Children in Therapy

Using the Family as a Resource

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Editor

W.W. Norton & Company
New York • London

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First Edition

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Composition by Paradigm Graphics
Manufacturing by Haddon Crafstmen

Library of Congress Cataloging-in-Publication Data

Children in therapy: using the family as a resource / C. Everett Bailey, editor.
p. cm.
"A Norton professional book."
Includes bibliographical references and index.
ISBN 0-393-70289-8
1. Family psychotherapy. 2. Child psychotherapy. I. Bailey, C. Everett.

RC488.5 .C468 2000
616.89'156--dc21 00-038022

W. W. Norton & Company, Inc., 500 Fifth Avenue, New York, N.Y. 10110
www.wwnorton.com
W. W. Norton & Company Ltd., 10 Coptic Street, London WC1A 1PU

1 2 3 4 5 6 7 8 9 0

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Emotionally Focused Family Therapy: Restructuring Attachment

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As a field, family therapy has been accused of becoming impersonal and mechanistic. Perhaps when we focus on the family "game," individual players and the compelling emotions that link them to others become almost invisible. We then lose touch with the "exquisitely elemental" (Liddle, 1991). For the emotionally focused family therapist, the elemental, the core of close relationships, is the attachment bond between family members and the compelling emotions that define that bond (Johnson, 1996; Johnson, Maddeaux, & Blouin, 1998). The goal of emotionally focused family therapy (EFFT) is to foster the secure emotional connectedness that then allows for open communication and effective problem solving. A process study of change in family therapy found that this kind of connectedness facilitates successful problem solving (Friedlander, Heatherington, Johnson, & Skowron, 1994). Emotionally focused therapy is best known as a brief, empirically validated couples therapy (Johnson, Hunsley, Greenberg, & Schindler, 1999). It is also used as a family intervention (Johnson, 1996, 1998) and preliminary research has documented positive outcomes with families where adolescents are struggling with eating disorders (Johnson et al., 1998).

Emotionally focused couple (EFT) and family (EFFT) therapies combine experiential interventions that expand and reshape inner experience with structural systemic interventions that change interaction patterns. An EFFT therapist might focus on the recurring cycle of *parent criticize/child withdraw and*

act out that characterizes the relationship between a father and daughter. The therapist might heighten the defeat and hopelessness implicit in the young daughter's angry outbursts and help her formulate her lack of connection with her father and her need for his reassurance. The therapist would then support the father to respond in ways that redefine the security of the bond between him and his daughter.

The EFFT therapist assumes the following:

- Family members are caught in negative interactional cycles that maintain powerful emotional states of fear, anger, and grief. These emotional states and interaction patterns mesh to form family dramas that narrow communication and maintain attachment insecurity.
- Family conflicts that elicit symptomatic behavior are most usefully viewed as attachment dilemmas resulting in separation distress. Attachment needs for security, protection, and comfort are seen as healthy and adaptive (Bowlby, 1969). It is how such needs are expressed or denied in an atmosphere of perceived insecurity that becomes problematic. Attachment needs are naturally most intense at times of transition and crisis when the responsiveness of others is most needed.
- Accessing and reorganizing key emotional experiences is the most powerful route to shaping new responses to the ones we love. Emotion plays a key role in interactions with those we depend on, focusing us on our most salient needs and bringing the core schemas or models that we use to define ourselves and others to the fore. Emotion may be seen as what Bertalanffy (1968), the father of systems theory, would call a leading or organizing element in system (Johnson, 1998). Emotion is the music of the attachment dance. Reshaping key emotional responses helps clients reconstruct their inner worlds and how they communicate with and define relationships with those they love.

The Attachment Perspective: A New Model for Family Therapy

The field of family therapy has taken an ambivalent view of emotional connectedness. It has most often focused on boundaries and viewed connectedness as enmeshment and as constricting individual development and autonomy. Traditional concepts such as enmeshment are now being criticized for confus-

ing coercion with closeness and caregiving (Green & Werner, 1996). In general, as family therapists, we seem to have pathologized dependency and neglected nurturance as a crucial dimension of family life (Bowlby, 1988; Mackay,1996). Feminist writers also suggest that "despair over disconnection" (Gilligan, 1987, p. 66) is a core and neglected issue in unhappy families.

EFFT is one of several recently emerging treatment models that use an attachment perspective to understand and guide intervention in families (Byng-Hall,1995; Diamond & Siqueland, 1995; Kobak, Duemmler, Burland, & Youngstrom, 1998; Liddle, 1994) and that recognize the power of emotion to organize attachment responses. The attachment perspective views optimal development and autonomy as arising out of secure connectedness with others. Such connectedness offers us a secure base from which to explore and grow and a safe haven in times of trouble that fosters resilience (Walsh, 1996).

An attachment bond, as defined by John Bowlby (1969), is a set of behaviors that maximizes proximity with irreplaceable others and so creates a felt sense of security. These behaviors are shaped by emotional responses and by sets of schemas concerning the reliability of others and the acceptability of self. This perspective has been used to understand and to address psychopathology in adolescence and adulthood (Atkinson & Zucker, 1997; Bartholomew & Perlman, 1994). The quality of attachment between parents and children has been specifically related to depressive symptoms and anxiety and to aggressive behavior (Adam, 1994; Kobak, Sudler, & Gamble, 1991; Lyons-Ruth, 1996). Empirical evidence is beginning to suggest that, even in adolescence, the challenge is to realign and refine secure connectedness with parents, rather than to promote separation (Grotevant & Cooper, 1984).

The central tenets of attachment theory are as follows:

- Seeking and maintaining contact with others is a primary motivating principle in human beings. Dependency is an innate part of being human rather than a childhood trait that we outgrow.
- Such contact is an innate survival mechanism. The presence of an attachment figure provides comfort and security, while the perceived inaccessibility of such a figure creates distress. Positive attachments create a *secure base* from which individuals can operate and most adaptively respond to their environment. Positive attachments also create a *safe haven* and provide a buffer against stress and an optimal context for the continuing development of the personality. In this model, separation from attachment figures or a lack of confidence in their availability and responsiveness is considered a potential lifelong trauma.

- The building blocks of secure family bonds are emotional accessibility and responsiveness, whether the relationship is between child and parent or between two adult partners.
- When the security of the bond is threatened, powerful affect arises and attachment behaviors are activated. If these behaviors fail to provoke responsiveness from the attachment figure, a prototypical process of separation distress occurs. This process involves angry protest, clinging, depression and despair, and finally, detachment.
- The number of ways that human beings have to deal with the unresponsiveness of attachment figures is limited. There are only so many ways of dealing with negative answers to the central question: "Can I count and depend on you when I need you?" When attachment or connection with a valued and irreplaceable other is threatened but still hoped for, the attachment system may go into overdrive. Attachment behaviors become heightened and manifest as anxious clinging and constant pursuit of the attachment figure or as aggressive attempts to control the way the attachment figure behaves. The second strategy for dealing with loss of safe emotional engagement, particularly when hope of responsiveness from the attachment figure has been lost, appears as avoidant or seemingly disinterested behavior and as hostile anger, which Bowlby (1973) calls the "anger of despair."

An EFFT therapist might see a child's angry, coercive behavior as attachment protest—an attempt to get a parent to respond to the child's attachment needs. If children feel securely connected with their parents, they experience others as responsive and see themselves as worthy of care and love. They are then more resilient in times of transition and stress. The quality of attachment in the family will then make all the difference in how children deal with difficult times and crises (as the case presented in the following pages illustrates). Attachment theory offers the therapist a map of family relationships. It specifies how habitual forms of engagement with those we depend on defines our world and our sense of who we are.

Goals of EFFT

EFFT is concerned with modifying the distressing cycles of interaction that maintain attachment insecurity in family members while also fostering positive cycles of accessibility and responsiveness (Johnson 1996; Johnson et al.,

1998). The goal of EFFT is to foster alternative formulations of emotional experience that create new points of contact with significant others. For example, a therapist might help Todd, an angry 9-year-old, explore how left out he felt in his new stepfamily and how he had "lost" his mom to his new stepdad. As he shares this with his new dad, his dad is able to respond with concern and reassurance and perhaps share some of his own fears about being rejected by Todd. This kind of new interaction is in sharp contrast to the *stepparent lecture from a distance* followed by a *child simmer-and-explode* pattern that had evolved in this family. This new interaction has the potential to change:

- How Todd regulates his emotions in the family. He could talk to his new dad rather than acting out.
- How Todd processes information. Safety promotes curiosity, openness to new information, and tolerance of ambiguity. Todd may start to see his dad as a resource and a source of comfort, rather than a threat. Todd may also start to see himself as a kid that his new dad might want to comfort and protect. He can perhaps listen to his parents' concerns about his behavior without an overlay of resentment and fear.
- How Todd communicates with both his parents. He is able to disclose his fears and concerns in a way that pulls for his parents to comfort and reassure him.
- How Todd's parents see him and how responsive they are able to be to him when they see his vulnerability.

Nichols (1987) suggests that therapists need "dynamite" to change emotionally loaded family interactions. The EFFT therapist uses the dynamite of newly formulated emotions and interactions to create a new family drama. Insight and behavioral solutions are often not enough to change the plot. A new experience of emotional connection is needed to change perceptions or models of self and other and attachment behaviors.

In sum, the goal of EFFT is to increase accessibility and responsiveness in family relationships, and thus help the parents to create a secure base and safe haven for their children while feeling confidant and competent as parents.

The Process of Therapy

Session Structure

In this form of family therapy the family is usually seen as a group for the first

one or two sessions, even if the parents identify the child as the patient. In these sessions the therapist assesses interactional positions and patterns and identifies problematic relationships and family cycles that appear to be related to the identified patient's problems. After these initial sessions, family subsystems are invited to individual meetings. Typically, for example, the parents are invited to come in and talk about their relationship and their parenting role; the sibling subsystem is invited to a different session; and the identified patient and each parent, or both parents, also meet. This treatment involves a flexible combination of dyadic, triadic, and family group sessions. The essential treatment process of using the expression of newly processed emotions to create new interactions is the same whether the session involves a client dyad or triad. Dyad sessions, in particular, encourage a sense of safety and focus that allows for increased emotional engagement. Sessions are one to one and one-quarter hours in length and are usually conducted weekly. Treatment usually takes ten to twelve sessions and is implemented by a single therapist or two cotherapists. Treatment ends with a session where all family members attend to ensure that specific changes are integrated into the system as a whole. Regardless of the number of people in the session, the process of therapy still involves accessing new emotions to create new interactions between family members.

The EFFT therapist must be able to gain the family's trust and confidence so that members actively engage in the therapy process. As with emotionally focused couple therapy, this kind of intervention is deemed inappropriate for abusive or violent families, since the expression of vulnerability and openness is part of the treatment process. Not only is this openness difficult to achieve in violent relationships, but it may also put family members at physical risk. This kind of treatment is also inappropriate for family members who wish to live very separate lives and do not want to examine or improve family contact.

The Therapist's Tasks

An EFFT session should help children and parents to reconstruct and articulate their experiences in a way that changes the interaction between them. For example, an EFFT therapist might help a child share with her father how despairing she is when he gives her advice, hearing in his advice that she has already disappointed him and will never please him. The therapist will then direct her in an interactional task where she shares this hurt with her father in a way that allows him to hear her and move closer to her. The therapist will then reframe her defiance of her father in terms of this hurt and hopelessness. In this interaction the

Other techniques used in therapeutic impasses such as painting diagnostic pictures of the impasse or mirroring the impasses in narratives called disquisitions are outlined elsewhere (Johnson, 1996; Milliken & Johnson, in press)

Assessment

The task of creating a positive therapeutic alliance with each member of the family is the first priority in EFFT. To accomplish this, the therapist must make a deliberate and constant attempt to validate each person's experience without invalidating the experience of other family members. The therapist might say: "I understand that you feel your parents are being unfair, Sarah, and I hear from your perspective, Mom and Dad, that you feel that you are struggling to be responsible parents."

At the beginning of therapy the Rogerian origins of EFFT are particularly apparent. The EFFT therapist follows Rogers's (1951) prescription of genuineness, empathy, and acceptance or positive regard. A belief in the "brilliance of ordinary people" and their ability to grow is an essential part of the therapist's stance. This collaborative, respectful stance is also advocated by recent post-modern theorists such as Anderson (1997). It is essential that the therapist empathetically attune to all family members and connect with each on a personal level while maintaining a nonjudgmental stance and creating a safe context in which change can take place. Although particularly essential during the first part of therapy, the monitoring of the therapeutic relationship should also continue throughout the entire process.

The initial assessment phase of EFT is completed in the first and second sessions. The therapist observes the organization of family interactions, the various family alliances, the predictability and rigidity of interactional patterns, the strategies used to deal with conflict and frustration, and how family members support and comfort each other. Questions such as "If you have a worry or a problem, who do you confide in?" or "Who do you go to when you are feeling sad and you need a hug?" help to assess alliances and family ability to provide comfort and support. Family members are encouraged to talk about recent events or crises that typify the way they interact. The therapist also notices the emotional tone of the family (sad? depressed?), how family members respond to each other, and patterns of accessibility (do family members listen to each other or dismiss problems with jokes and laughter?). Additionally, the therapist asks how family members view these patterns. By the end of the assessment phase the therapist should be able to identify key cycles of negative interactions

and formulate with the family how these cycles might help to maintain the symptoms of the identified patient. To obtain a picture of an interactional cycle, the EFFT therapist might ask sequence questions, such as "What do you do when your husband shouts at your daughter? How do you respond to that? What happens next? If I were a fly on the wall in your kitchen what would I see happen then? How do you see it, Sarah? What do you do when this happens?" The therapist then draws a picture of the family drama and how cycles such as *criticize/distance* seem to control family interactions and to be self-perpetuating, as well as priming negative symptoms in the most vulnerable family members.

The Steps of Therapy

The process of change in EFFT has been outlined in three stages and nine steps. The first four steps are concerned with assessment and de-escalation of negative cycles, and are accomplished in the first two to four sessions. After the initial assessment, the next three steps are: to formulate and clarify problematic cycles (step 2), to help the family members identify the emotions underlying their positions in the cycle (step 3), and to frame a shared version of a problem that validates all and blames no one (step 4). The middle stage of therapy, where interactional patterns evolve and change, occurs in steps 5 to 7. This stage involves accessing and exploring disowned or unformulated attachment needs and emotions and creating new interactions that address these needs and emotions. At the end of this stage of therapy new kinds of interaction occur that redefine the bond between family members. For example, a distant, depressed parent might express regret and ask for understanding and a child might then offer acceptance and assert a need for caring in a manner that evokes a reassuring response from the parent. In the last stage of therapy, steps 8 and 9, the therapist helps the family to consolidate new interactions, integrate them into the family system, and develop new problem-solving processes. The steps are outlined below and demonstrated in the case study that follows.

Stage 1: De-escalation

Step 1: Delineate the conflict issues and attachment struggles in the family. The therapist focuses on each family member's experience in the family, in particular on how members interact and how their responses mediate the closeness or the separateness of the bond between them. The assessment process, described above, is also part of this step.

Step 2: Identify and clarify negative interactional cycles that maintain insecure attachment. The therapist might describe a cycle as follows: "So Dad, when you attempt to help Helen, you experience her as rejecting and rebellious. This worries you, and you find yourself getting angry. Then if he gets to the point of shouting, Mom, you feel compelled to come in and protect your daughter. Is that it? Then Dad usually withdraws for a few days, feeling like there is nothing he can do, and Helen, you go off with your friends, the ones you told me were 'dangerous' but not 'critical' like your Dad, yes? And Mom, you get depressed and end up telling Helen that she is killing you all (everyone nods). Everyone ends up feeling upset and alone. Is that it?"

Step 3: Access unacknowledged emotions underlying interactional positions in the family. As significant events (fights, misunderstandings) occur, whether in or between sessions, the therapist focuses on them and heightens the experience.

THERAPIST: So when Helen acts rebellious you feel worried? Kind of helpless?

DAD: Yes, I feel like I am screwing up somehow because my kid isn't doing her schoolwork. I don't know what to do next. I feel like I'm failing as a parent.

THERAPIST: And Helen, is that when you begin to feel like you can never please your dad, never get his praise, so you might as well be as bad as he thinks you are? What's that like for you to feel like you can never meet your dad's expectations?"

Step 4. Redefine the problem. Once the underlying feelings have been accessed, the problem is redefined in terms of the negative cycle that the family is caught in and the powerful emotions associated with that cycle. So, for example, the father who appears punitive and controlling is, with more emotional information, framed as worried and feeling helpless. This reframe is highly credible because it is based on information that is vividly experienced in the session as the father speaks to his daughter about his sense of failure as a parent.

Stage 2: Interactional Shifts

Step 5. Promote identification with disowned needs and aspects of self. In this step the clients are first helped to explore and identify fully with their positions in respect to other family members and any implicit attachment needs. They are encouraged to encounter, embrace, and accept the emotions underly-

ing their position in the family dance. For example, a usually defiant daughter might be able to formulate and talk to her mother about her sense of despair when she feels her mother withdraw from her. She might also talk about how her mother's support is a touchstone for her in a changing world where growing up is scary and overwhelming.

Step 6. Foster the acceptance of each person's experience and new interactional responses. Here the therapist helps the other family members to hear, understand, and accept the emotions and needs expressed in step 5. So the mother, in the scenario described above, will be encouraged to see her daughter's defiance as desperation and accept her need for closeness and support.

Step 7. Facilitate the expression of needs and wants to restructure interactions. The therapist helps withdrawn and distant family members to become more engaged and more available. More aggressive or critical family members are supported to talk about their attachment emotions and needs in a way that evokes responsiveness from others and creates a sense of trust and secure connection. In this stage of therapy a child may be able to confront her now more engaged mother and ask for her respect and caring in a way that pulls for a supportive emotional response from her.

Stage 3: Consolidation of Change

Step 8. Establish the emergence of new solutions to previously problematic situations. Problem solving and negotiation are much easier when they are no longer contaminated by powerful negative affect and emotional agendas concerning the definition of the relationship. Research in couple therapy suggests this change process, in particular the occurrence of a change event called a softening, where a previously critical or aggressive person is able to turn to an attachment figure and ask for their needs to be met from a position of vulnerability, makes success in therapy more likely (Johnson & Greenberg, 1988). This kind of safe emotional engagement between family members has also been shown to facilitate successful problem solving in family therapy (Friedlander et al., 1994).

Step 9. Consolidate new positions. The last step of EFFT is concerned with strengthening and integrating the changes that have taken place in therapy. Family members are asked to clearly differentiate between old and new patterns of interaction and to take a meta-perspective on their problems and how they found new solutions for them. The therapist validates their struggle and summarizes the journey of change for them.

Case Illustration: Reach for Us and We'll Be There

Captain Bert Fuller ushered his family into the office, sat heavily in an armchair, and introduced the therapist (ACL) to everyone. His tall wife, Michelle, sat on the couch, avoiding eye contact with everyone in the room. Penny, whose punk haircut glinted a magenta hue, had a direct, disarming smile. She had just had her twelfth birthday. She nestled beside her mother, lifting her mother's arm and placing it around her own shoulders. Adrian, tall, thin, with the blotchy skin of a 15-year-old, sat apart from the family, his shoulders hunched forward.

"I simply told them we were coming in and here we are," began Captain Fuller. "I mean to get this problem sorted out." In fact, it was thanks to Penny's efforts that the family was referred to me. She had disclosed her frightening symptoms to their family physician: periods of dissociation, self-mutilation, binge eating with purging, and suicidal thoughts. After three visits with a psychologist colleague she was described as markedly depressed, with a notable sense of nonacceptance by her family and a high sense of acceptance by her peers.

The parents started the session by talking about Penny's new friends, a large group of youngsters who "hung out" at shopping malls where they were intimidating to local shoppers. Penny had just been banned from the local mall for shoplifting and had recently been suspended from school. Penny's friends streamed into the Fuller's home after school most nights, where they smoked, left burns in the carpet, and took over the household. The Fullers were unsure how to deal with this intrusion, because on one hand they wanted their children to bring their friends into the home, but on the other hand they found Penny's friends to be too much and too many. Captain Fuller was worried about Penny because she had a bright future ahead but was "derailing herself." She had been on the honor roll at school, but this term her grades had dropped drastically.

Captain and Mrs. Fuller did not know how to stop Penny from getting into trouble with her friends. They had tried grounding her and stopping her allowance. When these efforts to set limits proved unsuccessful, they began shouting and threatening, which now occurred frequently in their home. They were thinking of canceling their summer vacation in Hawaii.

Captain and Mrs. Fuller then moved on to discuss the constant fighting between Penny, whom they labeled as their "brainy child," and Adrian "the computer whiz." Adrian admitted that he provoked everyone in the family, and

Penny owned that she reacted to his provocation in a negative way. The fights frequently escalated to violence, resulting in cuts and bruises.

My goal in this initial step of therapy was to form a therapeutic alliance, maintain a nonjudgmental stance, and gain a picture of their conflict issues, attachment struggles, and negative interactions at home. So I followed what they said to me, asking questions such as: "So what happens, Adrian, when you say that to Penny? What does she do then?"

I then moved into step 2, and described to the family the negative cycle that I saw occurring in the session and heard described in their family life. "I'm going to rely on you to correct me if I get this wrong, okay? Penny, it sounds to me like you are somehow acting out, and your mom and dad sound like they're very worried about you. So you, Bert and Michelle, try to talk to Penny and protect her by trying to set limits, for example, by grounding her and stopping her allowance. Is that right? And as your parents pursue you in this way, Penny, you seem to withdraw. You are polite to them, but you just go to your room. Is that what it's like?"

"It's like talking to a brick wall," said Captain Fuller. "I think she's listening but she isn't. She goes up to her room and ignores us."

Adrian's role was also described. It seemed that he withdrew from everybody and spent his time on the Internet or watching television. He seemed to want some contact with his family but appeared to reach out in a negative way, sparking off fights. The main elements in the formulation of the cycle were the father's criticism of his daughter, Penny's withdrawal or outbursts of anger, the parents' continued anxiety and attempts to change their daughter, and the son's withdrawal. As we talked about this cycle, Penny told us that when she went to her room, she felt very bad because she was disappointing her father.

I explored the negative cycle in further sessions, accessing the underlying feelings (step 3). In session 2, I had a single session with Penny in order to strengthen our alliance. In this session, I found out more about Penny's part of the cycle. To access her underlying feelings I asked, "So what happens for you, Penny, when your mom and dad are angry with you and you go to your room?" She told me she felt upset because she was a "bad person." I simply reflected back to her, "You feel like a bad person?" Penny then described feeling herself go numb, everything becoming pink and then black. She would find herself up on the ceiling watching herself screaming, throwing her possessions around her room, and cutting herself. She rolled up her sleeves and showed me her arms. There were numerous cuts in various stages of healing. She also used food to

soothe herself. She told me: "I often sneak down to the kitchen when they are in bed and eat everything I can find, and then I throw up in the bathroom."

I explored with Penny what triggered these self-destructive behaviors. She told me of her feelings of depression, and how she longed to go to her father for support, but felt he was disappointed with her because of her performance in school. She was glad that he thought she was smart but thought it unfair that if Adrian achieved 75% at school he was applauded by their parents, while she was only told to work harder if her marks were as low as 75%. For the last 18 months she had been feeling very angry with her father because of this. She had always been very close to her father but she now experienced him as critical and distant. She was never very close to her mother, but had always been able to tell her dad anything. Now I knew that underlying Penny's position in the cycle was despair that her father was disappointed in her and this was occurring at a time when she was in critical need of his support.

I saw Captain and Mrs. Fuller together in session 3. Here, I was again trying to strengthen our alliance, and also assessing the marital relationship to see if the couple supported each other. Mrs. Fuller presented as a cool and detached woman. She was very successful in her career as a lawyer, and she commented that people need to cope with their own problems rather than come for psychotherapy. In contrast, her husband was very engaged, telling me how worried he was about his daughter, who was "extremely intelligent with great potential." He had been worrying since long before Penny reached her eleventh birthday that she would "go off the tracks" and spoil her whole life. He disclosed that he had "wasted his own youth" by drinking to excess and failing in school. This helped me to better understand his worry for his daughter. He told me that his son did not have the same potential as Penny, and acknowledged that he put a great deal of pressure on Penny to "maximize her potential."

In session 4, I decided to have a second session alone with Penny because I was concerned about her symptoms of distress. Penny felt safe enough to describe the events that led to her first "blackout." She had nearly been raped one year ago. She had been cutting through a back street, after a party, to a friend's house where she was staying the night, when she was attacked and dragged into a yard by an older teenager. She was lucky to get away unharmed, but later at her friend's house, she felt "dirty" and "bad." That night, she found herself up on the bedroom ceiling looking down and watching herself screaming. Penny was very frightened by this episode but did not dare to tell her parents about it. She believed that her father would be angry that she had been out

late alone, and that her mother would say that she was at fault—she never confided in her mother.

It became clear that Penny had become depressed after the attack. She longed to tell her father, but believed he would be critical of her for putting herself at risk. Where she had previously experienced him as the person on whom she could depend if she needed help, she now found her connection with him was threatened. I suggested to Penny that her acting out behaviors might stem from feeling lonely, unprotected, and despairing, and she thought this might be so.

Penny went on to describe how over the last year she had begun to leave her former friends, who were "goody-good" and lean more toward a new group of friends who "had problems too." When she got into trouble at home as a consequence of her behavior with her new friends, she felt very bad, and frequently dissociated in her bedroom when she would wreck her possessions or cut her arms. She was so distressed by these episodes that she often felt that she might kill herself.

As Penny told the story of the attempted rape, she became flushed, breathless, and sweaty. She said her heart was thumping in her chest. I validated how hard it was to tell and how brave she was. I also began to reprocess the event she had described, to help her see that she was not a "bad girl," but a victim. At the end of the session Penny said it felt good to finally share this secret.

Because I was concerned about her symptoms, I asked Penny if she felt that I could support her so that she could tell her parents this story. In addition, this disclosure would enable the parents to understand the emotions underlying Penny's position in the negative cycle. She agreed to try. Consequently, in session 5, I met with Bert, Michelle, and Penny, having promised Penny that I would give her as much support as she needed. In the following excerpt from the session, I am working on steps 3, 4, 5, and 6.

Penny began by taking a deep breath, rolling up her sleeves and telling her parents that she was cutting her arms:

MICHELLE: (*In an angry tone*) I knew you were lying to me about that. I knew that already. All your friends do it. It's a stupid craze.

PENNY: Mom, it's not a craze. I do it when I have a blackout.

MICHELLE: (*In a controlled and quiet voice*) It's so stupid. It breaks my heart to see you do that to yourself. Why do you do it?

THERAPIST: (*Reflects emotional experience of the child*) Michelle, I think Penny is trying to tell you about how badly she has been feeling inside. She's been holding it all in and it's been hard for her. (*Sets up a therapeutic task*) Penny, can you help your Mom understand?

PENNY: (*Puts her head down and fiddles with her watchstrap*) Mom, something happened, and I wanted to tell you but I was scared you and Dad would be angry (*begins to cry*). Last year a boy grabbed me and tried to rape me. He didn't. I got away. But I was so scared. . . . I thought you'd be so mad at me.

MICHELLE: (*Looks down at her interlocked fingers, a faint blush creeps over her cheeks*) That happened to me once. I never told anyone about it. It's best to keep these things to yourself (*Glances at her daughter and then out the window*).

BERT: (*Leans forward and puts his elbows on his knees; he looks worried*) Penny, why didn't you tell me about this?

PENNY: (*Sobbing*) You're angry with me. You think I'm screwing up my life.

THERAPIST: (*Reflects child's underlying fear that restricts connection with her father*) You are telling your Dad you were too scared to come and tell him?

PENNY: (*Nods, still crying and looking into her lap*) I thought you'd be mad at me. I'm screwing up. I felt dirty.

THERAPIST: (*Reflects underlying attachment-related fears that keep Penny in a disengaged position with her father*) It's kind of like you were afraid he'd be disappointed in you?

PENNY: Yes, and he gets mad if I screw up. He used to be proud of me. But he's not now.

THERAPIST: You sometimes worry your Dad isn't proud of you any more, right?

PENNY: (*Lifts her head and looks at the therapist tearfully*) Yes, he thinks I'm a lost cause. He thinks I'm no good now.

THERAPIST: (*Reflects the shame that has infused Penny's sense of self and evokes her need to hide and withdraw from her father*) And this happening—the attack—that really made you feel bad—dirty somehow—like you were no good. This made it even harder to believe you were okay and your dad might be proud of you? (*Penny nods and cries*) Can you let your Dad know what that's like for you, Penny?

PENNY: (*Crying*) I feel alone . . . bad . . . dirty.

BERT: (*Visibly upset*) Penny, it hurts me to hear that you were scared to tell me. I want to protect you—that's my job. If I could get my hands on that little creep I'd . . .

THERAPIST: (*Underscores father's availability to hear his daughter's pain*) You're feeling very upset that your little girl was hurt.

BERT: Too damn right. (*Turns to Penny and puts his hand on her knee*) Penny, I love you. I want to protect you. I feel so sorry that you could not come and tell me (*Bert has tears in his eyes*).

THERAPIST: When you put pressure on Penny and tell her to work harder, you're trying to protect her—make sure she does well—make sure she doesn't make the mistakes that you made. It's sad for you to hear that your efforts to keep her on track have backfired, and she's been feeling lonely and bad, like she's a disappointment. So when this attack happened she couldn't come to you.

BERT: (*Leans over to Penny and puts his hand on her knee again*) I never meant for you to feel so pressured. I guess I've screwed up. I just feel so awful that you couldn't come to me with this.

PENNY: (*Looks up at her father and wipes her eyes with a tissue*)

BERT: (*Turns to therapist*) It's so critical when they get into their teens. It's so important that they don't get off track. She's going to spoil everything for her future.

THERAPIST: (*Again, accessing emotions underlying the negative cycle, as well as fostering the acceptance of each person's experience, step 6*) You worry for Penny. You want to protect her. Yet when you try to help Penny take care of her life, she somehow hears that you are disappointed in her and when she hears this she feels kind of desperate.

BERT: (*Turns back to his daughter and takes both of her hands in his*) Sweetie, I don't mean you to think you're screwing up. I want to help you not to make the mistakes that I made when I was growing up. You've been scaring me.

PENNY: So you're not mad at me about that, the attack?

BERT: I'm not mad at you, no. If I could get my hands on that jerk I'd kill him. (*Bert turns to therapist*) What can I do to help our relationship?

THERAPIST: You'd like to help Penny to feel safe and to know she can come to you if she is scared or hurt?

BERT: Yes, I would.

THERAPIST: (*Facilitates the expression of needs and wants to restructure interaction, step 7*) Can you ask her how you can make it safe for her?

BERT: (*Turns back to Penny*) How can I help our relationship?

PENNY: I need you to trust me that I'll do a good job. I'm really trying at school. I want you to be proud of me and see I'm trying.

THERAPIST: (*Sees that Michelle is looking out the window and not joining her husband and her daughter as they speak*) Michelle, what's happening for you right now?

MICHELLE: (*Turns to the therapist, biting her lower lip*) I'm angry.

PENNY: (*Puts her head down again*) Mom, it wasn't my fault.

MICHELLE: (*To Penny*) I'm not angry at you. I'm angry with that boy—if I could get my hands on him . . .

THERAPIST: You are angry that someone hurt your child? (*Michelle nods silently*) Can you tell Penny this?

MICHELLE: (*Looks down at her hands*) I guess I'm angry at myself. . . . I've been so caught up in my work—I guess I've left you to fend for yourself. (*Michelle begins to cry*) It happened to me you know. I was attacked when I was fifteen.

In a flat voice, Michelle then described her family home. Her father used to drink heavily. They were a large family, with very little money. Her mother was always exhausted and her father hit her mother when he was very drunk. Michelle could never share with her mother any of her fears, concerns, or hurts. Her mother had enough on her plate. One day, Michelle was raped by a young man on her way home from a school concert. She never told anyone. During the telling of her story, Michelle turned away from us and looked out the window.

MICHELLE: (*Suddenly leans forward toward her daughter and touches the arm of her chair*) I don't want to be the kind of parent you can't tell things to. I guess I've always assumed that you were so close to your dad that you didn't really need me anymore. I'm so sorry. (*Penny leaves her chair and sits on the loveseat beside her mother. She snuggles up close to her mother, who puts an arm protectively around her shoulders.*)

THERAPIST: (*Moves to support Penny's asking for help with her fears. This new kind of interaction is a key part of change [step 7] in EFFT*) Penny, how could your mom and dad help you to come to them when you feel upset or scared or when you have a memory of the attack? Can you tell them how to help?

PENNY: (*Much brighter now*) It helps to say all this here. And when Mommy holds me, it's easier to talk then.

THERAPIST: Your Mom helps you by holding and comforting you. Maybe you need lots of hugs right now. Is that it? (*She beams and nods*) Could

	you come downstairs and tell Mom and Dad if you had one of those times when you space out and go up to the ceiling?
PENNY:	(*Nods*) I think so. I'll try.
BERT:	(*Reaches out to Penny*) We'll be there. Reach for us—we'll be there.

We followed up on this in session 6, again with Penny and her parents. Penny did have another blackout, and was able to tell her parents, who comforted her and talked with her about the attempted rape, assuring her that it was not her fault. In this session the Fullers also brought up the ongoing fights between Penny and Adrian. They asked me to see the children alone.

In session 7, Adrian and Penny were glad for the chance to discuss their fighting. Adrian told Penny about how excruciating it was for him that she and her friends got into such trouble at school and in the shopping malls. He was embarrassed and humiliated about the way she behaved on the school bus. "People will think that we are a bad family. I feel so ashamed. I get really mad at you. That's why I bug you a lot." Penny told Adrian that she understood. I then asked Adrian what it was like for him at home when Penny's friends came to the house. He described himself being taunted by Penny's friends and shutting himself in his room. He did not feel safe in his own home and was very angry.

Adrian also told Penny about his fear that Michelle liked her better than she liked him. Penny responded: "That's funny—she and Dad always clap when you get 75% at school but rag me out if I get 75%—who's the one they like best then?" They laughed together. We talked about how they had been good friends when they were younger. To facilitate the emergence of new solutions (step 8), I asked them what would need to happen for them to regain this friendship. I helped Adrian to tell Penny how he needed his home to be a safe place for himself (step 7). Penny understood this, and agreed to have only two friends visit at a time. She also volunteered to talk to her friends and tell them she expected them to respect her brother.

Three weeks after this session I met with the entire family again. They reported that the family atmosphere was much improved. Penny had kept her word about her friends and she and Adrian had stopped fighting. Penny had experienced only one more blackout, after which she went to her mother, who hugged and soothed her. She proudly showed her arms, which had begun to heal. She also told me that she had stopped binge eating and no longer vomited. Together we examined the changes that the family had made. Penny told

us that she felt her parents now understood her and was glad they were more responsive to her. Thus, she was less withdrawn. Bert and Michelle told us that they were less worried because they understood what had happened to their daughter. Bert was trying hard not to pressure Penny over her schoolwork. Adrian told Penny that he noticed that she had kept her word about inviting fewer of her friends in the house in the evenings, and the siblings agreed that they were glad they did not fight so often. This is how we worked on consolidating new family interactions (step 9). I validated the changes the family had made, and also described how, because they are human, inevitably they would not be perfect from then on. Fights and difficulties would occur again, and it would be important for them to be able to talk to each other about their needs and their feelings (preparation for termination).

We had a ninth session as a follow-up three months later. Captain Fuller told his family that the person who had changed most was himself: He was working very hard not to put pressure on his children, and he was proud of them. Penny's periods of dissociation had stopped altogether, her arms were now healed, and she had stopped bingeing and purging. Moreover, she was spending less time with "the gang" and had begun to spend time with her former friends. Her fights with Adrian were now infrequent, and she and her mother were now closer and better able to confide in each other. We spent more time in this session consolidating the new positions in the family interaction (step 9). In particular, we explored the difference in the pursue-withdraw cycle between Penny and her parents.

In this case study, a family had become disengaged just at a time when a traumatic incident occurred, making Penny, the identified patient, particularly sensitive and increasing her need for a safe connection. Penny felt distanced from her father and her mother, and had withdrawn. As she became more and more isolated, the ways she found of soothing herself became more and more dangerous, and her image of herself became more and more negative. The intervention helped the family to step aside from the negative cycle (punishment, threats, withdrawal, escalation) that was priming and exacerbating Penny's symptoms, and learn new cycles of confiding, open communication, and secure attachment.

Transitions, such as reaching adolescence, evoke attachment issues, and the experience of trauma intensifies the need for secure attachment (Herman, 1992; Johnson & Williams-Keeler, 1998). This family illustrates the point made by trauma theorists (van der Kolk, McFarlane, & Weisaeth, 1996) that the outcome of trauma is best predicted from the survivor's ability to seek comfort

from significant others, and, in this case, by the family's ability to respond and provide a safe haven for their child.

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