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EMOTIONALLY FOCUSED COUPLE THERAPY

Straight to the Heart

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Emotionally focused couple therapy (EFT; Johnson, 1996; Greenberg & Johnson, 1988) is an effective short-term approach to modifying distressed couples' constricted interaction patterns and emotional responses and fostering the development of a secure emotional bond. Such bonds are powerfully associated with physical and emotional health and well-being, with resilience in the face of stress and trauma, with optimal personality development, and with adaptation to the environment (Willis, 1991; House, Landis, & Umberson, 1988; Feeney & Ryan, 1994; Burman & Margolin, 1992; Mikulincer, Florian, & Weller, 1993). Perhaps because of this focus on the creation of secure bonds, over the last decade, EFT has also been used to successfully address marital distress complicated by other problems such as depression, posttraumatic stress disorder (PTSD), and chronic physical illness (Johnson & Williams Keeler, 1998). EFT is now one of the best empirically validated approaches to changing distressed relationships (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Alexander, Holtzworth-Munroe, & Jameson, 1994; Dunn & Schwebel, 1995). Research has clarified how the process of change occurs (Johnson & Greenberg, 1988) and who is best suited to this kind of intervention (Johnson & Talitman, 1997). A version of EFT is also used with families (Johnson, 1996, 1998). EFT

also compares well with other approaches in terms of treatment effect sizes (Johnson, Hunsley, Greenberg, & Schindler, 1999), rates of recovery and improvement, and evidence of long-term effectiveness (Gordon Walker, Manion, & Cloutier, 1998) after relatively short treatment (10 sessions; Gordon Walker, Johnson, Manion, & Cloutier, 1996).

To create lasting change in a brief and efficient manner, a treatment approach should optimally have certain characteristics. It should be founded on a clear, empirically validated theory of dysfunction and health, that is, the target of interventions and the goals of the change process should be as specific as possible. Interventions should be clearly specified. The therapist must know not only *what* to do and *how* to do it but *when* particular interventions are required. The change process in therapy should be specified so that the therapist knows when he or she is on track, and there should be some evidence as to how to match client to treatment. The treatment model should also be able to deal with the fact that marital distress often occurs in tandem with other problems and symptoms. The literature on EFT addresses the issues outlined above (Johnson, 1996). EFT is able to create change efficiently, perhaps because this approach integrates the intrapsychic and the interpersonal, using the compelling power of emotion to restructure the drama of distressed relationships and choreographing powerful bonding events that redefine the attachment bond between partners.

THE EFT PERSPECTIVE ON MARITAL DISTRESS AND ADULT INTIMACY: THE THEORETICAL MODEL

EFT assumes that the key factors in marital distress are the ongoing construction of absorbing states of distressed affect and the constrained, destructive interactional patterns that arise from, reflect, and then in turn prime this affect. This assumption combines an experiential intrapsychic focus on inner experience, particularly affect, with a systemic focus on cyclical self-reinforcing interactional responses. This focus on affect and interaction, and how they create and reflect each other, echoes the empirical work of John Gottman (1991). Gottman emphasizes the power of negative affect, as expressed in facial expression, to predict long-term stability and satisfaction in relationships and the destructive impact of repeated cycles of interaction, such as criticize and defend or complain and stonewall. The inability of distressed couples to sustain emotional engagement is also noted in this research (Gottman & Levenson, 1986) and appears more central in maintaining

distress than the number of disagreements or whether disagreements can be resolved. Gottman notes that there appear to be differences in affect regulation between men and women. Women seem to be more able to regulate their affect in interpersonal conflict and therefore more often seem to take the complaining position, whereas their male partners withdraw to contain their affect. Gottman's thorough and empirically validated description of marital distress and his ability to predict marital outcomes suggest that emotional responses and particular self-reinforcing interaction patterns are the most appropriate targets of intervention in marital therapy (Gottman, 1994).

To understand why affect and the interactional patterns outlined above are so central to marital distress, we need to place these empirical findings in the context of a theory of relationship. Marital therapy has, in general, lacked a clear theory of adult intimacy and therefore a clear sense of the primary goals and targets for the change process and of what constitutes health in relationships (Manus, 1966; Segraves, 1990; Roberts, 1992). If a therapy is to be brief, it's crucial to define what specific changes are necessary to create recovery from distress and promote long-term health and resilience. We must define what difference will really make a difference.

One theory that has come to the fore to provide a rich theoretical context for understanding adult intimacy is attachment theory (Bowlby, 1969; Hazan & Shaver, 1987). This theory was first elaborated in the context of parent-child relationships and has now been applied to adult bonds. From an attachment perspective, the description of marital distress outlined above is best understood in terms of separation distress and an insecure bond. A bond here refers to an emotional tie, a set of attachment behaviors to create and manage proximity to the attachment figure and a set of working models, or what are usually termed "schemas." These schemas are concerned with the dependability of others and the worth or lovableness of self.

Attachment theory states that compelling fear, anger, and sadness will automatically arise when an attachment figure is perceived as inaccessible or unresponsive. These emotions have what Tronick (1989) terms control precedence; they override other cues. Seeking and maintaining contact with others are viewed as the primary motivating principles in human beings and an innate survival mechanism, providing us with a safe haven and a secure base in a potentially dangerous world (Bowlby, 1988). When attachment security is threatened, affect organizes attachment responses into predictable sequences. Bowlby suggests that, typically, protest and anger will be the first response to such a threat, followed by some form of clinging and seeking, which then gives way to depression and despair. Finally, if the attachment figure doesn't

respond, detachment and separation will occur. The potential loss of an attachment figure, or even an ongoing inability to define the relationship as generally secure, is significant enough to prime automatic fight, flight, or freeze responses that limit information processing and constrict interactional responses (Johnson, 1996). So a husband corners his wife and yells "kiss me" in enraged protest at his wife's unresponsiveness, and so he ensures that she will completely shut him out. Fear narrows options.

Much of the research on adult attachment has concerned attachment styles. These styles can be seen in terms of the answer to the crucial question, "Can I count on this person to be there for me if I need him or her?" (Hazan & Shaver, 1994). There are a limited number of answers to this question and limited ways of dealing with these answers. Attachment styles, expectations, and responses formulated in past relationships help to create present interactions, and, in turn, present interactions tend to mitigate or intensify a person's habitual style. Many partners basically believe that significant others will be there if they need them and are able to trust their partners; they have a secure attachment style. They tend to see others as reliable and themselves as lovable and worthy of care. They are able to process attachment information, give clear emotional signals when their attachment needs arise, and they tend to feel confident enough to assert themselves in the face of the differences that inevitably arise in any long-term relationship. If and when a bond is threatened, they can then respond with resourceful flexibility. If, however, the answer to the question above is a tentative "maybe," and the attachment is thus defined as anxiously insecure, partners tend either to cling to attachment figures or aggressively demand reassurance, often fearing that they are somehow deficient or unlovable. If the answer to the above question is "no," partners tend to avoid closeness with others, exhibiting an avoidant, fearful style, or they tend to deny their need for attachment and frame others as untrustworthy, displaying an avoidant, dismissing attachment style (Bartholomew & Horowitz, 1991).

Insecure attachment styles, then, predispose people to certain predictable emotional responses and behavior and ways of experiencing self and other that make the repair of distressed relationships more difficult and help maintain marital distress. For example, avoidantly attached partners tend to particularly restrict contact when they or their partners are most anxious and in need of comfort (Simpson, Rholes, & Nelligan, 1992). A husband says, "It's not that I don't care. I get overwhelmed. I'm not sure how to comfort you. I'm scared that I won't do it right. So I freeze and withdraw. I guess this happens just when you need me the most."

Attachment theory provides a map for adult intimate relationships.

It outlines attachment needs for contact, comfort, security, and closeness as the features that define this landscape. These needs are viewed as adaptive and inherently human, rather than in any way a reflection of immaturity or pathology (Bowlby, 1988). This perspective is consonant with new directions in feminist thought (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991) that stress the definition of self in relation to others, rather than in terms of self-sufficiency and separateness. It's not attachment needs themselves that are problematic in distressed relationships. It is, rather, how partners process and enact such needs in a context of perceived danger and insecurity that primes this distress (Johnson, 1996).

Attachment theory has room for the consideration of both self and system, inner experience and organized interaction with others. It takes into account both the past, reflected in habitual attachment styles, and the present ongoing interactions, which may modify such styles. Attachment theory is, then, nonpathologizing and interactional and now has a considerable research base as a theory of adult love and relatedness (Bartholomew & Perlman, 1994; Shaver & Hazan, 1993).

An attachment perspective focuses the couple therapist on attachment insecurities, longings, and needs. It stresses the significance of experiences of deprivation and loss of trust and connection. It directs the process of therapy toward the creation of the accessibility and responsiveness that foster safe emotional engagement. Such engagement encourages partners to express their attachment needs. This perspective also gives us a potent and useful way of reframing typical problematic behaviors to make them accessible to reorganization. For example, angry blaming is viewed most often as an attempt to modify the partner's inaccessibility and a protest response to abandonment. Distancing is often framed as a way of regulating fears of loss or avoiding anticipated feedback about the self's unworthiness. This perspective also allows us to reframe each partner's responses in a manner that fosters compassion and contact. For example, an anxious partner's critical pursuit of the other may be framed as a fear of loss and a compelling desire for reassurance rather than as a desire for control or as hostility. These kinds of reframes then help the other partner to respond more positively. In general, placing distressed responses in an attachment context allows spouses to see and relate to their partner's pain. Partners talk in life and death terms about key interactions in attachment relationships. This is because they are facing basic concerns about security and contact and how they are defined by the person they depend on the most: So a wife says to her spouse, "You watch me drown. You don't respond. You throw me away like I am nothing."

In terms of the process of change, attachment theory directs the

therapist's attention to the accessing and reprocessing of attachment-related affect, the modifying of interactions that block contact, and the creation of bonding interactions. It also stresses the need for exploring and sometimes modifying the working models of self and other that underlie negative attribution patterns and so help to maintain marital distress.

This theory also complements Gottman's research on the importance of affect in the definition of close relationships. In attachment theory, emotion may be seen as alerting partners to the significance and nature of key relational experiences, evoking working models in a state-dependent fashion (when I'm anxious, I easily formulate all my fears about myself) and, most importantly for the couple therapist, priming attachment behaviors. In constructivist terms, emotion is seen as an organizing force in the processing of attachment information and the definition of the nature of the bond between partners. Emotion is the music of the attachment dance (Johnson, 1996). In marital distress, this interactional dance and each partner's experience of the relationship are constricted by compelling attachment fears and insecurities. The role of affect in close relationships and the change process in therapy are addressed further in the intervention section of this chapter.

The goals of EFT, which arise out of this attachment perspective and the view of marital distress summarized above, are: first, to expand attachment-related affect and so expand interactional positions, so when I experience and express my fear rather than my anger, I take a less dominating and more contactful stance with my partner; second, to do this in a manner that fosters emotional engagement, the expression of bonding needs and the attainment of comfort and security. EFT is conducted in 8 to 20 sessions in which the therapist uses both experiential techniques to explore and reconstruct the key emotional responses that arise in the session and directive, systemic techniques to shape new interactions. Change strategies occur in the context of a positive therapeutic alliance that provides a secure base (Bowlby, 1988) for the therapy process. The role of the therapist is that of a process consultant, working with partners to construct new experiences and new interactions that redefine their relationship.

KEY PHASES IN TREATMENT

The process of change in EFT has been delineated in nine treatment steps. The first four steps involve assessment and the deescalation of problematic interactional cycles. The middle steps (5-7) emphasize the

creation of specific change events where interactional positions shift, and new bonding experiences occur. The last two steps of therapy (8–9) address the consolidation of change and the integration of these changes into the everyday life of the couple. These steps are described in linear form. In fact, the therapist circles through them in spiral fashion as one step incorporates and leads into another. In a mildly distressed, securely attached couple, the partners generally work quickly through the steps at a parallel rate. In more distressed couples, the more passive or withdrawn partner is usually invited to go through the steps slightly ahead of the other. The increased emotional engagement of this partner then helps the other more active, critical partner shift to a more trusting stance.

The nine steps of EFT are as follows:

Cycle deescalation

- Step 1 Assessment. Creating an alliance and explicating the core issues in the marital conflict 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.

Changing 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 experience in the relationship and new interactional behavior.
- Step 7 Facilitating the expression of specific needs and wants and creating emotional engagement. 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.

Consolidation/integration

- Step 8 Facilitating the emergence of new solutions to old problematic relationship issues.
- Step 9 Consolidating new positions and new cycles of attachment behavior.

In all of these steps, the therapist moves between: first, helping partners to crystallize their emotional experience in the present, tracking, reflecting, and then expanding this experience; and second, setting interactional tasks that add new elements to and reorganize the interactional cycle. The therapist might, then, first help a withdrawn, guarded spouse formulate his sense of paralyzed helplessness that primes his withdrawal, then help the partner to hear his experience, and finally move to structure an interaction around this helplessness: as in, "So can you turn your chair, please, and can you tell her, 'I feel so helplessness and defeated. I just want to get away and hide.'" This kind of statement, in and of itself, represents a move away from passive withdrawal and the beginning of active emotional engagement. The steps of EFT are described in greater detail elsewhere (Johnson, 1996, 1998).

Stages of Therapy

In terms of the change process, it is especially helpful to the therapist who is committed to brief structured interventions to delineate key change events in the therapy, so that the process stays focused and on course. In EFT, the first shift, which usually occurs at the end of Step 4, is a deescalation of the negative cycle. This is a first-order change (Watzlawick, Weakland, & Fisch, 1974). The way interactions are organized hasn't changed, but the nature of the elements has. Reactive emotional responses are less intense; negative attributions about the partner are less rigidly held, and responses toward the spouse are generally less extreme. Partners are more hopeful and experience the therapy sessions as a safe place to learn about their relationship. The couple begins to risk more engagement and to view the cycle as the enemy, rather than the other spouse. If the partners have very different agendas for therapy, for example, if one has already emotionally divorced the other, this may be the end of the therapy process. The therapist is able at this point to clarify the nature of the present relationship and the choices open to the couple. In most couples, however, this shift sets the stage for the work of second-order change, reorganizing the interactional dance in the direction of safe attachment. At this point, a partner might say, "Well, things are better. We're fighting less, and I see him a little differently, but it's a truce. He still runs and hides, and I still go for him. We're still not dancing in the dark together."

In the middle stage of therapy (Steps 5-7) there are two change events that are crucial turning points in EFT. The first is withdrawer reengagement where this partner changes his or her interactional position and becomes more active in defining the relationship and more accessible to his or her partner. So, for example, a silent and always distant partner might become angry and assert her need for respect and

support in the relationship in a way that gives her mate a chance to respond to that need.

The second change event, a softening, occurs when a previously critical, active spouse is able to risk expressing needs and vulnerabilities and to begin to trustingly engage with his or her partner. Research on the process of change has found that this event predicts recovery from marital distress in EFT (Johnson & Greenberg, 1988). If there is only partial engagement in these change events, or if the couple reach an impasse here, the relationship may still improve, but the impact of therapy will be less potent. For example, problem cycles will have diminished, but the trust in the relationship is often limited, since positions are essentially unchanged. Bonding is then also circumscribed, and the couple are more susceptible to relapse. Transcripts and detailed descriptions of a softening can be found elsewhere (Johnson & Greenberg, 1995; Johnson & Williams-Keeler, 1998).

This softening event is a shift in the critical partner's position, both in terms of affiliation and control, that then restructures the cycle of interactions. In its final stages, it is also a prototypical bonding event where two now accessible partners initiate a new cycle characterized by engagement and responsiveness. This kind of bonding event (occurring when the second partner completes Step 7) has the ability, because of its emotional salience in terms of basic attachment needs, to heal past injuries and wounds in the relationship and to redefine the nature of the bond. So a critical, often accusing partner is able to share his deep fears of loss and abandonment and let himself be comforted and reassured by the partner. He then experiences a shift from isolation to connectedness and from frustration in the face of the problem cycle to a sense of efficacy in the creation of a new kind of relationship. Once this kind of change event has occurred, the couple naturally moves into consolidating this new positive cycle and begin effectively problem solving conflictual, pragmatic issues.

ASSESSMENT AND THE SELECTION OF CLIENTS

In brief therapy, it's particularly important to have some way of matching client to treatment. Addressing this issue, first, EFT is not used for couples where abuse is an ongoing part of the relationship and is used only in an abbreviated form (as referred to above) for couples who are separating. Abusive partners are referred to group or individual therapy to help them deal with their anger and abusive behavior. They are offered EFT only after this therapy is completed and their partners no longer feel at risk. It is important that the latter is used as a criterion for readiness for marital therapy rather than the abusive partner's assess-

ment that his or her behavior is now under control. The goal of treatment, after the assessment, is then to encourage the abusive spouse to enter treatment and the victimized partner to seek supportive counseling or individual therapy.

Research on success in EFT (Johnson & Talitman, 1997) allows us to make some specific predictions as to who will benefit from EFT. First, the quality of the alliance with the therapist predicts success in EFT. This is to be expected; it is a general finding in research on all forms of psychotherapy that a positive alliance is associated with success. However, to be more specific, the quality of the alliance in EFT seems to be a much more powerful and general predictor of treatment success than initial distress level. In our study, initial distress level was not an important predictor of success 3 months after therapy. This is an unusual finding because initial distress level is usually by far the best predictor of long-term success in marital therapy (Whisman & Jacobson, 1990).

In addition, our research indicated that the perceived relevance of the tasks of therapy seems to be the most important aspect of the alliance. Perceived task relevance was more central than a positive bond with the therapist or a sense of shared goals. The couple's ability to join with the therapist in a collaborative alliance and to view the tasks of EFT, tasks that focus on issues such as safety, trust, and control, as personally relevant seem to be crucial. This may, of course, also be a reflection of the therapist's skill in presenting these tasks and in creating an alliance. Generally, this research suggests that EFT works best for couples who still have an emotional investment in their relationship and therefore some willingness to genuinely engage in the therapy process and who are able to see their problems in terms of insecure attachment and conflicts around closeness and distance. These results suggest that the first concern of the EFT therapist must be to form and maintain a strong supportive alliance with each of the partners. EFT interventions are only as potent as the alliance.

A lack of expressiveness or of emotional awareness has not been found to hamper the EFT change process. In fact, EFT seems to be particularly powerful in helping male partners who are described by their partners as inexpressive. This may be because when such partners are able to discover and express their experience, the results are often compelling, both for them and for their partners. Traditional relationships, where the man is oriented to independence and is often unexpressive while the woman is oriented to affiliation, were found to be responsive to EFT interventions. EFT was also more effective with older men (over 35), who may be more responsive to a focus on intimacy and attachment.

The female partner's initial level of trust, specifically her faith that her partner still cared for her, was a very strong predictor of treatment

success. In a culture in which women have traditionally taken most of the responsibility for maintaining close bonds in families, if the female partner no longer has this faith that her partner cares for her, this may define the bond as nonviable and may stifle the emotional investment necessary for change. Accumulating evidence suggests that emotional disengagement, rather than factors such as the inability to resolve disagreements, is predictive of long-term marital unhappiness and instability (Gottman, 1994) and of lack of success in marital therapy in general (Jacobson & Addis, 1993). Low levels of this element of trust may then be a bad prognostic indicator for couples engaging in any form of marital therapy. In these particular situations, the EFT therapist might then help a couple to clarify their goals and the limits of their engagement. For example, in a small number of cases, the couple may curtail the cycle of distress by choosing to redefine their relationship as a parallel friendship, without expectations of romance or closeness.

Unfortunately marital distress often occurs hand in hand with other symptoms and problems, particularly clinical depression. The brief therapist then has to find a way to address these issues in an integrated fashion, that is to address how these individual symptoms and the distressed marital interactions prime and maintain each other. If not addressed, these individual problems tend to undermine progress in redefining the relationship. Conversely, if they are successfully addressed, the therapist is often able to "kill two birds with one stone." There is empirical evidence that EFT is effective with depressed partners (Dessaulles, 1991; Gordon Walker, 1991). Marital discord is the most common life stressor that precedes the onset of depression, and 25-fold increased risk rate for depression has been reported for those who are unhappily married (Weissman, 1987). Research also demonstrates that EFT works well with couples experiencing chronic family stress and grief, for example families with chronically ill children (Gordon Walker et al., 1996). EFT has also been used for couples where one partner is suffering from PTSD resulting from physical illness, violent crime, or childhood sexual abuse (Johnson & Williams-Keeler, 1998). These clients have typically received some individual therapy before requesting marital therapy and may be referred by their individual therapist, who recognizes the need to address marital issues. Trauma increases the need for protective attachments and, at the same time, undermines the ability to trust and therefore to build such attachments. If the marital therapist can foster the development of a secure bond between the partners, this not only improves the marital relationship but also helps partners to deal with the trauma and mitigate its long-term effects. So a spouse might say to his partner, "I want you to be able to feel safe in my arms and to rest in that safe place when the ghosts come for you: I can help you fight them off."

PLANNING TREATMENT AND BUILDING AN ALLIANCE

In the initial sessions of EFT, we assess the nature of the problem and the strengths of the relationship by listening to the couple's history of their relationship and their current difficulties, eliciting specific descriptions of problematic responses and incidents, for example, the most recent fight, and inviting the couple to interact in the session. We also probe for instances when the couple partners have experienced their relationship as satisfying and supportive and their understanding of the shift into the problem cycle. We also elicit a very brief personal history from each person. This focuses upon their attachment history, including questions such as "Who were you close to growing up?" "Who held and comforted you?" It's pertinent for the EFT therapist to know if partners have experienced safe attachment with this partner, any partner, or any attachment figure, and if partners have been traumatized in close relationships. We track and reflect sequences of interaction and begin to formulate and reflect each partner's habitual position in the relationship. Consonant with the nonpathologizing stance of EFT, we validate each partner's construction of his or her emotional experience and place this experience in the context of the pattern of interactions. This reflection and validation not only focuses assessment on affect and interaction and encourages disclosure, but it also immediately begins to forge a strong alliance. A focus on the problem interactions or cycles allows us to frame both partners as victims, to assign responsibility without blame, and to begin to link the couple against these cycles. The cycles then become their common enemy.

Assessment and the formation of an alliance are not separate from treatment in EFT; they are an integral part of active treatment. By the end of the first or second session, we usually have a clear sense of the typical problem interactions (e.g., "I feel alone and frustrated, so I pick at you. You feel lost and confused and become intellectual and distant. I then intensify my barbs. You shut down and avoid me for 2 or 3 days."). At this point, we can also assess the strengths of the relationship and form hypotheses as to key underlying emotions and definitions of self and other that operate at an implicit level in the couple's interactions. We actively intervene with the couple and assess how open the partners are and how easy they will be to engage in therapy. From the beginning, the EFT therapist is active and directs the partners' disclosures toward attachment-salient interactions, attributions, and emotional responses. We check with the couple as to their specific treatment goals and formulate a therapy contract briefly describing the process of treatment, setting an expectation that treatment will be concluded in approx-

imately 8 to 15 sessions. We encourage couples to view us as consultants, who can be corrected and who will need their active participation to redefine their relationship. We then can admit mistakes and allow clients to teach us about their unique experience and their relationship.

The creation of the alliance in EFT is based on the techniques of experiential therapy (Rogers, 1951; Greenberg, Rice, & Elliott, 1993). The EFT therapist focuses upon empathic attunement, acceptance, and genuineness. We assume that the alliance must always be monitored and any potential break in this alliance must be attended to and repaired before therapy can continue. The alliance is viewed in attachment terms as a secure base that allows for the exploration and reformulation of emotional experience and engagement in potentially threatening interactions. We begin by taking people as they are (Johnson, 1996). We then try, by the leap of imagination that is empathy (Guerney, 1994), to understand the valid and legitimate reasons for their manner of relating to each other and exactly how this maintains their marital distress. The therapist must be able to validate each partner's experience of the relationship without blaming or invalidating the other. We acknowledge that partners will perceive the relationship differently and are doing their best to protect themselves and the relationship within the present narrow cycles of interaction.

CORE INTERVENTIONS

There are two basic therapeutic tasks in EFT, the exploration and reformulation of emotional experience and the restructuring of interactions. Before describing the interventions associated with these tasks, it is pertinent to discuss briefly the role and significance of emotion as it is conceptualized in this approach.

Emotion, here, refers to a small number of basic universal affects: anger, fear, surprise, hurt/distress, shame, sadness/despair, and joy (Plutchik, 1980). An emotional response integrates physiological arousal, meaning schemes, and action tendencies. For example, I see a movement; I feel hot; I decide it's a tiger, and I run. Emotion gives us compelling feedback as to how our environment is affecting us, organizing and priming us to respond to this impact. It often takes control precedence and overrides other cues, especially in attachment relationships. Specifically, in such relationships, emotion is first a major organizer of responses to our partner and second, emotional expression is a regulator of key dimensions of social interaction, such as closeness/distance and control/submission.

In terms of organizing our experience of and response to significant

others, emotion is designed to rapidly reorganize behavior in the interests of security and the fulfillment of basic needs. In intimate relationships, emotion orients us to our own needs as well as colors environmental cues and meanings. So when I'm angry, I focus on my injury and the need implicit in that injury. In a state-dependent fashion, I also recall all the other times when this need has been frustrated, and I move rapidly to address the situation, perhaps by protesting and demanding a response from my partner. Emotion particularly primes attachment behaviors (when I'm afraid, I move closer to you and seek out comfort). It also activates associated core definitions of self and other. For example, my hurt at your criticism touches all my doubts about my own adequacy and worth.

In terms of regulating social interaction, emotional expression, especially tone of voice and facial expression, communicates to others in a manner that defines the nature of a particular relationship and pulls for particular responses. For example, the expression of vulnerability tends to disarm and invite approach. The power of emotion is such that, if unaddressed, it can also easily undermine or block shifts in cognition and behavior by igniting fight or flight responses. If used in the process of change, emotion also has the power to elicit key responses that cannot be elicited by any other means, such as affection and compassionate comforting that can rapidly redefine the attachment relationship and prime new positive behaviors.

The EFT therapist begins by reflecting and validating the secondary reactive responses (see Johnson & Greenberg, 1994, for a discussion of different kinds of affect) that the couple displays, such as anger. The therapist then expands these responses into the primary underlying emotions that are often unattended to, undifferentiated or disowned, and so remain unexpressed in the relationship, such as the hurt underlying rage. Emotion in EFT isn't simply discussed from a distance or relabeled. It is evoked and developed by helping clients to focus on the leading edge of experience and to differentiate new elements in that experience. For example, numbness, when explored, might first become hopelessness and then defiance. A partner might say, "I give up. I can't do it. Then I say to myself, 'I'm not even going to try.'" This defiance may then be used by the therapist to create new kinds of interactions; it could, for example, be used to prime engaged assertiveness.

How does the therapist know which emotion to focus on? The therapist focuses on (1) the most present poignant emotions that arise in the therapy process, the nonverbal gesture, or the "hot" image; (2) the emotion that's most salient in terms of attachment needs and fears; and (3)

the emotion that seems to organize problem interactions or has the potential to organize positive ones. For example, the therapist might highlight the look of relief on a husband's face when his partner says that she "interrogates" him out of fear, not out of hostility or contempt. Fear is addressed extensively in EFT, primarily because fear especially constricts and constrains both information processing and interactional responses.

Exploring and Reformulating Emotion

The following interventions are used in EFT to address this task.

Tracking and Reflecting Emotional Experience

Example: "Could you help me to understand? I think you're saying that you are so caught up with your own feelings and how to deal with them that you find it hard to even make sense of his response; everything seems confusing and overwhelming, is that it?"

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

Validation

Example: "You feel so alarmed that you can't even focus. When we're that afraid, we can't even concentrate, is that it?"

Main functions: Legitimizing responses and supporting clients to continue to explore how they construct their experience and their interactions; building the alliance.

Evocative Responding: Expanding by Open Questions the Stimulus, Bodily Response, Associated Desires, and Meanings or Action Tendency

Examples: "What's happening right now, as you say that?" "What's that like for you?" "So when this occurs, some part of you just wants to run, run and hide?"

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

Heightening: Using Repetition, Images, Metaphors, or Enactments

Examples: “So could you say that again, directly to her, that you do shut her out?” “It seems like this is so difficult for you, like climbing a cliff, so scary.” “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: Highlighting key experiences that organize responses to the partner and new formulations of experience that will reorganize the interaction.

Empathic Conjecture or Interpretation

Example: “You don’t believe it’s possible that anyone could see this part of you and still accept you, is that right? So you have no choice but to hide?”

Main functions: Clarifying and formulating new meanings, especially regarding interactional positions and definitions of self.

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

Restructuring Interventions

The following interventions are used in EFT to address this task.

Tracking, Reflecting, and Replaying Interactions

Examples: “So what just happened here? It seemed like you turned from your anger for a moment and appealed to him. Is that okay? 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 key interactional sequences.

Reframing in the Context of the Cycle and Attachment Processes

Example: “You freeze because you feel like you’re right on the edge of losing her, yes?” “You freeze because she matters so much to you, not because you don’t care.”

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

Restructuring and Shaping Interactions: Enacting Present Positions, Enacting New Behaviors Based upon New Emotional Responses, and Choreographing Specific Change Events

Examples: “Can you tell him, ‘I’m going to shut you out. You don’t get to devastate me again?’ ” “This is the first time you’ve ever mentioned being ashamed. Could you tell him about that shame?” “Can you ask him, please?” “Can you ask him for what you need?”

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

TERMINATION

In this phase of treatment, the therapist is less directive, and the couple themselves begin the process of consolidating their new interactional positions and finding new solutions to problematic issues in a collaborative way. We emphasize each partner’s shifts in position. For example, we frame a more passive and withdrawn husband as now powerful and able to help his spouse deal with her attachment fears, while this spouse is framed as needing his support. We support constructive patterns of interaction and help the couple put together a narrative that captures the change that has occurred in therapy and the nature of the new relationship. We stress the ways the couple have found to exit from the problem cycle and create closeness and safety. Any relapses are also discussed and normalized. If these interactions occur, they are shorter, less alarming, and are processed differently, so they have less impact on the definition of the relationship. The couple’s goals for their future together are also discussed, as are any fears around terminating the sessions. At this point, the couple express more confidence in their relationship and are ready to leave therapy. We offer couples the possibility of future booster sessions, but this is placed in the context of future crises triggered from outside the relationship, rather than any expectation that they will need such sessions to deal with marital problems per se. For example, a couple returned for three sessions of therapy after their son had been killed in an accident.

CASE DESCRIPTION AND TRANSCRIPT

As they walked into my office, I had the image of an annoyed Doris Day marching ahead of a laconic John Wayne. Clara was a pretty lady in her 60s, and she had been married to Len, her tall gangly partner, for 40 years. He grinned at me and lounged in the chair, apparently very relaxed, and he spoke in a slow drawl. She, on the other hand, sat on the edge of her chair, alert and tight-lipped. They immediately told me with pride that they had three children, all of whom had left home, and two grandchildren. Len was a high-profile politician going through the process of retiring as therapy started. They were referred by Len's individual therapist who was treating him for a recent depression. This depression had developed after Len decided to retire because of his arthritis. Clara had undergone treatment for lung cancer the year before. She told me in a steady voice that she felt that she had beaten the disease. However she understood that there was a high risk of recurrence. Clara described the problem between them as "constant bickering" and said that unless something changed she was going to leave Len and "find some peace." Clara referred to a particular past episode again and again. In this episode, Len had become very stressed and overwhelmed in his job and had pressured Clara to help run his office. Clara said passionately, "I hated this job. I told him again and again that I had to stop. I told him the job was killing me." She described how he had minimized her distress at the time, and he continued to do so in the session. He laconically told her that she was exaggerating, turning to me and telling me that "she really didn't mind that much." As he smiled at me and informed me that his wife would "calm down in a minute," she spat out angrily that he had pressured her to keep on running the office for a year until she had been diagnosed with cancer. His unwillingness to listen to her was then associated with the occurrence of a life-threatening illness.

Len and Clara played out the dominant cycle in their relationship while discussing this incident. She attacked him, saying "You discounted me and only took care of yourself, and I hate you for this." He dismissed her statement, responding with, "It wasn't that bad, and you don't hate me, and I took care of you when you were ill." As Len defended himself in a calm reasoning manner, Clara became more and more enraged. "I'm tired of being told how I feel and who I am," she said. "This has gone on for 15 years, and now I'm on the point of leaving." Len's manner immediately changed when she said this. He went still and silent. He then turned to me and began to tell me a rambling detailed story designed to prove his point that Clara hadn't been that upset about working in his office. Clara looked like she was going to

explode and then sighed and told me in a quiet hopeless tone, "He buries me in words." She commented that this kind of interaction occurred frequently at home and that this kind of stress "was going to make me sick again." As she said this, he furrowed his brow and looked really upset for the first time in the session.

In the EFT model, the episode that Clara described might be labeled as an attachment "crime" or "injury." Clara had expressed her exhaustion and distress and Len had not responded. He had discounted her pain and remained inaccessible, both in the past and in the current dialogue. Underlying many such attachment injuries, that continue to define the relationship, is a potent experience of danger or physical threat in which the partner was perceived as failing to provide caring and protection.

Clara and Len presented with a classic complain/attack versus stonewall/defend cycle. In this case, Len was withdrawn and also clinically depressed. He was also facing a significant life transition that he experienced as an enormous loss. In the past Clara had usually initiated closeness, but she had now put up a "wall." Len commented that he would try to cuddle her in the mornings in bed, but he often felt "pushed away." Again and again he would comment to me, "She exaggerates; she gets wild-eyed over nothing." Clara acknowledged that Len had taken care of her when she was ill with cancer, but then she wagged her finger at him, saying, "Mostly though, through the years, you've taught me to be alone and put your career first." Illness was very present in this relationship. Clara's sister had recently died of cancer, her daughter was ill, and the specter of a possible remission of Clara's cancer was always present. She said with tears in her eyes, "If I have a shortened life to live, I'm determined not to live it in a box, with him sitting on the lid. I'm tired of trying to get through to him."

After the initial sessions and the building of an alliance, we articulated the interactional cycle described above, putting each person's responses in the context of the other's behavior (Step 2). The couple were framed as victims of this cycle of angry complaint and rational defense. This cycle had robbed them of the comfort and closeness they had experienced at previous times in their relationship. They told their story of the evolution of the relationship. Clara stated that for many years she "had allowed him to define reality," and Len admitted that he had been "rather authoritarian." She felt "bullied by his impenetrable rationalizing." He spoke of the need to convince her to "dampen down her feelings about a few isolated negative incidents." Past events in Len and Clara's personal histories and in the history of the relationship were only pursued if they were directly relevant to present attachment issues and problematic interactions. For example, Len pointed out that, in his

career, there were many times when it was very important for him to stay calm and rationalize people's complaints. I used this to validate his style, and we were then able to talk about how, here, it simply seemed to make his wife more angry and desperate.

I then helped the couple to move into Step 3 of therapy, exploring the emotions underlying their interactional positions. Len began to talk about his hurt at being "shut out" by Clara and by her threats to leave him. I focused on his voice and facial expression rather than his words and helped him formulate that he was "sad" and "in shock." I helped him talk about his fear of losing Clara, either through her angry distancing, her leaving the relationship, and/or through a recurrence of her illness. We began to talk about how this fear paralyzed him. Clara spoke of her sense of having no impact on Len, no way of getting him to acknowledge her hurt and desperateness, and so alternating between rage and helplessness. I helped Len to articulate that the loss of his career, where he felt affirmed and valued, had left him feeling vulnerable and sensitive to Clara's criticism. She was able to talk of how she felt abandoned and disqualified by his "denials and discounts" and now by his withdrawal into depression. I framed both of them as isolated and vulnerable and as having lost a sense of control over their lives and their relationship.

The experience and expression of the emotions implicit in the interactional cycle began to expand the dialogue, and moments of engagement began to occur. For example, when Clara talked openly of her cancer, Len was able to directly express his fear of losing her. She was touched by this. She commented to him, "I never knew you were that worried. Maybe you're just trying to calm yourself down with all that rationalizing. I thought you were just trying to bully me." Then she reached over and laid her hand on his arm.

I set interactional tasks based on these emotional responses that promoted the deescalation of the problem cycle and the beginnings of emotional engagement. For example, I asked Len to talk to Clara about how he had lost his sense of power and competence when he retired. Together we articulated that his "job" now was to take care of her and he "didn't know how to do it." "In fact," he said "I'm blowing it. I'm failing." His response to this sense of failure was then to feel hopeless and to withdraw. She began to view his withdrawal in terms of how much impact she had, rather than how little. He became less distant and self-protective, and she became less angry and blaming. At this point, (Step 4), they talked about the cycle and their "sensitivities" as the problem. They were kinder to each other. The cycle had deescalated, and we were through Stage 1.

In Steps 5 and 6 of EFT, first one partner and then the other formu-

lates and expresses attachment-related affect in a way that fosters acceptance from the other and rapidly reorganizes attachment behaviors. In Session 6, Len began to express with much weeping how terrified he was of her anger and of hearing her say that he'd failed her. Her illness, his retirement, and his own depression had all intensified his awareness of how much he needed her. As we explored what happened to him when he got the message that he was disappointing her, he was able to describe the "panic" that preceded his attempts to "cool down" her anger. He was then able to move to Step 7 (creating emotional engagement) and ask her to stop threatening to leave and to control her rage, so that he could, as he put it, "learn to take care of her and become good at this new job." His reengagement then allowed her to move into formulating her sense of helplessness when he did not recognize her experience and her need for his validation and comfort. She moved in terms of her interactional position from a blaming stance to expressing her fear of having her pain denied and therefore being abandoned. She said to him, "It's too scary to count on you when you don't even seem to see or hear me." Both partners were now much more available and responsive to each other and were able to comfort each other.

A new cycle of closeness and comfort began, and this couple was able to create pragmatic solutions to old issues (Step 8), such as his occasional inebriation and the effect this had on her. She was able to share with him that she needed him to "be with" her, rather than against her or distant from her. At the end of therapy, the couple's interactional patterns had changed. They were able to curtail the problem cycle when it occurred and to respond to each other in a manner that initiated new cycles of closeness and confiding (Step 9). Their attributions about their relationship and the other partner had changed. She saw him as overwhelmed and afraid, rather than as a bully. He saw her as desperate for his validation and caring, rather than as hysterical and hostile. The relationship was now defined as a "safe haven" (Bowlby, 1988) where their attachment needs could be articulated and met. Each partner's sense of self had also expanded. For example, Len was able to accept his vulnerability and feel a sense of competence in dealing with his affect and responding to his wife's needs. As a result he became less depressed. By the end of therapy, their emotional experience was formulated differently. They both were able to accept their own emotions and express them in a way that pulled their partner closer to them. They were now also able to use the relationship to regulate distress, such as the fear of illness. Len and Clara completed 12 sessions of therapy.

The following exchange occurred during Session II in the context of a threatened relapse at the end of treatment where Len began to with-

draw and is therefore a replay of Steps 5 and 7 for him. Here, he owns vulnerabilities and needs and expresses them in an engaged manner to his partner.

LEN: The relationship is better. I don't spend near as much energy dodging her rage. She's less angry. *(He smiles at her.)*

CLARA: *(She smiles back at him.)* Well, you hear me more, and you're less depressed and withdrawn, so it's less lonely for me. But *(She turns to me and her voice becomes higher and more clipped.)* I have to be sure that he really gets this, that he can keep on doing this.

LEN: *(He studies the nails on his right hand and says slowly:)* I'm not stupid. I understand more than you give me credit for. *(He looks out the window.)*

CLARA: *(Her voice now goes up a decibel, and she moves to the edge of her seat.)* Well, when you have more than one drink you get really pushy and loud. Then on Saturday you got all mopey and distant.

LEN: *(very slowly, still looking out the window)* I got a little pushy, and I got a little down *(long pause)*, but I wasn't that bad. *(He tears and looks away.)*

SUSAN: What's happening for you now, Len? *(He mutters that he's fine. I see him as in obvious pain.)* What's it like for you when Clara says she sees you as being easier for her to get close to, to contact, and then she adds a "but"?

LEN: I don't like it. It's hard. *(He looks directly at her, but she stares at her hand.)*

SUSAN: Ah-ha. It's hard. And some part of you even feels like weeping, is that right?

LEN: *(Pause; he focuses on me and rubs his eyes.)* No, it's just my eyes watering. Well, okay, it's like she's accusing me again, and that's scary.

SUSAN: Right. And that's part of the cycle you guys get trapped in.

LEN: Right. *(long silence and then a deep sigh)* Maybe I can't make it.

CLARA: *(She looks up at him. Her voice is soft, and she sits back in her chair.)* I'm trying to give you a chance. We've had some really good days. *(Now her lips tighten again. She smooths her skirt with her hand, and her voice is clipped.)* But then, I gave you the recipe, I suggested no alcohol and . . .

SUSAN: *(I decide to stay with Len and help him stay engaged. I use a soft voice.)* You're disappointed—that she is doubting you?

LEN: Yeah. She starts to accuse me. (*He turns to Clara.*) I can read recipes, but . . . (*He tears and wrings his hands.*)

SUSAN: What happened on Saturday afternoon, Len, before you had a few drinks?

LEN: I got into a . . . (*He is searching for the right words. He then speaks empathically and deliberately.*) a massive internal flap.

SUSAN: A massive internal flap. Can you help me understand? A flap is, like, frantic?

LEN: Yeah. She was talking about the drinking, and I was already uneasy, but then, but then (*His voice cracks, and he squirms in his chair.*) she went in the study and read the medical books my brother gave me.

CLARA: (*She turns to me and speaks in a very calm tone.*) I went and read about my kind of cancer, and it wasn't good. It said that basically recurrence is just a matter of time.

LEN: And she still has that pain. (*He puts his hands over his eyes.*)

CLARA: (*She leans toward him and says very calmly:*) But we knew that, really.

SUSAN: You were able to read the book and look at that with some calmness, Clara? (*She nods.*) But for you, Len, anticipating that Clara is about to be disappointed with you or angry at you was difficult, that's still difficult, but then knowing that she had read that book, the book you had already read, yes? (*He nods and his eyes widen, telling me I am on track here.*) That brought on a massive internal flap, a panic, for you, yes?

LEN: Yes. (*He weeps.*) I want to make her happy. I try. Her anger scares me. She talks of leaving, and we've got better at handling that, but then, then she talked about this recurrence thing. (*His voice trails off.*)

SUSAN: And you start to feel helpless (*He nods.*), like you can't make her happy, at least that's what came up on Saturday afternoon, and the fear that you might lose her, she might leave, by getting mad enough at you, or by getting sick again. Is that it? [We are recycling through Step 5 here. I am reflecting and heightening his panic and his fear of loss.]

LEN: Yes. (*He weeps.*) She used to say the fights we had were killing her. Things have improved a lot, but . . . Saturday . . .

CLARA: (*She now looks concerned and leans toward him. She sees his distress. She is much more empathic than she was the first time we*

went through this process of him expressing and owning his hurts and fears.) I know I have said that you're not listening and discounting me kills me, but . . .

SUSAN: (to Len) On Saturday afternoon, all your fears of not being able to hold on to Clara, of not being able to keep her, keep her happy and with you, of losing her, came up again, yes? (He nods emphatically.) You even heard her say that the relationship was hurting her, making her sick, and you got frantic.

LEN: That's it. (He weeps and wipes the tears away with his enormous hands.) It's terrifying. I get totally paralyzed. I do.

SUSAN: And that's the massive internal flap that has you minimizing and trying to persuade Clara that she doesn't hurt, that everything is fine. Finally when that doesn't work, you feel beaten, and you withdraw into your despair; that's what it's all about? [I summarize the inner panic that primes his despair and his withdrawal.]

LEN: Right, I get all scared. I hover around, trying to be optimistic, and she feels discounted.

CLARA: (looking surprised) But you were always so separate, so into your work. I never felt you even needed me.

SUSAN: It's a little strange for you to hear his fear, to see how much he needs you, how afraid he is of hurting or disappointing you?

CLARA: (Long pause; she stares at Len.) I guess so . . . so, so, you're afraid. (He nods and tears.)

SUSAN: Maybe he's even more afraid of fighting the cancer again than you are, maybe?

CLARA: (again in a surprised tone) Oh, . . . Oh, well, I guess so . . . yes, maybe he is.

SUSAN: His massive internal flap pulls him into trying to make everything smooth, better. He tries to make your hurts smaller, but then you get even more hurt and angry, and he gets defeated and depressed. You're so precious to him, is that okay, Len? (He nods.) He goes into a panic. [His minimizing and discounting are framed in an attachment context. All these formulations of underlying feelings and interpretations have been used before. They are now applied specifically in the context of her possible relapse and his fear of that.]

CLARA: Oh, . . . (She turns to Len.) is that it?

LEN: (in a much more relaxed tone) That's about it. When you get in a hissy fit and say you're leaving, I just can't handle that. And then

you tell me that the way I am with you will bring back the cancer . . . I just freeze up.

CLARA: (*She puts her hands up to her face.*) Oh dear, maybe I shouldn't do that.

LEN: (*He leans toward her.*) It doesn't help. I'm trying. I think I'm doing better. I wasn't good at listening in the past. I can't handle being afraid of losing you and then hearing that I'm making you sick. I want to be with you, not hurt you.

SUSAN: (*softly*) What happens for you as you see his fear, Clara?

CLARA: Well, I guess . . . it all seems different. It puts things in a different light.

SUSAN: Ah-ha. Maybe it's his fear that he is trying to control when he plays down your feelings and withdraws.

CLARA: Right, and I always saw it as him trying to control me!

LEN: (*He smiles at her and then at me. He's John Wayne again.*) I wouldn't dare. (*He laughs.*)

SUSAN: Len, can you help her see more? Can you help her understand how much you want to protect and hold her, how afraid you are when the shadow of her leaving, through anger or getting ill, looms?

I then drew the session to a close on the theme of how fear isolated them from each other. All of these themes had been touched on before, and Clara and Len had already changed their problem cycle and initiated a more positive bond. However, here the themes all came together and could be addressed in an integrated fashion that prevented relapse, consolidated his engagement and her softening, and explicitly brought the issue of cancer into the interaction. The next session was the last. The couple came in and reported that they had talked for hours together about her need to be seen by him and to depend on his responsiveness and about his fears of failing her and losing her. This process was a repeat and elaboration of the initial process of Len's reengagement that had occurred in earlier sessions. She was able to respond here because she had already expressed her needs in a previous session and experienced his comfort and caring.

They had also talked openly after this session of the possibility of her death and experienced being much closer to each other through the week. She stated that she realized that because they were closer she felt, "no panic" about the idea of recurrence. She said to me in a quiet voice, "If it happens, we will face it together." They had also been able to talk together and formulate pragmatic plans and coping strategies to deal

with such a recurrence. The couple here were able to use their relationship as a safe haven and a secure base in dealing constructively with the trauma of cancer.

Many things happened in this session on the level of individual partners, relationship definition, and existential realities. Specifically, this session touched on Len's depression and adjustment to retirement, the nature of Len and Clara's attachment and marital satisfaction, and their ability to cope with the possibility of a recurrence of her illness and possible death.

To further clarify the process of change in EFT, it may be useful to look at key moments in Clara's softening, which occurred in Sessions 8 and 9, and how these moments redefined the relationship:

- In Step 3 of therapy, Clara formulated the emotions underlying her critical angry stance in terms of helplessness. She said, "I can't get through to him. I hurl myself at this mountain. He just defines me away. He tells me I don't hurt."
- In the softening process, in Step 5, she was able to tell him, "I get desperate when you discount me. It's like I don't exist. It's like when I said I felt ill before the cancer diagnosis, you said I was fine, but I was dying (*she wept*). I can't reach you."
- In Step 7, this process evolved into Clara stating with quiet intensity her fear of abandonment and her need for comfort. She said, "I'm afraid of the cancer coming back, but I'm more afraid of being alone. I need you to see me and hold me. Hold me so I'm not so afraid. Please don't leave me all alone." She got up and held onto him.

When these moments occur:

1. Clara focuses on and expresses vulnerability rather than anger. She is then able to formulate her needs. She is also able to express them in a way that makes it easier for Len to respond. It is when we are experiencing intense emotion that we find it easiest to formulate our most pressing needs and concerns. Emotion carries with it a clear message about what matters most to us.

2. Clara's expression of vulnerability constitutes a less dominant, more affiliative stance toward Len. Emotion is an action tendency; as Clara experiences her fear and longing, she reaches for Len and asks for comfort. In doing so, she changes her interactional position. She is no longer simply the critical accuser.

3. As Clara expresses her fears and hurts, Len sees her differently. She is less dangerous. She is therefore easier for him to respond to. The expression of "new" emotion pulls for a "new" response from the

spouse and so reorganizes the interaction, creating a shift from the problem cycle.

4. As interactions expand, so does each partner's sense of self. Both partners see themselves as more able to control their relationship and deal with their emotions. Intense emotions are also a direct route into our core cognitions about who we are. Len is able to touch his sense of failure in this process and have it evolve into a new sense of how essential and irreplaceable he is to his wife.

5. New emotions structure new steps in Len and Clara's dance. A new cycle of confiding and responsiveness begins. This new cycle of trust and confiding creates a more positive relationship and tends to be self-reinforcing.

6. This new cycle is not just a new set of behaviors replacing the destructive cycle. It is a cycle that addresses inherent attachment needs. It redefines the relationship as a place of safety and comfort. This then influences both partners' resilience in the crises and challenges of life.

Perhaps one of the most creative ways to view the whole issue of brief therapy is to view it in terms of efficiency rather than simply in terms of time; that is, rather than thinking in terms of having to create limited change in a very small number of sessions, focusing on making specific changes that have an immediate, lasting, and significant impact on people's lives. Perhaps, of all modalities, marital therapy has the most potential to create multiple impacts (Lewis, Beaver, Gossett, & Phillips, 1979), potentially affecting individual, couple and family functioning. EFT attempts to tap the power of compelling emotional responses and of basic attachment needs and processes to create a difference that really makes a difference in a brief format.

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