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ATTACHMENT INJURIES IN COUPLE RELATIONSHIPS: A NEW PERSPECTIVE ON IMPASSES IN COUPLES THERAPY

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This article identifies and operationalizes the newly defined construct of attachment injury. An attachment injury occurs when one partner violates the expectation that the other will offer comfort and caring in times of danger or distress. This incident becomes a clinically recurring theme and creates an impasse that blocks relationship repair in couples therapy. An attachment injury is characterized by an abandonment or by a betrayal of trust during a critical moment of need. The injurious incident defines the relationship as insecure and maintains relationship distress because it is continually used as a standard for the dependability of the offending partner. The concept of an attachment injury is defined here in the context of emotionally focused therapy, an empirically validated, short-term approach to modifying distress in couples. The broad theoretical underpinnings of this concept may be found in attachment theory as applied to adult romantic relationships. Through the delineation of attachment injury events and the ongoing development of a detailed model of resolution, couples therapists will be better able to identify, describe, and effectively treat such injuries and address the therapeutic impasses that are associated with them.

Attachment theory, now one of the most promising theories of adult love relationships (Shaver & Hazan, 1993), emphasizes the propensity for human beings to make and maintain powerful affectional bonds to significant others (Bowlby, 1988). Virtually every aspect of human experience is strongly influenced by the quality of these bonds. In couples, a secure attachment bond is an active, affectionate, reciprocal relationship in which partners mutually derive and provide closeness, comfort, and security. These bonds are not simply based on "reciprocal altruism" but, rather, on a "profound psychological and physiological interdependence" (Hazan & Zeifman, 1999, p. 351). Attachment theorists have pointed out that, perhaps because of this interdependence, incidents in which one partner responds or fails to respond at times of urgent need seem to influence the quality of an attachment relationship disproportionately (Simpson & Rholes, 1994).

Negative attachment-related events, particularly abandonments and betrayals, often cause seemingly irreparable damage to close relationships. Many partners enter therapy not only in general distress but also with the goal of bringing closure to such events, thus restoring lost intimacy and trust. During the therapy process, however, these events, which we have termed attachment injuries, often reemerge in an alive and intensely emotional manner, much like a traumatic flashback, and overwhelm the injured partner. When the other partner then fails to respond in a reparative, reassuring manner, or when the injured spouse cannot

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accept such reassurance, the injury is compounded. As the couple experiences failure in their attempts to move beyond such injuries and to repair the bond between them, their despair and alienation deepen. So a partner's withdrawal from his wife while she suffers a miscarriage, as well as his subsequent unwillingness to discuss this incident, becomes a recurring focus of the couple's dialogue and blocks the development of new, more positive interactions.

In this article we discuss attachment injury as a construct that may be useful in understanding impasses and repair processes in attachment relationships. In particular, the understanding of the nature of particular impasses in couples therapy increases the likelihood that interventions will result in significant and lasting change, rather than resulting in more temporary and limited improvement as is often now the case (Jacobson & Addis, 1993).

The couples therapy literature has recently attempted to deal with particular kinds of betrayals or relationship traumas that make relationship repair more difficult. There has been much discussion of infidelity, for example, and how to help couples deal with such events (Abrams Spring, 1997). The forgiveness literature is relevant here (Flanigan, 1992; Worthington & DiBlasio, 1990). However, there is little understanding of the negative events that call for forgiveness, and it is often defined as an intrapersonal rather than an interpersonal process. Views of forgiveness have also not been integrated into broader theories of marriage (Coop Gordon, Baucom, & Snyder, 2000). Perhaps as a result of this lack of a broad theoretical framework, there is little consensus as to the critical elements of forgiveness and how and why particular kinds of negative incidents affect relationships in particular ways.

The concept of attachment injury does not focus so much on the specific content of a painful event but on the attachment significance of such events. Some incidents involving some form of infidelity might be experienced as attachment injuries, whereas other incidents would not. The attachment injury concept arises out of a specific theoretical perspective on close relationships. This perspective, apart from its general conceptual relevance as a theory of adult love and its growing empirical support, also seems to be a particularly appropriate conceptual frame for the events discussed here. Attachment theory has been called a theory of trauma (Atkinson, 1997) in that it emphasizes the extreme emotional adversity of isolation and separation, particularly at times of increased vulnerability. This theoretical framework offers an explanation of why certain events become pivotal in a relationship as well as an understanding of what the key features of such events will be, how they will affect a particular couple's relationship, and how such events can be optimally resolved.

The concept of attachment injury emerged from the observation of impasses in the therapy process of couples whose relationship improved but who did not recover from distress in emotionally focused couples therapy (EFT; Greenberg & Johnson, 1988; Johnson, 1996). Recent research suggests that EFT has a higher success rate (70%–73% of couples are no longer distressed at the end of therapy) than other empirically validated approaches and less of a problem with relapse (Johnson, Hunsley, Greenberg, & Schindler, 1999). Nevertheless, understanding the factors that limit therapeutic effectiveness is an important undertaking for EFT and for all models of couple therapy.

Observations of the process of therapy with couples who did not respond optimally to therapy revealed a clear pattern. As the more withdrawn partner became more accessible and the therapist began to encourage the other, more blaming partner to risk trusting and confiding, an emotionally laden incident, often first described in the beginning of therapy, would become the focus of the session. As the therapist fostered the confiding of attachment vulnerabilities and needs, for example, a partner would balk and hark back to a specific incident of betrayal, while the other partner might discount or not even remember the event. This incident sometimes appeared, at first glance, to be relatively insignificant, but it evoked compelling, constricted emotional responses and interaction patterns, such as blame/defend, that blocked further progress. We noticed that partners would use the language of trauma when describing such injuries. They spoke in life-and-death terms. They spoke of isolation and abandonment. A past violation of trust would be described and the injured party would take a stance of "never again," refusing to risk becoming vulnerable to the other. The other partner would then become angry or withdraw. Unless the therapist could find ways to help the couple deal with this perceived violation of trust, the couple would then be unable to create the positive cycles and bonding events found in the sessions of more successful couples (Johnson & Greenberg,

1988). Because these observations and subsequent understandings of how such injuries could best be resolved emerged from the context of EFT, we now briefly describe this approach.

Emotionally Focused Couple Therapy

Emotionally focused therapy is a short-term, structured approach to the repair of distressed relationships. This approach, which is also used with families (Johnson, Maddeaux, & Blouin, 1998), has demonstrated clinical effectiveness (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998). Furthermore, it has been successfully used in treating relationship distress that cooccurs with extreme stress due to chronic illness, depression, and posttraumatic stress disorder (Johnson & Williams-Keeler, 1998).

Interventions and change processes in EFT are rooted in a clear theoretical base that arises from a synthesis of the humanistic-experiential, and systemic perspectives. The EFT perspective on close relationships is grounded in attachment theory, arguably now the most cogent theory of romantic love (Cassidy & Shaver, 1999; Hazan & Shaver, 1987). This approach is congruent with empirical studies on the nature of relationship distress that stress the power of emotion to organize interactions (Gottman, 1994; Gottman, Coan, Carrere, & Swanson, 1998). The therapeutic tasks of EFT have been clearly specified and the process of change delineated into three stages and nine steps (Johnson & Greenberg, 1995).

The goals of the EFT are to expand constricted emotional responses that prime negative interaction patterns, to restructure interactions so that partners become more accessible and responsive to each other, and to foster positive cycles of comfort and caring. The therapist particularly focuses on emotion because it so potently organizes key responses to intimate others, acts as an internal compass focusing people on their primary needs and goals, and primes key schemas about the nature of self and other. Negative emotional responses, such as frustration, if not attended to and restructured, undermine the repair of a couple's relationship, whereas other "softer" emotions, such as expressions of vulnerability, can be used to create new patterns of interaction. From a systemic point of view, emotion is viewed as the "leading element" in the organization of the couple's relationship (Johnson, 1998). A sudden increase in the emotional intensity of the couple's interaction is one of the main markers that alerts the therapist to the fact that the couple are caught in dealing with an attachment injury.

EFT and attachment theory. The attachment perspective provides perhaps the strongest model we have for understanding the nature of adult love relationships. Bowlby (1969) carefully delineated a specific type of bond that is distinguishable from other types of social ties. This emotional bond is unique in that it arises from the operation of an innate behavioral system that is designed to serve four functions: Proximity seeking (maintaining contact with an attachment figure), the creation of a secure base (i.e., a source of security that makes exploration possible), the creation of a safe haven (i.e., using the attachment figure as a source of comfort and protection), and initiating separation protest (resisting separation). Bowlby wished to depathologize dependency. He stressed, as do many feminist writers, that identity and a sense of efficacy are formed and maintained by the nature of our interactions with those who are closest to us. Physical or emotional separation from an attachment figure results in a predictable sequence of responses: Protest, clinging and seeking, depression and despair, and, finally, detachment (Kobak, 1999). Elements of adult relationships, such as reciprocal care taking and sexuality, once viewed as separate from attachment, are now being formulated as part of the attachment bond (Hazan & Zeifman, 1994).

Early attachment bonds are the precursors to and models for adult relationships. Internal working models of self (as lovable vs. unlovable) and others (as responsive and accessible vs. unresponsive and inaccessible) that are first formed at a young age help to guide adult relationships (Collins & Read, 1990). Individual differences in mental representations of self and other have been linked to three patterns of child attachment: Secure, ambivalent, and avoidant. Hazan and Shaver (1987) adopted this tripartite model and applied it to couples. More recent research, however, has provided empirical support for four attachment styles or tendencies to perceive and engage others in particular ways. This more recent model includes secure, preoccupied, and two avoidant styles, dismissive and fearful (Bartholomew & Horowitz, 1991). The differences in attachment styles influence the way in which people process attachment information, regulate their affect, and communicate in social interactions (Johnson & Whiffen, 1999).

In terms of couples, once an attachment bond is established, each partner assumes a "preeminent status

in the attachment hierarchy" (Hazan & Zeifman, 1999, p. 340). These attachment bonds have a profound effect on psychological well-being. Secure attachment has been linked with positive aspects of relationship functioning, including high levels of trust, commitment, and higher dyadic satisfaction (Kobak & Hazan, 1991). Supportive relationships encourage the creation of optimal relational experiences that enhance both self and other. However, when the partner is emotionally inaccessible and unresponsive to the other's needs and longings, attachment insecurity and relational distress ensue.

The EFT perspective on relationship distress. Although partners may provide each other with safety and comfort, paradoxically, they may also be the source of a substantial amount of stress. According to EFT theory, although other factors, such as the socialization of gender roles, may play a role in the development of relationship distress, the most important factor is attachment insecurity and how the couple deals with such insecurity (Johnson, 1999). Attachment insecurity complicates the process of emotional engagement and responsiveness and so creates a pathway to the absorbing states of negative affect and constricted interactions, such as criticize, defend, and withdraw, that have been identified in research on divorce prediction (Gottman, 1994).

Relationship distress is characterized by ineffective communication, reciprocal negativity, and negative relationship schema (Halford, Kelly, & Markman, 1997). Distressed couples have difficulty expressing their underlying emotions and attachment needs, which impedes their ability to resolve conflicts, particularly "hot" conflicts that are imbued with attachment significance. As a result, when such conflicts occur, one partner tends to criticize and complain, while the other takes a defensive and distancing stance. Overwhelming negative affect coupled with rigid interactional patterns then obstruct the process of working through recurring issues and bringing closure to negative events.

Distressed couples often selectively interpret each other's behavior and responses in ways that perpetuate their distress. These couples tend to make stable, blameworthy, and global attributions for their partner's negative behavior (Halford et al., 1997; Johnson & Sims, 2000). From the attachment perspective, negative working models of self as undeserving of love and of the other as undependable guide interpretations of partner's behavior. Small disappointments may then, for an insecure spouse, echo back to major hurts and injuries and disproportionately reinforce relationship distress. Unhappy couples develop a generally negative schema about the entire relationship history and tend to remember particular relationship events in ways that are consistent with such schema. They then perceive current interactions in the light of past negative events, and the more significant these events are, the more the present relationship becomes hostage to them.

Therapeutic tasks and the process of change

In EFT, the process of change has been delineated into nine steps that are designed to be implemented in approximately 10–15 sessions (Johnson, 1996). The first four steps involve assessment and the delineation of problematic cycles and the absorbing states of emotion that are associated with them. At the end of this first stage of therapy, the couple is able to unlatch from their negative cycles and stabilize their relationship. They tend to view the cycle as the enemy rather than each other.

In the second stage of therapy (steps five to seven) partners, no longer overwhelmed by their emotions, are able to use their emotional experience as a guide to their needs and communicate these needs in a way that maximizes the other's responsiveness. Withdrawn partners are able to explore the emotional experiences that evoke their withdrawal and to become more emotionally engaged. More hostile partners become able to express their hurts and fears and take new risks with the other partner. It is at this point, as such partners are invited into a new dance, that attachment injuries are particularly likely to come alive.

If there have been no attachment injuries or if these injuries are resolved in the process of therapy, more hostile partners are now able to explore insecurities and ask for comfort, caring, and reassurance. This final interaction constitutes a change event that is associated with success in EFT, namely, a softening (Johnson & Greenberg, 1988). The couple is then able to complete a positive bonding interaction where each can risk, share, and find a safe haven in the other. This is a powerful antidote to the negative cycle, and it defines the relationship as a secure attachment. The couple can then go on to the consolidation phase of therapy in which they construct clear models and narratives of their relationship, its distress, and its recovery and, with

a new ability to communicate clearly about crucial issues, solve pragmatic, ongoing problems in the relationship (Johnson, 1999).

Couples are sometimes clear right from the first session that specific, attachment-related events in the past marked a shift in the bond between them and continue to define the relationship. Injured partners may refer to such events and use them as proof of their partner's inadequacies and failings in the relationship. An argument then often ensues about what occurred and what meaning should be assigned to the event. It appears that these kinds of wounds to the attachment bond cannot be left behind, nor can they be resolved in the negative emotional climate of the first stage of therapy. Indeed, some partners do not even bring up these events until later in therapy. In any case, it is not until the second stage of therapy that these events can be—and perhaps must be—dealt with if the couple is to reconfigure their relationship as a secure bond. If such events cannot be resolved, trust remains tentative, positive bonding cycles are more circumscribed, and relapse is more of a possibility.

Conceptualizing Attachment Injuries

An attachment injury is then a specific type of betrayal that is experienced in couple relationships. It is characterized as abandonment or a violation of trust (Johnson & Whiffen, 1999). It is not a general trust issue; it concerns a specific incident in which one partner is inaccessible and unresponsive in the face of the other partner's urgent need for the kind of support and caring that we expect of attachment figures. The injurious incident is continually used as a touchstone for the dependability of the other partner. These events, if unresolved, not only damage the nature of the attachment bond between the partners, they prevent the repair of this bond.

The actual incident that precipitates an attachment injury is not necessarily the primary causal factor in a couple's marital distress. Some partners may have endured insecure or frayed attachment bonds over a period of years and for a number of reasons. One incident in particular then exacerbates this distress and acts as a symbolic marker of insecure attachment for the injured partner. Other couples may have a relatively secure bond and this kind of incident marks the beginning of their relational distress.

Different forms of attachment injuries that are experienced by couples need to be considered. Some may appear to be trivial or exaggerated to an outsider, or they may be more obvious betrayals of trust, such as infidelity. Feelings of abandonment and betrayal may emerge at any time when one partner fails to respond to the other at moments when attachment needs are particularly salient. These moments often occur during times of transition, loss, physical danger, and uncertainty. Classic times are during the birth of a child, at times of physical illness (e.g., after a cancer diagnosis) during life transitions (such as retirement or immigration), and at times of loss (miscarriage or the death of a child). Also, what may be a manageable hurt for one couple may be a momentous interpersonal cataclysm for another. For example, a wife was inadvertently left out of a family photo taken by her husband. This occurred after she had recently immigrated to a new country where she knew no one but her husband. This incident dramatically altered the way this couple's relationship was defined. Another partner might have responded differently and another couple might be able to deal with such an incident in a way that left their relationship relatively unharmed.

Much depends on how the injured partner interprets the event in question and how the other spouse responds to expressions of hurt by the injured party. When this spouse discounts, denies, or dismisses the injury, this prevents the processing of the event in the relationship and compounds the injury. The unresolved event may be the topic of constant bickering, or it may lay dormant and unexpressed for a period of time. However, it eventually reemerges with a vengeance, especially when a small current incident evokes an emotional response related to the initial injury.

For example, a couple was referred because the husband's retirement had precipitated his clinical depression and marital distress. When the couple came in, though, the main problem seemed to be the wife's unwillingness to engage in activities with her husband. As he was encouraged by the therapist to ask his wife for hugs and physical affection, his wife exploded. She then explained with quiet intensity that she did not intend to respond to him. She asked, did he remember, exactly 16 years ago, on a particular winter afternoon when he had returned from work to find her in the kitchen, ill and depressed and trying to care for three very small children? Did he recall that she had desperately begged him to hold her for a moment or that he had then gone off to make a series of long phone calls? She had then collapsed, and in her despair, she had

promised herself never to ask him for comfort again. She had kept this promise. He did not recall this incident and she had never discussed it with him. As she described this incident, however, she flushed, wrung her hands, and wept.

Attachment injury and trauma. Attachment injuries must be distinguished from the ordinary highs and lows of an ongoing relationship. It may be useful to view them as relationship traumas. The word trauma comes from a Latin word meaning to wound and the word injury comes from a word meaning to wrong (Walser & Hayes, 1998). Not all painful events are traumatic or evoke a sense of being wronged or betrayed. A number of authors have begun to examine betrayals in relationships as a form of trauma (Gordon & Baucom, 1998; Abrams Spring, 1997). Traumatic experience shatters assumptions, changes the way we see ourselves and others, and induces a sense of existential vulnerability.

Betrayals, such as attachment injuries, call into question basic beliefs about relationships, the other, and the self. As partners commit to an intimate relationship, they have an internal model of what the relationship will look like and how they expect to be treated. Couples typically expect their partner to be attentive, responsive, and supportive. More specific expectations (i.e., time spent together, socializing, division of domestic labor, etc.) evolve out of the everyday relationship experiences. Under normal circumstances the violation of expectations would not necessarily harm the attachment bond; however, when the person is most vulnerable and comfort is essential, such violations can rupture the relational bond in significant ways.

When a partner cries out for help and there is no response, the sense of basic trust that is the "bedrock upon which the welfare of their bond depends," (Baxter et al., 1997, p. 656) is shattered. The most basic assumption of attachment relationships, that one's partner will be there when he or she is needed, is suddenly destroyed. This shattering of basic assumptions is, in and of itself, disorienting, and it is part of the sense of helplessness that is perhaps the most salient feature of traumatic experience. Such a violation may also constitute a serious threat to assumptions about the self. As a client stated, "I was just not that important to him. I wasn't precious. My hurt didn't matter." When one partner fails to respond to the other's basic dependency needs, this threatens not only the other partner's sense of security in the world but also that partner's sense of self-worth.

Attachment theory, as previously stated, has been referred to as a theory of trauma. When people are without physical or emotional support, they are at their most vulnerable and have most difficulty regulating their emotions. Disturbances of affect are central to all descriptions of traumatic stress and its sequelae. Wounds to attachment relationships that result from emotional unresponsiveness at times of intense need may be equated to trauma with a small "t." In therapy, couples often talk about injurious events in terms of life and death (e.g., "I was so sick I could have died," "You let me drown," "You didn't care that I crashed and burned after that argument"). Following traumatic abandonment, the entire relationship often becomes organized around eliciting emotional responsiveness from the other partner, or defending against the lack of this responsiveness. Moreover, the injured partner may exhibit symptoms that are characteristic of posttraumatic stress disorder (PTSD), such as reexperiencing, numbness, and hypervigilance.

Reexperiencing traumatic events emanates from the "indelible imprint" (Herman, 1992, p. 35) of the traumatic moment. Memories and emotions connected to the event linger and manifest themselves in the form of dreams, flashbacks, and intrusive memories. Much energy may be spent in ruminating about every minute detail of the event and the reasons why it occurred. Offending partners may apologize for their transgressions, but injured partners cannot let the matter go. These events are pivotal moments in the ongoing definition of the relationship that constantly come up and color present realities.

Avoidance and numbing are natural self-protective responses to the barrage of intrusive symptoms that arise from traumatic experience (van der Kolk & McFarlane, 1996). These strategies can be very costly for a relationship, however. Although numbing may help an injured spouse to cope with his/her pain, it actually prevents emotional engagement with the partner and interferes with resolution of the attachment injury. Alternating sequences of numbing, intrusive images, and hyperarousal are a response to the paralyzing attachment paradox that the injured party experiences. As attachment theorists (Main & Hesse, 1990) have pointed out, situations in which the primary attachment figure is at once a source of and a solution to pain and fear are inherently difficult to tolerate and result in a fundamental disorganization of the attachment

system. The injured party tends to swing between hypoarousal and hyperarousal, first accusing and clinging, then numbing and withdrawing. This then becomes chaotic and aversive to both partners. Even when the injured spouse can elicit comfort from the other, he or she does not trust it. The open confiding that allows us to give meaning and structure to difficult experiences (Pennebaker, 1985) is also almost impossible. In short, the couple's ways of coping with the attachment injury become aversive in themselves and perpetuate the alienation between partners.

Physiological hyperarousal, another cardinal symptom of PTSD, reflects the persistent expectation of impending danger. Relatively subtle echoes of a traumatic experience may evoke extreme fight, flight, and freeze responses. Exaggerated sensitivities and hypervigilance for further signs of betrayal then become the norm. Normally positive interactions become tentative and colored by doubts. The couple is then caught in a drama in which the injured spouse sets tests and the offending spouse is always found wanting.

If an attachment injury is viewed as traumatic, what does this imply about the process of resolution? Recovery from trauma generally involves the following elements: The ability to construct an integrated narrative of the event, its meaning and its consequences, the ability to regulate and integrate the emotion associated with the event, and the ability to create secure connections with others that offer restitutive emotional experiences of efficacy and belonging. In general, most trauma theorists view a relationship that offers a safe haven and a secure base as the most basic condition for healing. A central role of the couples therapist is then to provide such a safe haven.

A Clinical Example of an Attachment Injury

Lisa and Bob are in their early thirties, and they have two young children. Initially they came to therapy to learn how to "communicate better" and "express feelings more appropriately." The attachment injury did not surface until the third session of EFT. An attack/distance cycle, with the wife critically attacking and the husband defending and distancing, had been identified in previous sessions. During the third session, the couple began to focus on the lack of emotional engagement in their relationship. They began to talk about the loss of trust, setting the stage for the following description of an attachment injury.

When the therapist asks whether there have been specific incidents that have eroded the trust between them, Lisa suddenly becomes very quiet and still. When the therapist asks where she has gone, she stares at the floor and whispers:

Lisa: When I had the miscarriage, I was in the bathroom. I remember seeing blood all over the place and I realized that I had just lost this baby. I had lost the baby [she weeps]. I was okay at the time. I thought 'I can handle this,' that when I saw Bob everything would be okay. He would take me to the hospital and take care of me.

Therapist: What happened after that, after you realized that you had lost the baby?

Lisa: I called for Bob to come and help me. He came, but he seemed cold, like he didn't know what to do. I didn't want him to call anyone, just wanted him to take care of me.

Therapist: You wanted him to take care of you. What did you need right then?

Lisa: [Looking down, she speaks very softly] To . . . well . . . I guess . . . to hold me and do what people do when somebody dies. To me, if somebody I know had someone who died, I would ask if they are okay. I would listen and if they started to cry, I would comfort them, or even just be there. But Bob seemed fine. He didn't seem upset by it.

Therapist: So, you really needed him to be there and to hold you [Lisa weeps].

Lisa: Yes. But he shut down. He went away and I just remember being alone. And then my sister came in and drove us to the hospital. She was just trying to rush us off. I was in the car feeling totally alone. I was staring down at the butter container filled with my baby. I just wanted him to be there, really be there for me so I could cry. [She looks up. Her voice becomes very cold.] After that I just knew I would have to deal with this on my own.

Therapist: Deal with all this hurt and loss on your own?

Lisa: Yes, I knew right then that I was alone in this. And then I realized that was how it has been for a while. And for us things kind of fell apart right there . . .

Therapist: Ah ha, that was a pivotal moment for you and for the relationship [Lisa nods her head].

Bob, do you remember this? [He nods.] What was going on for you when you entered the bathroom and saw Lisa?

Bob: I saw the look on Lisa's face and I immediately was very worried . . .

Therapist: Worried that something had gone wrong with the pregnancy?

Bob: Yes, I knew that something had gone wrong with the pregnancy. I felt a little freaked out too [pause].

Therapist You felt freaked out?

Bob: Well yes. I was really worried and I knew that she needed to get to hospital. So I tried to keep things calm, to give her space. I tried to take care of things. I called her sister and started getting ready to go. I was being as helpful as I could. I felt I was right there for her the whole time.

Therapist: So you were taking care of all the outside things to help out.

Bob: I was doing everything I possibly could to make things easier for her. It was sad.

Therapist: You were sad to know she had lost the baby?

Bob: Yes, of course. I think Lisa knew that . . . that is what I felt.

Lisa: No, I didn't know that. I had no idea. [She raises her voice and sounds angry.] All I saw was that you were Mr. Cool. Even after we came back from the hospital, you wouldn't talk about it. You kept walking out of the room and leaving me to cry alone. This was supposed to make me feel cared for? You won't talk about anything that makes you feel uncomfortable, and that's the bottom line.

This attachment injury occurred during a traumatic loss in the couple's relationship. Lisa's attachment needs were fully primed, but Bob seemed emotionally inaccessible and unresponsive to her need for comfort. When she saw her husband frozen and helpless, she experienced a flood of attachment-related fears. When he left her to make the necessary arrangements, she felt a deep sense of abandonment. Despite the physical presence of her husband and sister she felt alone, vulnerable, and resigned to grieving the distressing loss on her own. Furthermore, Lisa reported feeling that this event marked a major shift in their relationship.

Although the couple reported some distress before the miscarriage, this attachment injury markedly damaged the relationship bond, and at the same time, it blocked the couple's ability to take steps to restore trust and emotional engagement. It was clear in the therapy sessions that Lisa could not let go of the event, nor was she willing to risk being in a vulnerable position with Bob again. The couple became stuck in a negative blame–withdraw cycle. When Bob did try to reach out to his wife, she would bring up this event and he would then again withdraw.

This incident was not difficult for the therapist to understand. However, the presentation of such injuries is not always so clear and straightforward. For example, a couple presented with an extreme attack/defend cycle in which the wife would sarcastically berate the husband for many "crimes," but particularly for his recent friendship with a female cousin who was in trouble. She did not suspect an affair and seemed to be irrationally moralistic and accusatory. The therapist began to have difficulty empathizing with this client's position. The wife focused with obsessive concentration on an incident in which her husband offered to go out in a snowstorm and start his cousin's car for her after a party at the couple's house. The picture only became clear when the therapist remembered a brief allusion the wife had made to returning home after a minor operation where, for a moment, she had faced death. She reported that she had began to share her fears with her spouse, but he told her that he was exhausted and just had to go to bed. She had never brought up this topic again. The therapist then suggested that the wife could not bear to see her husband give to another the caring and protective soothing that she herself had longed for but for which she could not directly ask. The wife responded with an intense, vivid reentry into the experience of the operation and her isolation on returning home. This was a turning point in the therapy with this couple, and the therapist then went on to help the wife to address her vulnerability and her contempt for her own attachment needs. The husband was then able to respond to his wife's hurt and fear. The couple was able to resolve the injury and complete bonding sequences of mutual comfort and caring.

The Resolution of Attachment Injuries

A preliminary investigation of the process of resolution of attachment injuries is in progress. However, according to the task analytic framework proposed by Greenberg (1986), the understanding of key change events begins with a rational outline of the conjectured process of change. This is then checked and refined by observing a small number of cases before a formal study can be initiated comparing the client processes that lead to a successful change event to the process in less successful events. The present outline of the resolution process for attachment injuries that emerge in the second stage of treatment in EFT and block the progress of therapy is given below. It is now in the process of refinement.

1. A marker denotes the beginning of the event. In this case, as the therapist encourages the injured spouse to begin to risk connecting with her/his now accessible partner, this spouse begins to describe an incident in which he/she felt abandoned and helpless, experiencing a violation of trust that damaged his/her belief in the relationship as a secure bond. This spouse speaks of this incident in a highly emotional manner. The incident is alive and present rather than a calm recollection. The partner either discounts, denies, or minimizes the incident and his partner's pain and moves to a defensive stance.
2. With the therapist's help, the injured spouse stays in touch with the injury and begins to articulate its impact and its 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. The partner, supported by the therapist, begins to hear and understand the significance of the injurious event and to understand it in attachment terms as a reflection of his/her importance to the injured spouse, rather than as a reflection of his/her 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.
4. The injured partner then tentatively moves toward a more integrated and complete articulation of the injury and expresses grief at the loss involved in it and fear concerning the specific loss of the attachment bond. This partner allows the other to witness his/her vulnerability.
5. 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. The injured spouse then risks asking for the comfort and caring from the partner that were unavailable at the time of the injurious event.
7. The other spouse responds in a caring manner that acts as an antidote to the traumatic experience of the attachment injury. The partners are then able to 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.
8. Once the attachment injury is resolved, the therapist can more effectively foster the growth of trust and the beginning of positive cycles of bonding and connection. The couple can then complete change events, such as a softening, in which the more blaming spouse can confide his/her attachment needs and the other can respond (Johnson, 1996). This process defines the relationship as a safe haven, fostering the resolution of other difficulties and entry into the final stage of therapy.

CONCLUSION

The purpose of this article was to outline the newly developed construct of attachment injury. Although the literature suggests that different kinds of betrayal (e.g., disloyalty, deception, infidelity) are detrimental to intimate relationships, these formulations have generally lacked a guiding theoretical paradigm. Grounded in a strong theoretical base, attachment injury is conceptualized as a wound that occurs when one

partner fails to respond to the other in a critical time of need, and this incident then becomes a clinically recurring theme and creates a barrier to relationship repair.

Attachment injury as a construct has important implications for both clinicians and researchers. This concept has clinical significance in that it may help to explain why some couples have difficulty responding to therapy. Such events also need to be addressed and resolved to prevent relapse after therapy. The delineation of such events also allows for the formulation of a systematic set of interventions for their resolution. For researchers, the delineation of specific problems and tasks in therapy facilitates inquiry into pivotal factors in the change process. Once the process of injury resolution has been mapped out, research can turn to delineating the factors that predict a partner's becoming "stuck" in such injuries and reaching resolution in therapy. We would predict that such factors will be both relational and personal to particular partners. Relational factors might be factors such as the rigidity of negative interactional cycles, the existence of some form of safe emotional engagement and commitment. Personal factors might be previous specific experiences of betrayal, for example sexual abuse in childhood tends to make issues of trust and dependency particularly problematic and the nature of working models of self and other in general. We may surmise that partners who endorse a fearful dismissing attachment style in the present relationship who are highly ambivalent about trusting others (Johnson & Whiffen, 1999) may be more difficult to help out of the impasse that is created by attachment injuries.

For the couples who come to therapy, addressing the task of resolving attachment injuries has the potential to restore the security of the emotional attachment that is "the primary protection against feelings of helplessness and meaningless" (McFarlane & van der Kolk, 1996, p. 24) and is a potent factor in creating resilience both in individual partners and in long-term relationships.

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