safe and loved."

6. **Promote acceptance of the other partner’s experiences and new Interactional responses.**
Work to get each partner to accept, believe, and trust that what the other partner is describing in terms of underlying emotional needs is accurate.

7. **Facilitate the expression of needs and wants and create emotional engagement and bonding events that redefine the attachment between the partners.**
Help them learn to express their emotional needs and wants directly rather than through the old patterns and create emotional engagement. This will help each person see the other person in a more benign manner. (Feeling vulnerable and insecure vs. rejecting.)

**Notes:**
Stage 3, Steps 8 – 9 Consolidation / Integration.

8. Facilitating the emergence of new solutions to old relationship problems.
Without the old negative interaction style and with the new emotional connection and attachment, it is easier to develop new solutions to old problems.

Help couples clearly see and articulate the old and new ways of interacting to help the couple avoid falling back into the old interaction style.

Notes:
Therapist Tasks

1. Create a collaborative therapeutic alliance

2. Explore agendas for the relationship and for therapy

3 & 4. Assess relationship factors:
   a) Their perceptions of their strengths
   b) Their cycle
      • Action tendencies/behaviors
      • Perceptions
      • Secondary Emotions
      • Primary Emotions
      • Attachment Needs
   c) Relationship history / key events
   d) Brief personal attachment history
   e) Observe interaction (enactment)
   f) Check for violence / abuse / drug usage
   g) Briefly check of their sexual relationship, particularly if and how often they cuddle.

5. Assess prognostic indicators:
   a) Degree of reactivity and escalation – intensity of negative cycle
   b) Strength of attachment/commitment
   c) Openness – response to therapist – engagement
   d) Trust/Faith of the female partner

The Cycle

Partner

Behavior

Perceptions/Attributions

Secondary Emotion

Unmet Attachment Needs

Primary Emotion

Unmet Attachment Needs

Partner

Behavior

Perceptions/Attributions

Secondary Emotion

Primary Emotion
**Contraindications for EFT**
The major contraindications for a full course of EFT include anything that makes safety impossible. They include:
- ongoing violence
- serious addictions
- ongoing affairs
These must be successfully addressed before engaging in a full course of EFT treatment.

**Attachment History**

- An attachment history involves doing a history of each person’s experiences in attachment relationships.
- It is particularly important to focus on
  1) what people learned about comfort and connection in relationships
  2) past traumas and how people adapted
  3) how people may have found healing in relationships.

**Notes:**
**Childhood Attachment Relationships**

- An attachment history involves doing a history of each person’s experiences in attachment relationships.
- It is particularly important to focus on:
  a) what people learned about comfort and connection in relationships
  b) past traumas and how people adapted
  c) how people may have found healing in relationships.

**Childhood Attachment Relationships**
1. Who did you go to for comfort when you were young?
2. Could you always count on this person/these people for comfort?
3. When were you most likely to be comforted by this person/these people?
4. How did you let this person/these people know that you needed connection and comfort?
5. Did this person/these people ever betray you or were they unavailable at critical times?
6. What did you learn about comfort and connection from this person/these people?
7. If no one was safe, how did you comfort yourself? How did you learn that people were unsafe?
8. Did you ever turn to alcohol, drugs, sex or material things for comfort?

**Romantic Attachment Relationships**
1. Have there been times when you have been able to be vulnerable and find comfort with your partner?
2. Have there been any particularly traumatic incidences in your previous romantic relationships?
3. How have you tried to find comfort in romantic relationships?

**Notes:**
Overview of EFT Interventions

Access, Expand, and Reprocess Emotional Experience
1) Empathic reflection.
2) Validation of client realities & emotional responses.
3) Evocative Responding: Questions and prompts that call up emotion through open questions about stimuli, bodily responses, desires, meanings, or action tendencies.
4) Heightening: Expand and intensifies emotional experience through repeating, re-enacting, focusing, refocusing, and using imagery.
5) Empathic conjecture, interpretation and inferences.

Restructuring Processes
1) Track and reflect process of interaction, make positions and cycles explicit.
2) Reframe experience/interaction in terms of attachment context and interactional cycles.
3) Restructure and shape interactions (enactments).

Notes:

Reflecting Emotional Experience

Example: “So this gets so painful, it hurts so bad that you just close up. Am I getting it right?”

Main Function: Focuses the therapy process; builds and maintains the alliance, and clarifies emotional responses underlying interactional positions.
Validation
**Example**: “Yes, when you are in this kind of pain, of course you have a hard time concentrating – that is normal.”
**Main functions**: Legitimizes responses and supports clients to continue to explore how they construct their experience and their interactions. It also builds the alliance.

Evocative Responding
Questions and prompts that call up emotion through open questions about stimuli, bodily responses, desires, meanings, or action tendencies.
**Examples**: (a) "What's happening right now, as you say that?" "What's that like for you?" (b) "Your face just seemed to change – can you tell me what is happening for you right now?"
**Main functions**: Expands elements of experience to help reorganize the experience; accesses unclear or marginalized elements of experience and encourages exploration and engagement.

Heightening
Expand and intensify emotional experience using repetition, images, metaphors, focusing, or enactments.
**Examples**: (a) "So you want to crawl into a ball - this is painful, very painful, when he says he still loves her, the hurt is so deep, so painful, so difficult that you just want to crawl into a ball" (b) "It seems like this is so hard for you, like climbing a cliff, so scary" (c) "Can you turn to him and tell him, 'It's too hard to ask. It's too hard to ask you to take my hand.'"
**Main functions**: Highlights and intensifies key emotions, experiences and new formulations of experience that help re-organize the interaction.

Empathic Conjecture or Interpretation
**Examples**: (a) "You don't believe it's possible that anyone could see this part of you and still accept you, is that right?" (b) "I am getting the idea that underneath your frustration you may feel sad. Am I getting that right, that you feel sad?"
**Main Functions**: Promotes a more intense awareness of emotional experience, meanings, or action tendencies.

Notes:
Tracking, Reflecting and Replaying Interactions

**Example:** "So what just happened here? It seemed like you turned from your anger for a moment and appealed to him. Is that right? But Jim, you were paying attention to the anger and stayed behind your barricade, yes?"

**Main functions:** Slows down and clarifies steps in the interactional dance; replays and clarifies key interactional processes.

Reframing in the Context of the Cycle and Attachment Processes

**Examples:** (a) "You freeze because you feel like you're right on the edge of losing her, is that right?" (b) "You freeze because she matters so much to you, not because you don't care."

**Main functions:** Shifts the meaning of specific responses, clarifies their attachment significance, and fosters more positive perceptions of the partner.

Restructure and Shape Interactions (Enactments)

**Examples:** (a) "Can you tell him, 'You don't get to devastate me again'." (b) "This is the first time you've ever mentioned being ashamed. Could you tell him about that shame?" (c) "Can you ask him right here, right now for what you need?"

**Main Functions:** Clarifies and expands negative interaction patterns, creates new kinds of dialogue, new interactional processes and bonding events; leads to positive cycles of accessibility and responsiveness.

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**Enactment – having one partner talk directly with the other usually with specific direction:**

1) Enacting present positions
2) Turning new emotional experience into new interactions
3) Highlighting rarely occurring responses

**Impasses:**

1) Diagnostic pictures – make impasse explicate
2) Alliance building and repair
3) Individual sessions
4) Disquisition
5) Video review (self supervision)
6) Outside supervision

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**Notes:**
RISSSC
R – Repeat
I – Images
S – Simple
S – Slow
S – Soft
C – Client’s words

RISSSC Role Play: Observer, Client, Therapist
- Therapist begins by asking client “Did you have any notable experiences this week?” Then, “what was this experience like for you?”
- Observer identify the number of times each RISSSC response was used to enhance the conservation.
- Goal: For the therapists to engage the “client”, to elicit and support the client’s experience using ALL six aspects of the RISSSC.

RISSSC Tally Sheet
Repeat___________________________
Images___________________________
Simple___________________________
Slow____________________________
Soft_____________________________
Client words _______________________

Notes:
Client Statement: “I feel numb/empty”
Therapist Responses:
- Can we just stay there a moment? (process directive)
- You feel numb (reflect)
- When Mary says “…..”, you feel numb. (repeat stimulus, put in context of cycle/interaction)
- And then you stay silent, say nothing? (action primed by “numb” withdrawal).
- What’s that like for you, to go numb, stay numb?
- How do you feel as you talk about this right now?
- What’s happening for you as you talk about this? About going numb?
- How do you do that? (Frames client as agent in creation of experience).
- That’s how you protect yourself? (Conjecture about function)
- If you didn’t do that what would happen?
- As you say that, you clench your fist tight, like holding on?
- That must be hard, to feel you have to numb out all the time?
- That’s the way you have of protecting yourself here?
- You shut down, shut off, go somewhere else, go away, hide, chill out.
- It’s like, I won’t feel, is that it? You can’t get me?
- And then you feel like he’s not there with you? (to other)
- You can’t stay and hear her say “…..”, you have to go away?
- Can you tell her “I shut you out”? (enactment)
- For you it’s like you feel so battered, so criticized that you are numb?
- When you talk about this it reminds me of one of my other clients. He spoke of how it was so painful to hear that he had disappointed his wife that he’d just space out... (Disquisition).

**Cycle De-escalation**
1) Develop a strong alliance with both partners.
2) Assume that there is a good reason for the reactivity.
3) Access underlying emotions (Step 3).
4) Validate each person’s position.
5) Use the power of reflection (emotion, the cycle etc.) in managing the process in the room, and in developing and strengthening the alliance.
6) Use metaphors and imagery.
7) Reframe the problem in the context of the negative cycle, which becomes the common enemy (Step 4).

Notes:
Withdrawer Engagement/Softening

1) Involves engaging the withdrawer in the process of therapy and in the relationship.
2) It is essential to access and expand the underlying emotional experience of the withdrawer (fear, shame, sadness etc.).
3) Primary and secondary emotions need to be tied to the perceptions, action tendencies, and to the relationship cycle.
4) Withdrawal is generally a way people learn to protect themselves and manage conflict.
5) Reframe withdrawal as an attempt to protect the relationship or protect the self rather than as rejection or not caring.
6) The withdrawer often takes a stand with the spouse in the process of coming out and engaging.
7) A reasonable degree of withdrawer re-engagement is essential for a softening to occur.

Softening
A softening is when a previously hostile/critical spouse asks, from a position of vulnerability, a newly accessible partner for attachment needs and longings to be met (Johnson, 2004).
- Powerful, watershed process, second-order change (Johnson, 2004)
- Powerful healing attachment event that helps to redefine the relationship and bring a shift towards positive emotional engagement, accessibility, and responsiveness.
- Often most difficult task for therapist & couple (Greenberg & Johnson, 1988).
- THE most common impasse in EFT (Johnson, 1996).
- Requires the effective implementation of steps 1 - 7.

Levels of Change in an EFT Softening
With an female blamer and a male withdrawer:

1) She expands her experience and accesses attachment fears or shame and the longing for contact and comfort. Emotions tell us what we need.
2) She engages her partner in a different way. Fear organizes a more affiliative stance. She articulates emotional needs and changes her stance in the dance. New emotions prime new responses/actions.
3) He sees her differently, as afraid rather than dangerous, and is pulled towards her by her expressions of vulnerability.
4) She reaches and he comforts. She sees him differently. A new compelling cycle is initiated – an antidote to negative interactions – a redefinition of the relationship as a secure bond.
5) They exhibit more open communications, flexible problem solving and resilient coping. The couple resolve issues and problems (Stage 3 of EFT).
6) There are shifts in both partner’s sense of self. Both can comfort and be comforted. Both are defined as “lovable”.

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Therapist Checklist

1) What is the cycle that characterizes this relationship?
2) What are the hypothesized or acknowledged primary emotions embedded in this cycle?
3) What are the attachment issues/fears/needs?
4) Where are they in the process of change – in the nine steps? The next step/task is?
5) Are there pivotal incidents that crystallize issues, in relationship history, in session?
6) Are they key images, definitions of self and partners used?
7) What are the current blocks to engagement with emotions, engagement with other?
8) Is the alliance with the therapist in tact?
9) What happened in the last session (process)?
10) What are this couple’s strengths?

Attachment Injuries
- An attachment injury is a specific type of betrayal, abandonment or violation of trust that is experienced in a couple relationship.
- The betrayal usually occurs at a crucial moment of need that fundamentally redefines the relationship as insecure for the injured party.
- Attachment injuries can be viewed as relationship traumas which call into account basic assumptions about the relationship.
- In couples therapy attachment injuries come alive and create impasses in the process of relationship repair.
- Sometimes there is a single injury and sometimes there are multiple injuries that have occurred over a period of years.
- Are best understood in terms of their attachment significance, not the content.
- Can involve flash back at moments of risk, emotional engagement.
- Form pivotal moments in relationship definition.
- Parallel PTSD type symptoms (excessive rumination, hyper vigilance)
- Cannot be left behind or ignored - they leave an “indelible imprint”.

Notes:
1. **Injured partner articulates injury & impact – “Never Again!”**
   - The therapist encourages the injured partner to begin to risk connecting with her/his now accessible partner.
   - The injured partner begins to describe the incident where there was violation of trust that damaged belief in the relationship as a secure bond.
   - This partner speaks of this incident in a highly emotional manner. The incident is alive and present in the room rather than being a calm recollection.
   - Often the other partner discounts, denies or minimizes the incident and the partner’s pain in a defensive stance.

2. **Injured partner integrates narrative and emotion and accesses attachment fears and longings associated with injury event.**
   - With the therapist’s help, the injured partner stays in touch with the injury and begins to articulate its impact and attachment significance.
   - New emotions frequently emerge at this point. Anger evolves into clear expressions of hurt, helplessness, fear and shame.
   - The connection of the injury to present negative cycles in the relationship becomes clear. For example, a spouse says, “I feel so hopeless. I just smack him to show him he can’t pretend I’m not here. He can’t just wipe out my hurt like that”.

3. **Other understands significance of the event and acknowledges the partner’s pain and suffering.**
   - The partner, supported by the therapist, begins to hear and understand the significance of the injurious event.
   - As the partner understands the injury in attachment terms it becomes a reflection of his/her importance to the injured spouse, not as a reflection of personal inadequacies or insensitivity.
   - This partner then acknowledges the injured partner’s pain and suffering and elaborates on how the event evolved for him/her.

**Notes:**
4. Injured partner moves toward a more integrated articulation of the injury and ties it to attachment bond.
   - The injured partner then tentatively moves towards a more integrated and complete articulation of the injury.
   - This allows for the expression of grief at the losses involved and fear concerning the specific loss of the attachment bond.
   - This partner allows the other to witness his/her vulnerability.

5. Other acknowledges responsibility and empathically engages.
The other spouse becomes more emotionally engaged and acknowledges responsibility for his/her part in the attachment injury and expresses empathy, regret and/or remorse.

6. Injured partner asks for reparative comfort & caring.
The injured spouse then risks asking for the comfort and caring from the partner, which were unavailable at the time of the injurious event.

7. Bonding event which is an antidote to the traumatic experience. Relationship is redefined as a safe haven.
   - The other spouse responds in a caring manner that acts as an antidote to the traumatic experience of the attachment injury.
   - The partners construct together a new narrative of the event.
   - This narrative is ordered and includes, for the injured spouse, a clear and acceptable sense of how the other came to respond in such a distressing manner during the event.

Forgiveness & Reconciliation Study General Conclusions
   - The general EFT model for resolving these impasses is valid.
   - EFT can impact distress for these couples caught in forgiveness dilemmas
   - Change is stable.
   - Compound injuries in less trusting couples – need more sessions.

Makinen, J. and Johnson, S. Journal of Consulting and Clinical Psychology 2006 Vol. 74, No. 6, 1055 - 1064

Notes:
1) A history of trauma is common, particularly in clinical populations.
2) PTSD follows exposure to extreme stressor involving intense fear, helplessness or horror.
3) The effects are especially severe if stressor is “of human design” which is a “violation of human connection.” (Herman, 1992)
4) The best predictor of the effects of trauma is not trauma history, it is whether a person can seek comfort in the arms of another.
5) PTSD symptoms are symptoms involving difficulties in affect regulation.
6) Survivors often oscillate between angry outbursts and frozen numbness.
7) Sexuality and the associated intimacy is often a problem.
8) Flashbacks, regression, and internal disorganization are common.

**Symptoms**

1) **Persistent Re-Experiencing** (Being “there not here”)
2) **Avoidance and Numbing**
   - Avoidance of internal and external cues associated with trauma.
   - Detachment / Dissociation / Restricted affect / Estrangement from others/ Sense of limited future.
3) **Hyperarousal**
   - Hypervigilance / Anger Fits & Irritability / Sleep Disorders
   - Exaggerated Startle Response

**Traumatic Stressors**

1) Combat
2) Assault
3) Natural Disasters
4) Severe Accidents
5) Physical Abuse / Torture / Incarceration
6) Incest / Sexual Abuse
7) Life Threatening Illness
8) Extended Isolation

**Mediators:**

- Severity
- Duration
- Proximity of Stressor
- Resilience of Victim
- Attachment Style / Connection.

Notes:
Trauma and Couple Distress

- Trauma / Violation of human connection results in the increased need for a safe haven / secure attachment.
- Trauma also leads to increased lack of trust and vigilance for danger.

1) Paradox:
- Other is safety, contact is the solution.
- Other is danger, contact is a source of fear.

2) Trauma Impacts:
- Affect Regulation
- Information Processing
- Communication

- Distress in a relationship can lead to a recurrence of the violation, resulting in the maintenance of symptoms.
- The Lack of a safe haven perpetuates the effects of trauma, and the effects of trauma perpetuate relationship distress and the lack of a secure base.

Dealing with Trauma Together—Quotes
- “Emotional attachment is the primary protection against feelings of helplessness and meaninglessness.” (McFarlane & Van der Kolk, 1996)
- A deep sense of belonging results in the “taming of fear.” (Becker, 1973)
- Proximity to an attachment figure “tranquilizes the nervous system.” (Schore, 1994)
- “Fear needs to be tamed in order for people to be able to think and to be conscious of their needs. A person’s bodily response of fear can be mitigated by the safety of attachments . . . and a body whose response to stress can be mitigated and controlled.” (Van der Kolk, 1996)
- When one is confident an attachment figure will be there when needed, a person, “will be much less prone to either intense or chronic fear than will an individual that has no such confidence.” (John Bowlby, 1973)

Notes:
## Traumatic Experience / Secure Attachment

<table>
<thead>
<tr>
<th>Traumatic Experience</th>
<th>Secure Attachment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Floods us with physical fear/helplessness.</td>
<td>Soothes and comforts.</td>
</tr>
<tr>
<td>Colors the world as dangerous/unpredictable.</td>
<td>Offers a safe haven.</td>
</tr>
<tr>
<td>Creates overwhelming emotional chaos.</td>
<td>Promotes affect regulation/integration.</td>
</tr>
<tr>
<td>Threatens a cohesive sense of self.</td>
<td>Promotes personality integration.</td>
</tr>
<tr>
<td>Assaults self-efficacy and a sense of control.</td>
<td>Promotes confidence/trust in self and other.</td>
</tr>
<tr>
<td>Scrambles the ability to engage fully in the present, and so to adapt to new situations.</td>
<td>Promotes openness to experience, risk taking, and new learning.</td>
</tr>
</tbody>
</table>

Table reproduced from Johnson, 2002, p. 37

### Notes:
1) Creates a healing environment that regulates negative affect and re-experiencing symptoms.
2) Fosters specific new learning about others --- incompatible with effects of trauma. (Source of Comfort)
3) Shapes confiding that promotes integration of trauma experience. The numbing lessens.
4) Fosters “Here-ness” versus “There-ness”. Engagement.
6) Protects against re-traumatization. Creates resilience & an antidote to isolation.

How is Relationship Repair Different with Traumatized Couples?
2) Psycho-educational component regarding trauma. Relate effects of trauma to cycle.
3) Violence and substance abuse are more endemic.
4) Alliance is always fragile, monitor it. Collaboration & transparency.
5) Emotional storms and crises must be expected.
6) Emotion must be contained as well as heightened. Defenses are validated. (Don’t take the defenses away - validation allows people to slowly let go).
7) Shame overrides even positive cues. Model of self is crucial.
8) Destination is different, e.g. limits on sexuality.
9) Need to coordinate with other therapists.
10) Safety is everything. Risks must be sliced thin and supported at each step.

Stages and Tasks: Stage 1—Stabilization
Task 1: Create a safe context and build a strong alliance.
1) Therapist affirms the trauma survivors and works to establish a secure base
2) Therapist is transparent and real
3) Reflect and validate experiences and emotions
4) Collaborate with the couple in the formulation of safety rules and limits
5) Educate partners about after effects of trauma and how they impacts relationships

Notes:
Stages and Tasks: Stage 1—Stabilization

Task 2: Clarify interactional patterns and the emotional responses that shape them.
1) Track and identify negative interaction cycles that maintain distress.
2) Do both a trauma and an attachment history.
3) Begin to specify how emotional responses in both partners reflect the impact of trauma and attachment insecurity.
4) Help them see the interactional patterns and emotional responses in a way that helps them align with each other against the cycle, rather than seeing each other as the enemy.
5) Frame the relationship as a potential safe haven and a source of healing.

Stage 2—Restructuring the bond between partners

Task 1. Expanding and restructuring emotional experience.
1) Heighten core emotions and attachment fears and vulnerabilities from trauma in both partners.

Task 2. Expanding self with other.
1) Formulate new responses and emotions into a new sense of self as benign, lovable, and competent.
2) Access marginalized and disowned emotions and integrate them into a new and expanded sense of self.

Task 3. Restructuring Interactions toward Accessibility and Responsiveness
1) At this point partners can own their interactional positions and openly process them (“I shut you out because I am testing you to see if you really care”).
2) Partners can openly share vulnerabilities and have new, safe emotional bonding connections as well as discuss how to create safety.
3) Support partners to accept each other’s experience and respond; asking for needs to be met or stating boundaries in ways that foster the relationship.

Stage 3—Integration

Task 1: Integrating and heightening new interaction, definitions of the relationship and ways of coping with trauma.
Task 2: Integrating new experiences of self into the interaction.
Task 3: Explicitly integrating into models of self and into the relationship system the new ways of coping with the ghosts and scars of trauma.
- Help them construct an empowering story of how they changed and heighten bonding events that define the relationship as secure.

Notes:
A Softening with a Traumatized Partner

The wife in the couple was an incest survivor who had begun to experience severe flashbacks three years before and had a history of self-mutilation. The couple presented with a classical critical pursue defend withdraw pattern. They had three children and had been married for twelve years. They were a professional couple and the wife was referred to marital therapy by her individual therapist.

This extract is intended as an example of how changing the relationship impacts the symptoms and consequences of trauma and changing how the trauma is dealt with can change the relationship.

The therapist focuses upon a key incident that reflects how the emotional responses arising from trauma define the relationship and how the patterns in the relationship maintain the trauma symptoms.

Session 12

Therapist: 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),

Therapist: 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.

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

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

Therapist: 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)

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

Therapist: 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 paralyzed 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.

Therapist. You want to learn how to help her, yes? You would like to be able to comfort her (he agrees).

Julie. No. He wants to keep things calm. He wants to know if I need to be baby-sat. He’d be angry at me waking him.

Therapist. 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 his desire to be engaged.

Julie.  (Tears)------(Stops tearing, takes on a dead flat voice), I’m a histri-onic witch any way, he’s right, I should smarten up. (She exits into self-criticism away from his invitation to engage.)

Therapist 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’s face goes blank, she curls up in her chair, puts her hand down on her chest and is silent... long pause.)

Therapist Julie, where are you? What’s happening?

Julie  (Long pause, she begins to breathe faster when 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).

Therapist (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 touching (she breaks into sobs).

Therapist Ah-ha, (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.

Therapist 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 deep concern on his face all this time)
A Softening with a Traumatized Partner (Continued)

Therapist

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 am a cry-baby. My dad called me that when I got upset.

Therapist.

I understand. Can you look 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 a secure base, directs interaction, fosters risk taking with partner.** *(She turns her head and looks up. As her eyes meet his, he reaches out for her hand she hesitantly takes it)*.

Therapist.

What do you see in his face?

Julie.

I think, I think......, he feels sad for me.

Therapist.

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.

Therapist.

You can understand a little of how afraid Julie is and that she had good reasons for those fears. **Heightening process/his invitation.**

Julie.

I’m not a good wife. *(She is trying to exit)*.

Therapist.

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. *(She is trying to exit)*.

Therapist

Julie, did you hear him say that he wants to be with you, that he is 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)*.

Larry

Yes, sometimes I feel hopeless, like she’ll never trust me.

Therapist

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?

*(He does) **Therapist Directs Interaction.**

Notes:
Other Populations—Where EFT is Going

1. Adapting to Culture
2. Type of Families
3. Sexuality
4. Addictions
5. General vs. Clinical Population

The hope for a better human future lies not in an endless succession of technological developments but in a realistic grappling with the fundamental issue of the quality of human relationships; and central to that fundamental task I see the urgent need to make the achievement of a deeply satisfying and rewarding relationship possible for an emerging number of married couples.

(David Mace, April 1987, Journal of Marital and Family Therapy)

Emotionally Focused Therapy Resources

EFT Books
EFT Resources

Outcome Research

**Process & Predictors Research**
4. Talitman, E. & Johnson, S. (1997) Predictors of Success in Emotionally Focused Marital Therapy. *Journal of Marital & Family Therapy*, 23, 135-152. It is interesting to note that in this study, couples continued to significantly improve from the end of therapy to follow-up.

**Reviews of EFT Research / Commentaries**

Meta-Analysis

Research on EFT Training / Learning EFT

Programs Based on EFT Research
EFT Training Note Form

Date: _______ Session # _____ Length: _____ Clients: _______________________________________

Therapy Stage: □ De-escalation □ Reengagement □ Consolidation
Steps Covered:
Stage 1 De-escalation
□ 1. Alliance and assessment integrating into interactions
□ 2. Identify negative interaction cycle and positions in that cycle
□ 3. Access emotions underlying interactional positions
□ 4. Reframe the problem in terms of emotions, attachment needs, & the cycle
Stage 2 Reengagement
□ 5. Identification with disowned needs and aspects of self and integrating these into relationship interactions
□ 6. Promote acceptance of partner’s experiences & new patterns
□ 7. Restructure the interaction and create emotional engagement
Stage 3 Consolidation
□ 8. New solutions to old issues
□ 9. Consolidating new cycles of attachment

Session Content Issues:

Key Emotions, Metaphors, Images, Client Phrases, and Positive Shifts in Session:

Withdrawer

Behavior

Perceptions/Attributions

Secondary Emotion

Primary Emotion

Attachment Needs

Pursuer

Behavior

Perceptions/Attributions

Secondary Emotion

Primary Emotion

Attachment Needs

Aspect of cycle highlighted in session (including action, perceptual, reactive emotion and primary emotion levels):

Interventions used:
□ Empathic reflection
□ Validation of client realities & emotional responses
□ Evocative responding
□ Heighten
□ Empathic conjecture/interpretation and inferences
□ Track and reflect process of interaction, make positions and cycles explicit
□ Reframe experience/interaction in terms of attachment context & cycle
□ Restructuring and shaping interactions (enactments)
□ Diagnostic pictures explicate
□ Individual sessions
□ Disquisition

Homework:

Plan for Next Session:

Signature ___________________________________________