for contact and comfort. Emotions tell us what we need.

- An engagement of the partner in a different way. Fear organizes a less angry more affiliative stance. The partner in the example above puts words to her emotional needs and changes her part of the dance. New emotions prime new responses/actions.
- A new view of the softening partner is offered to his/her mate. The husband in the example above sees his wife in a different light, as afraid rather than dangerous, and is pulled toward her by her expressions of vulnerability.
- A new compelling cycle is initiated. In the example above, she reaches and he comforts. This new connection offers an antidote to negative interactions and redefines the relationship as a secure bond.
- A bonding event occurs in the session. This bond then allows for open communication, flexible problem solving, and resilient coping with everyday issues. The partners resolve issues and problems, and consolidate their ability to manage their life and their relationship (Stage Three of EFT).
- There are shifts in both partners' sense of self. Both can comfort and be comforted. Both are defined as lovable and entitled to care in their interaction, and as able to redefine and repair their relationship.

For a therapist to be able to guide a couple in the direction of such an event and help the partners shape it, this therapist has to be willing to engage emotionally. He/she has to learn to have confidence in the process (the inherent pull of attachment needs and behaviors), and in clients' abilities to reconfigure their emotional realities when they have a secure base in therapy. Even so, not every couple will be able to complete a softening. Some will improve their relationship, reduce the spin of the negative cycle, attain a little more emotional engagement, and decide to stop there. The model suggests that although such improvement is valid and significant, such couples will be more vulnerable to relapse.

TERMINATION

In Stage Three of treatment, the therapist is less directive, and the partners 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 For example, we frame a more passive and withdrawn husband as now powerful and able to help his wife deal with her attachment fears, while the wife is framed as needing his support. We support constructive patterns of interaction and help the couple put together a narrative capturing the change that has occurred in therapy and the nature of the new relationship. We stress the ways the couple has found to exit from the problem cycle and create closeness and safety. Any relapses are also discussed and normalized. If these negative interactions occur, they are shorter, are less alarming, and are processed differently, so they have less impact on the definition of the relationship. The partners' goals for their future together are also discussed, as are any fears about terminating the sessions. At this point, the partners 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 relationship problems per se.

TREATMENT APPLICABILITY

EFT has been used with many different kinds of couples facing many different kinds of issues. It was developed in collaboration with clients in agencies, university clinics, private practice, and a hospital clinic in a major city where partners were struggling with many problems in addition to relationship distress. Many of these hospital clinic couples' relationships were in extreme distress. Some of these partners were in individual therapy as well as couple therapy and some were also on medication to reduce the symptoms of PTSD or other anxiety disorders, bipolar disorder, or chronic physical illness. The EFT therapist will typically link symptoms such as depression to the couple's interactional cycle and attachment security. The therapist focuses on how the emotional realities and negative interactions of the partners create, maintain, or exacerbate such symptoms, and how symptoms in turn create, maintain, or exacerbate these realities and interactions. In general, it seems that placing "individual" problems in their relational context enables a couple to find new perspectives on and ways of dealing with such problems. As one client, Doug, remarked, "I am less edgy now we are more together—but also, if I feel that edgi-

ness coming, well, I can go and ask her to touch me, and it makes it more manageable. So I have reduced my meds a bit, and that makes me feel better."

As mentioned previously, EFT is used in clinical practice with couples of diverse ages, classes, backgrounds, and sexual orientations. The traditionality of a couple does not appear to have a negative impact on interventions (Johnson & Talitman, 1997). It seems to us that it is not the beliefs partners hold, but how rigidly such beliefs are adhered to, that can become problematic in therapy. Some beliefs, particularly regarding the pathologizing of dependency needs, are challenged in the course of EFT. Women, for example, may be labeled as "sick," "immature," "crazy," or generally "inappropriate" when they express their attachment needs in vivid ways that their partners do not understand. The ambivalence about closeness that women who have been violated in past relationships express can also be pathologized by frustrated partners. In terms of sensitivity to gender issues, EFT appears to meet the criteria for a gender-sensitive intervention defined by Knudson-Martin and Mahoney (1999): The model focuses on connection and mutuality, and validates both men's and woman's need for a sense of secure connectedness that also promotes autonomy. The ability to share power and to trust, rather than to coercively control the other, is inherent in the creation of a secure adult bond.

EFT is used with gay and lesbian relationships, and although there are special issues to be taken into account, these relationships seem to us to follow the same patterns and reflect the same attachment realities as heterosexual relationships. Special topics (e.g., partners' having differing attitudes to coming out and the realities of HIV) arise and have to be dealt with in sessions, but the process of EFT is essentially the same with these couples. We have not found lesbian partners to be particularly "fused" or gay male partners to be "disengaged," and there is now research suggesting that these stereotypes are inaccurate (Green, Bettinger, & Zacks, 1996). An EFT therapist would tend to see the extreme emotional reactivity that might be labeled as evidence of "fusion" as reflecting attachment insecurity and the negative relationship dance maintaining that insecurity.

What does the research on EFT tell us about how interventions affect couples with different presenting problems? Low sexual desire been found to be difficult to influence significantly in a brief number of sessions (MacPhee, Johnson, & van der Veer, 1995); indeed, this presenting problem seems to be generally difficult to affect in psychotherapy. However, there is empirical evidence that for other problems that typically go hand in hand with distressed relationships, effects are positive. Depression, the "common cold" of mental health, seems to be significantly influenced by EFT (Dessaulles, 1991; Gordon-Walker, 1994; see later discussion). Marital discord is the most common life stressor that precedes the onset of depression and a 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, chronic illness in children (Gordon-Walker, Johnson, Manion, & Clothier, 1997).

Traumatized Partners

EFT has also been used extensively for couples where one partner is suffering from PTSD resulting from physical illness and/or abuse, violent crime, or childhood sexual abuse (Johnson & Williams-Keeler, 1998; Johnson, 2002). EFT appears to be particularly appropriate for traumatized partners, perhaps because it focuses on emotional responses and attachment. PTSD is essentially about the regulation of affective states, and "emotional attachment is the primary protection against feelings of helplessness and meaninglessness" (McFarlane & van der Kolk, 1996, p. 24). As Becker (1973) suggests, "a deep sense of belonging" results in "the taming of terror," and such taming is a primary goal of any therapy for PTSD.

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 EFT therapist can foster the development of a more secure bond between the partners, this not only improves the couple relationship but also helps partners to deal with the trauma and mitigate its long-term effects. For instance, a husband might say to his wife, "I want you to be able to feel safe in my arms and to come to that safe place when the ghosts come for you. I can help you fight them off." When his wife is able to reach for him, she simultaneously builds her sense of efficacy ("I can learn to trust again"), her bond with her husband ("Here I can ask for comfort") and her ability to deal with trauma ("I can lean on you. You are my ally when the ghosts come for me").

Trauma survivors have typically received some individual therapy before requesting couple therapy

and may be referred by their individual therapists, who recognize the need to address relationship issues. Indeed, for someone who has experienced a "violation of human connection" (Herman, 1992), such as sexual or physical abuse in his/her family of origin, the specific impact of such trauma manifests itself in relationship issues; it is in this context that the effects of trauma must be addressed and corrected. When EFT is used with traumatized partners, an educational component on trauma and the effects of trauma on attachment is added to the usual Stage One interventions. This is often crucial, especially for a survivor's partner, who often has no real understanding of what the survivor is dealing with and therefore cannot be expected to respond empathically.

In general with these couples, cycles of defense, distance, and distrust are more extreme, and emotional storms and crises must be expected. The therapist has to pace the therapy carefully, containing emotions a survivor is unable to tolerate. Risks must be sliced thin, and support from the therapist must be consistent and reliable. The endpoint of therapy may be different from that in therapy with nontraumatized partners; for example, some kinds of sexual contact may never become acceptable for a survivor of sexual abuse. For a survivor of either sexual or physical abuse, the other spouse is at once the "source of and solution to terror" (Main & Hesse, 1990, p. 163). Such partners then often swing between extreme needs for closeness and extreme fear of letting anyone close. This ambivalence has to be expected and normalized in therapy. The therapist also has to expect to be tested, and in general has to monitor the alliance on a constant basis, since it is always fragile. The solutions survivors find to the recurring terror that stalks them are often extremely problematic. Such solutions may include substance abuse, dissociation, and violence against self and others. The first stage of therapy may then also include formulating "safety rules" around key stressful moments when trauma cues arise in the relationship (e.g., sexual contact), as well as developing general strategies for dealing with fear and shame. Shame is particularly problematic with survivors; confiding in or showing themselves to valued others is often very difficult for them. A negative model of self as unworthy, unlovable, deserving of abuse, and even toxic is likely to come up, especially in key moments of change (see transcript in Johnson & Williams-Keeler, 1998). The first antidote to such shame may be the validation of a therapist; however, the most potent antidote is the support and responsiveness of one's primary attachment figure, one's partner. The EFT treatment of survivors and their partners is dealt with extensively elsewhere (Johnson, 2002).

The treatment of disorders such as PTSD or even clinical depression can seem intimidating to a couple therapist who is already dealing with the multilayered complex drama of a distressed relationship. Factors that help the EFT therapist here are, first, the way the client is conceptualized and the alliance is viewed; and, second, the map of close relationships offered by attachment theory. Humanistic theory views clients as active learners who have an intrinsic capacity for growth and self-actualization. The therapist then learns to trust that when clients can be engaged with, in contact with, and fully present to their experience–including the neglected emotions, felt meanings, and tacit knowing inherent in that experience–they can be creative, resourceful, and resilient. The clients' evolving experience becomes a touchstone for the therapist, to which he/she can return when confused or unsure as to the best road to take at a particular moment in therapy. The therapist can also use his/her own feelings as a guide to decode clients' responses and dilemmas.

Depressed Partners

The map offered by attachment theory also facilitates couple therapy with partners dealing with multiple problems as well as relationship distress. Let us take depression as an example. As noted earlier, couple therapy is emerging as a potent intervention for depressed partners who are maritally distressed (Anderson et al., 1999). Couple and family therapy is emerging as the logical treatment of choice in all recent interpersonal approaches to depression (Teichman & Teichman, 1990). Research supports this focus: A partner's support and compassion predict more rapid recovery from depression (McLeod, Kessler, & Landis, 1992), whereas a partner's criticism is related to more frequent relapse (Coiro & Gottesman, 1996).

Attachment theory views depression as an integral part of separation distress that arises after protest and clinging/seeking behaviors have not elicited responsiveness from an attachment figure. Research has found that the more insecure partners see themselves to be and the less close they feel to their mates, the more relationship distress

seems to elicit depressive symptoms (Davila & Bradbury, 1999; Beach, Nelson, & O'Leary, 1988). Depressed individuals describe themselves as anxious and fearful in their attachment relationships (Hammen et al., 1995). Attachment theory also suggests that a person's model of self is constantly constructed in interactions with others, so problematic relationships result in a sense of self as unlovable and unworthy. The depression literature has identified the key aspects of depression as follows: (1) unresolved loss and lack of connection with others; and (2) anger directed toward the self in self-criticism, together with a sense of failure and unworthiness, as well as a sense of hopelessness (a sense of the self as having been defeated and disempowered). These aspects of depression—self-criticism and anxious dependency—are often highly intertwined. Many of those who cannot find a way to connect safely with a partner, for example, and are engulfed with loss, also despise themselves for needing others and contemptuously label themselves as weak. In experiential models of treatment for depression, clients are supported to find their voices and use their emotions as a guide to what their goals are, whether it is more secure connectedness with others or a more accepting engagement with themselves (Greenberg, Watson, & Goldman, 1998).

So when an EFT therapist sees a depressed partner who is nagging, seeking reassurance, and trying to control the other's behavior—all behaviors that have been found to characterize depressed partners' interactions with their mates—the therapist will view this as attachment protest. This perspective also predicts that depressive symptoms will arise at times of crisis and transition, such as after the birth of a child, when attachment needs become particularly poignant and partners are not able to support each other to create a safe haven and a secure base (Whiffen & Johnson, 1998). An EFT therapist assumes that even if a partner comes to a relationship with a particular vulnerability to depression or insecurity, new kinds of emotional engagement with his/her emotional experience and with the mate can break old patterns and create new realities and relationships.

How may the process of change in EFT specifically affect a partner's depression? In the first stage of therapy, depressive responses are placed in the context of interactional cycles and unmet attachment needs. The partners then become allies against the negative cycle and the effects of this cycle, including the dark cloud of depression. Legitimizing depressive responses as natural and arising from a sense of deprivation or invalidation in an attachment relationship tends to balance the depressed partner's tendency to feel shameful about the struggle with depression. In the second stage of therapy, the experience of depression evolves into explicit components such as grief and longing, which evokes reaching for the mate, or anger, which evokes an assertion of needs or shame that can be explored and restructured in the session. The process of therapy directly addresses the sense of helplessness that many partners feel by offering them an experience of mastery over their own emotional states and their relationship dance. New positive interactions then offer the depressed partner an antidote to isolation and feedback from an attachment figure as to the lovable and worthy nature of the self.

For instance, when Mary stepped out of her career and had a baby, she was "dismayed" a year later to find her new life "disappointing" and "lonely." Her physician diagnosed her as clinically depressed and referred her for couple therapy. She accused her partner, David, of only caring about his work, while he would state that he did not understand what she wanted from him and he was working for their future. David withdrew more and more, and began sleeping downstairs so as not to wake the baby. Mary became more critical of him and more overwhelmed and depressed. She also felt like a "bad mother" and decided that "David doesn't really care about me. I was a fool to marry him." As therapy evolved, Mary began to formulate her sense of abandonment, and David began to acknowledge his sense of failure and need to "hide" from his wife. After 10 sessions of EFT, this couple no longer scored as distressed on the Dyadic Adjustment Scale. More specifically, Mary's score rose from 80 at the beginning to 102 at the end of therapy. Mary's physician independently reported that she was no longer depressed, and the couple displayed new cycles of emotional engagement and responsiveness. These partners experienced themselves as coping with stress more effectively, and a 1-year follow-up these results remained stable. Since a partner's criticism and lack of supportiveness predict relapse into depression, and secure attachment is a protective factor against stress and depression, we assume that cycles of positive bonding interactions would help prevent a recurrence of Mary's depressive symptoms. If we were to take snapshots of key moments in David's reengagement in the relationship and of Mary's move to a softer position, what would these snapshots look like?

David

"I don't want to run away from you. I just saw your anger, not that you needed me."

"I want to support you and be close, but I need some help here. I need some recognition when I try, like when I look after the baby."

"If you are fierce all the time, it makes it hard for me to hold and support you. I feel like I'm a disappointment. So I hide out and work harder at my job."

"I want to feel like I can take care of you and the baby. I want you to trust me a little and help me learn how to do it."

Mary

"I'm afraid that I will start to count on you, and off you will go again. I was let down in my first marriage, and now in this one too. I'm afraid to hope."

"Maybe I am fierce sometimes. I don't even know that you are hearing me. It's hard for me to admit that I need your support."

"I need to know that I am important to you, and that we can learn to be partners and parents together."

"I want to know that I can lean on you, and that you will put me and the baby first sometimes. I need you to hold me when I get overwhelmed and scared."

Violence in Relationships

Although violence is a contraindication for EFT and for couple therapy in general, couple therapy may be considered if violence and/or emotional abuse is relatively infrequent and mild; if the abused partner is not intimidated and desires couple therapy; and if the perpetrator takes responsibility for the abuse. The therapist will then talk to the couple about a set of safety procedures for them to enact if stress becomes too high in the relationship and increases the risk of abusive responses. The position taken by such authors as Goldner (1999)—namely, that perpetrators must be morally challenged but not reduced to this singular shameful aspect of their behavior, their abusiveness—fits well with the stance taken in EFT. So, for example, a man who has become obsessed with his wife's weight, and frequently becomes contemptuous and controlling, is challenged when he minimizes his wife's outrage and hurt at his behavior. However, he is also listened to and supported when he is able to talk about the desperation and attachment panic that precede his jibes and hostile criticisms. The therapist supports his wife to express her pain and her need to withdraw from him, and facilitates her asserting her limits and insisting on respect from her husband. The husband is encouraged to touch and confide his sense of helplessness, rather than regulating this emotional state by becoming controlling with his wife.

The couple is supported to identify particular cues and events that prime this husband's insecurities and lead him into the initiation of abuse, as well as key responses that prime the beginnings of trust and positive engagement. Rather than being taught to contain his rage per se, such a client is helped to interact from the level of longing and vulnerability. When he can express his sense of helplessness and lack of control in the relationship, he becomes less volatile and safer for his wife to engage with. It is interesting to note that we do not teach assertiveness in EFT, and yet clients like the wife in this couple become more assertive. How do we understand this? First, her emotional reality is accepted, validated, and made vivid and tangible. The therapist helps her tell her husband that she is burned out with "fighting for her life" and that he is becoming "the enemy." Once this wife can organize and articulate her hurt and anger, the action impulse inherent in these emotions, which is to protest and insist on her right to protect herself, naturally arises. She is able to tell him that she will not meet his expectations about her physical appearance, and he is able to piece together how he uses her concern about her appearance as a sign that she cares about his approval and still loves him. This couple illustrates the work of Dutton (1995), which suggests that the abusive behaviors of many abusive partners are directly related to their inability to create a sense of secure attachment and their associated sense of helplessness in their significant relationships.

Having discussed the use of EFT with different kinds of couples and problems, let us now look a little more closely at a typical distressed couple going through the therapy process.

CASE ILLUSTRATION

Brad and Ann told one of us (SMJ) that their 30-year-old relationship was now stuck in "constant bickering." This husband and wife were in their late 50s, and their five children had now all left home. Brad had recently retired from a senior

administrative position, but Ann continued to work as a financial analyst. Brad had experienced bouts of depression all through his life, but these were now "well contained" by medication. Both identified considerable anger at each other and a sense of uncertainty as to how important they now were in each other's lives. Ann had begun to take regular trips away from home to visit her adult children and spent long hours working, especially since she had just received a significant promotion. In the first session, Brad tended to speak quietly and to make efforts to be "reasonable," whereas Ann was very quick, very assertive, and at times very sharp with him. They stated that they had begun recently to have strident arguments about their very different perspectives on the history of the relationship. Ann commented that she now understood that this relationship had been "a lie," and that Brad had felt trapped into marriage because she had gotten pregnant. Brad agreed that he had felt trapped at first and had been "resistant" to the level of involvement that Ann wanted, but that he had grown to love his wife very much. He stated that he now felt very desolate about their recent fights, where they would "demean and wound each other" and then not speak to each other for days. He added that he would like to have married someone who was "gentler and more open." Ann responded by becoming very indignant and summing up the history of the relationship as a story of her moving from being "docile" and pursuing Brad for closeness for many years, to finally learning to assert herself and find happiness in her own career.

This couple was typical of many middle-class marriages in which the man's career is winding down just as the woman's career is taking off. Ann stated that she had supported Brad in his long fight with depression (and he agreed with this), but that she had gotten to the point of feeling drained and resentful. Brad experienced that she had withdrawn from him in recent years. She replied that he had not been available to her for most of their marriage, especially when the children were young and she needed his support. This couple were both fervent Catholics, but also fought over points of their religious faith. When Ann also pointed out that Brad had not supported her after a recent minor operation, he replied that this was because she was just too difficult and too angry to take care of. Ann ended the first session by pushing out her chin and stating in a determined voice, "This has to change, or we have to split."

This couple's interactional cycle appeared in the session to be critical attack on Ann's part, followed by defense and withdrawal on Brad's part. Both would then withdraw for several days until the cycle began again. Ann was also spending less and less time at home, as she and Brad became ever more alienated from each other. They still had occasional moments where they could discuss ideas or enjoy an activity, but they were increasingly spending time apart and had not made love for over a year. Ann agreed with Brad that she was indeed "judgmental" and added that she had very high standards for herself and others. She also noted that he took no responsibility for his passivity and past withdrawal into depression. With some support from the therapist, Brad was able to express his sense of "panic" when he tried to show Ann affection but was "rebuffed again and again." Ann replied that he had always pursued her "just for sex" and that she was not interested. When asked whether she had ever felt supported and taken care of by Brad, she said that he was "too immature" to do that, and anyway, she took care of herself. At such times, Brad would become silent; when the therapist probed, he admitted that he felt upset by Ann's "constant disapproval" and his sense of failure and powerlessness around her.

In his individual session, Brad elaborated on how he felt unsure of his importance to his wife, and how she had turned to her friends in the last few years rather than to him. He felt "dominated" by her but afraid to assert himself, fearing that she would then leave him. He admitted to being surprised when she expressed distress in the first sessions, but he had remained cautious, since he generally did not see her as vulnerable but as "dangerous." In her individual session, Ann admitted that she was "on guard" in the relationship and had "taken over" in the face of Brad's depression. She felt that she had fought in the beginning of the relationship to show she wasn't a "dumb housewife married to the intellectual," and that she saw Brad as "weak" and an "emotional cripple." More sadly, she added, "He can't take care of me." She agreed that she was very angry with him and did not always understand how enraged she felt. She knew she could be "rigid," especially around "broken rules." As the therapist reflected the cycle and noted how it left both of them defeated and alone, and also probed for the emotions underlying the steps in the dance, Brad was able to agree that he did not respond to his wife; instead, he went "still like a stone" because he was so afraid of her judgments. She then became angrier and more contemptuous.

This husband and wife were a highly educated couple from a strict, religious, conservative back-

ground. The building of an alliance was not an easy process. They questioned the process, the model, and the way therapy was done; the therapist had to struggle to stay as transparent, genuine, and nondefensive as possible. Respectful curiosity and requests for help in connecting with each partner's experience did gradually create an alliance. They began to see events that had happened in the relationship from each other's point of view, and to admit that both of them were afraid of losing their marriage. They began to spend more time together and to frame the cycle as holding them both hostage. Brad became noticeably more open and began to express his hurts and fears. After six sessions, deescalation seemed to have been achieved.

The process then seemed to move naturally into Brad's becoming more involved and beginning to talk about feeling "discarded" as Ann moved more and more into her career. Brad's friendship with a female cousin who was in a personal crisis and calling on his support also became an issue. Ann did not believe that this relationship was a potential affair, but became enraged when Brad went to spend an hour with this cousin. The most notable rift in the alliance occurred when the therapist tried to modulate Ann's rage by commenting that it was as if Ann wanted Brad to go to confession and admit his "sin" in this matter. She agreed that this would be appropriate, but added that she resented the therapist's light tone. The therapist admitted to being confused about the nature of Brad's offense, and Ann was unable to explain her sense of outrage. Step by step, with the therapist evoking and heightening underlying emotions, Brad moved into a more present and assertive stance. Brad moved toward increased engagement in this series of statements:

"It's hard to be warm to you when you don't give me any respect."

"I can't win here—you are so angry, like you want to tear me apart. It does intimidate me. I'm hurt too. I am not going to plead and plead and spend my life being judged."

"You are right; I wasn't there for you when the kids were small—I got lost in my depression."

"I have been a wimp, but when you get prickly, well, I just freeze—I know I'm a target. I know I will lose. I don't want to be controlled, so I do shut you out."

"I feel like a sinner and you are like Jehovah. If I tell you I'm hurting, you will see me as just weak. So I button up and go off to where it's safe. But I am getting angry now."

"You override me—I have to take a stand. I feel like dirt when you scream at me. I'm tired of being intimidated. I can never pass the test."

"I want to be able to express myself, not withdraw all the time. I won't be constantly tested."

"Just sometimes, here, I see that you are hurt too, not just angry. I want to be there for you. I want to be with you. I want you to respect me."

At this point, just as Ann seemed to be becoming more curious about her partner and less openly hostile, a crisis occurred. Ann walked into the next session and announced the marriage was over. She stated that she now felt that Brad's friendship with his cousin was "morally wrong," and told him, "You are not going to hurt me ever again." A particular event had occurred where Brad had struggled out into a winter snowstorm after a family supper, to help his cousin, who had stumbled on the path, into the house. As Brad tried to reassure his wife that this was polite consideration on his part, she became more and more enraged. He stated that he loved Ann and that his cousin was not important to him. He apologized if he had hurt her by being solicitous of his cousin. Ann replied by saying she felt she was "going crazy" and accusing him of not "seeing my pain at all." The therapist tried to frame her sensitivity to her husband's kindness to his cousin as her hurt at not receiving his attention and support herself, but Ann rejected this and became even more angry, stating that she was "humiliated" and was moving out of her and Brad's bedroom. Just as Brad was reengaging and the opportunity for more mutuality and connection presented itself, Ann withdrew into rage. We were at an impasse.

In the following session, the therapist began to expand Ann's rage with reflection, evocative responding, and heightening. Ann began to speak of how she felt "hysterical" and "off balance," and had begun to avoid Brad altogether by sleeping in the basement. The therapist decided to "unpack"—that is, expand or deconstruct—the incident at the supper. As Ann described again the snowy evening incident, the therapist suddenly heard echoes of the emotions Ann had touched on very briefly in the first sessions, when she had described undergoing her recent operation. As the therapist focused on this, Ann revealed that there had been a moment during this procedure when she had suddenly felt helplessness, realizing that she could die if things went wrong. As the therapist probed for what had happened when she had returned home, Ann shouted in rage that Brad had greeted her with a

statement that he was glad she was home, since he could now go to bed. He had then taken his sleeping pill and gone to sleep. He had left the next day for a long trip. The therapist realized that this incident had been an attachment injury for Ann. The incident at the supper was significant in that she watched Brad give caring—caring that she suddenly became aware she had needed but could not ask for on the night of the operation—to someone else. As the therapist linked the emotions of "helplessness" and "lonely abandonment" to both incidents, Ann broke down into sobs and grief. These incidents had become particularly salient when the therapist had begun to frame Brad as accessible and encourage her to consider risking with him in therapy sessions.

Let us look at part of the process that followed.

ANN: I don't think I can do this. It's like I'm in shock. I feel broken—out of control. I am so anxious, I went and got some anxiety pills from my doctor.

SMJ: It's hard for you to touch this place where you feel vulnerable and need Brad—and remember how abandoned and alone you felt. Is that it ? (*She nods.*) You feel broken. [Reflection. Heightening.]

ANN: I guess. I see him trying to be solicitous (*he nods*), but I can't respond.

BRAD: I try to comfort her, but her flashes of anger throw me off balance too. I have never seen her be vulnerable before. I can't quite figure it out.

SMJ: (*To Brad*) It's hard for you to really see her hurt, her fears. You are used to seeing her as so strong and so in control? (*Brad nods emphatically.*) [Validation.]

BRAD: I'd like to comfort her. I'd like to nurture her. (*Therapist gestures to him to tell her this. He does. Ann turns away from him.*) [Shaping interaction with task.]

SMJ: (*Softly*) What is happening, Ann, as Brad says that he'd like to comfort you? [Evocative responding.]

ANN: Fragile. (*Very soft voice, holds herself with her arms.*)

SMJ: When you hear him offer comfort, you feel fragile—broken? It's hard to let him in, to feel that need? You decided never again—after the operation? [Evocative responding. Interpretation.]

ANN: (*Angrily*) Right. It's humiliating.

SMJ: You feel small—somehow ashamed to feel so vulnerable? Am I getting it? You had steeled yourself for years, and then your walls shattered—and he wasn't there. (*Ann nods and cries.*)

BRAD: I am trying. I tried to show you last night that I see how I've let you down in the past and that night after the operation. I never saw you as needing me.

SMJ: What is it like for you to know that Ann needs you and wraps her anger around herself so you won't see how she needs? (Evocative responding. Interpretation)

BRAD: I don't want her to hurt—but to know I am important to her, that's a relief. Makes me feel whole again. I see her differently.

SMJ: Can you tell her, "I see you're hurting. I see how I've hurt you. I want to comfort you. I want to be needed"? [Shaping interaction. Heightening message.]

ANN: (*In an angry voice*) Now you see me—now—do you? After all these years? (*She weeps.*)

BRAD: (*Very softly*) I know. Why should you believe me? I guess I let you down lots, and instead of thinking of my cousin, I should have been thinking of you—taking care of your hurt. I know how much I have hurt you. I guess the party incident was just the last straw.

SMJ: Can you hear him, Ann? Telling you he does see and care about your pain? Is there another voice besides the one that says, "Don't let him in—don't give him a chance to shatter you again"? [Reflection of process. Evocative responding.]

ANN: I feel hopeless. (*She weeps. Her voice goes dead and low.*) I'm invisible if I don't shout. I'd rather be angry—hostile.

SMJ: Can you tell him, "I've felt invisible, so now I dare not hope that you will really want and hold me—and be there when I need you. It's hard to let my guard down and put myself in your hands"? (*She nods.*) "Especially when I touch that night, at the supper—when you leapt up to take care of her"? [Reflection. Validation. Interpretation. Heightening.]

ANN: I'm not ready yet.

This process continued for three more sessions. The therapist framed the partners' responses in terms of attachment needs and fears, and in terms of the cycle of angry protest and defensive withdrawal that kept them apart. Ann began to be less volatile; she started to stand back and reflect on the attachment injury at the party and the long-term patterns in their relationship. She said, "We box each other into narrow corners." She began to talk about the "wound" of watching him offer caring to his cousin, and described how when it was touched, she went into "free fall." Brad stated that he now saw his wife in a different light and

felt stronger around her. He said, "We are communicating for the first time in our lives." As the injury of the abandonment after the operation and the party incident began to heal, he became more confident and commented, "I am learning how to lead in the dance." Ann began to express the attachment fears that most partners express when approaching more mutual connectedness at the end of Stage Two in EFT. She talked about how it was hard to "let go of the reins" and to admit that he could hurt her. He reassured and validated her, and asked her to take the risk of leaning on him. This process, having addressed the attachment injury in the relationship, then took on the pattern of a softening event: Ann risked more and spoke of her attachment needs, and Brad stayed available and responsive. They began to hold each other, make love, and be "tender" with each other. The spouses then moved into the third and last stage of therapy, resolving differences about their children and dealing with time management issues related to Ann's career and Brad's retirement needs. They were able to deal with the transition to Brad's retirement in a more cooperative way. The therapist helped them formulate a concise narrative about their relationship, their problems, and how they had repaired their bond. Ann said, "We have fallen in love again—and it feels a bit perilous—but I like it."

At the end of therapy, Ann and Brad reported that they still had "blowups" but were able to end them and reconnect much faster. They also described and demonstrated positive cycles of mutual comfort and reassurance. These cycles define the relationship as a safe haven and a secure base for both partners. As individuals, both Brad and Ann learned new ways to deal with their emotions and had expanded their model of self in the relationship, as well as their view of each other. Ann described herself as less of an "iron lady" and saw Brad as warmer and more open. Brad commented that it had taken him "forever to mature"—to "step out of his depression" and be able to take care of his wife. He told her that he was glad she had stayed with him and worked things out. The repair of this relationship was complicated by alliance issues and by the attachment injury that arose in Stage Two of the process of change. Nevertheless, this process followed the classic pattern of change in EFT and illustrated the research finding that the initial level of distress is less predictive of outcome than the quality of the partners' engagement in the repair process and the female partner's faith that her partner cares about her and her needs and fears.

BECOMING AN EFT THERAPIST

What are some of the challenges that face the novice EFT therapist? We presume that all couple therapists struggle with integrating the individual and the system, the "within" and the "between" dimensions of couple relationships. We also presume that most couple therapists struggle with leading and following their clients. Furthermore, most couple therapists struggle to foster not only new behaviors but also new meaning shifts (Sprenkle, Blow, & Dickey, 1999). However, the EFT therapist assumes that each partner's emotional engagement with inner experience and with the other partner is necessary to render new responses and new perspectives powerful enough to affect the complex drama of marital distress. The novice therapist has to learn to stay focused on and to trust emotion, even when a client does not (Palmer & Johnson, 2002). Our experience has been that clients do not disintegrate or lose control when they access the emotional experience in the safety of the therapy session; however, novice therapists may, in their own anxiety, dampen key emotional experiences or avoid them altogether. We find that novice therapists are reassured by being given techniques such as grounding to enable them to help clients (e.g., trauma survivors) regulate their emotions in therapy, on the rare occasions this becomes necessary (see Johnson & Williams-Keeler, 1998, for an example). In the same way, novice therapists who are distrustful of attachment needs may find themselves subtly criticizing a partner's fragility. The cultural myths about attachment are that "needy" people have to "grow up," and that indulging their neediness will elicit a never-ending list of demands. On the contrary, it seems that when attachment needs and anxieties are denied or invalidated, they become distorted and exaggerated. Supervision or peer support groups that provide such therapists with a safe base can help them explore their own perspectives on emotional experience and attachment needs and desires.

A novice therapist also has to learn not to get lost in pragmatic issues and the content of interactions, but instead to focus on the process of interaction and the way inner experience evolves in that interaction. The therapist has to stay with the cli-

ent rather than the model, and not try to push partners through steps when they are not ready for them. Sometimes it is when a therapist just stays with a client in his/her inability to move or change that new avenues open up. For example, when one frightened man was able to explicitly formulate his fear of commitment, and the therapist stood beside him in that fear, he was then able to become aware of the small voice telling him that all women would leave him, just as his first love had done on the eve of their wedding. As he grieved for this hurt and registered the helplessness he still felt with any woman who began to matter to him, his partner was able to comfort him. He then began to discover that he could address his fears with his present partner, and they began to subside. This process differed from a previous session, when the novice therapist had pushed the client to make a list of risks he was willing to take and when he would take them, only to find that he became even more withdrawn after this session.

Novice therapists may also have problems at first moving from intrapersonal to interpersonal levels. Therapists can get caught in the vagaries of inner experience and forget to use this experience to foster new steps in the dance. The purpose of expanding emotional experiences in EFT is to shape new interactions. The therapist has then to move into the "Can you tell him/her?" mode on a regular basis. Inexperienced therapists can also become caught in supporting one partner at the expense of the other. It is particularly important, for example, when one partner is moving and taking new risks, to validate the mate's initial mistrust of this, sense of disorientation, and inability to immediately respond to this new risk-taking behavior. When the caveats above are attended to, recent research (Denton et al., 2000) suggests that novice therapists can be effective using this model.

EFT AS A MODEL OF INTERVENTION FOR THE NEW MILLENNIUM

One of the clear strengths of the EFT model in the present social context is that its interventions are clearly delineated, but it still places these interventions in the context of the client's process and responses. It is not an invariant, mechanical set of techniques. It can address general patterns found across many relationships, as well as the uniqueness of a particular couple's relationship. The need for efficient brief interventions also requires interventions to be on target. It requires that they reach the heart of the process of relationship repair. EFT formulations and interventions are consonant with recent research on the nature of distress and satisfaction in close relationships, and with the ever-expanding research on the nature of adult love and attachment relationships. In the present climate, it is also particularly pertinent that EFT interventions have been empirically validated and found to be effective with a large majority of distressed couples. Results seem to be relatively stable and resistant to relapse. This model appears, then, to be able to reach different kinds of couples in a brief format and to create clinically significant and lasting change.

A recent decade review of the field (Johnson & Lebow, 2000) points out that the utilization of couple interventions has increased enormously in the last decade, and that couple therapy is used more and more as a resource to augment the mental health of individual partners, particularly those who may be suffering from such problems as depression or PTSD. These two individual problems seem to be particularly associated with distress in close relationships (Whisman, 1999). As a client remarked, "Trying to deal with my depression without addressing my unhappy relationship with my wife is like pushing against both sides of the door. I never get anywhere." For individual changes to endure, they must also be supported in the client's natural environment (Gurman, 2001). EFT fits well into the emerging picture of couple therapy as a modality that can address and significantly affect "individual" problems, which are now more and more viewed in their interpersonal context.

EFT also seems to fit with the need for the field of couple therapy to develop conceptual coherence. We need conceptually clear treatment models that are linked not only to theories of close relationships, but also to pragmatic "if this . . . then that" interventions. Research into the process of change in this model offers a map of pivotal steps and change events to guide the couple therapist as he/she crafts specific interventions to help partners move toward achieving a more secure bond. One coherent theme that is emerging in the couple and family therapy field is a renewed respect for, and collaboration with, our clients. We learned and continue to learn how to do EFT from our clients. To echo Bowlby's (1980) words in the final vol-

ume of his attachment trilogy, we must therefore thank our clients, who have worked so hard to educate us.

REFERENCES

Anderson, H. (1997). *Conversation, language and possibilities*. New York: Basic Books.

Anderson, P., Beach, S., & Kaslow, N. (1999). Marital discord and depression: The potential of attachment theory to guide integrative clinical intervention. In T. Joiner & J. Coyne (Eds.), *The interactional nature of depression* (pp. 271–297). Washington, DC: American Psychiatric Press.

Atkinson, L. (1997). Attachment and psychopathology: From laboratory to clinic. In L. Atkinson & K. J. Zucker (Eds.), *Attachment and psychopathology* (pp. 3–16). New York: Guilford Press.

Bartholomew, K., & Perlman, D. (Eds.). (1994). *Advances in personal relationships: Vol 5. Attachment processes in adulthood* London: Jessica Kingsley.

Beach, S., Nelson, G. M., & O'Leary, K. (1988). Cognitive and marital factors in depression. *Journal of Psychopathology and Behavioral Assessment, 10*, 93–105.

Becker, E. (1973). *The denial of death*. New York: Free Press.

Bograd, M., & Mederos, F. (1999). Battering and couples therapy: Universal screening and selection of treatment modality. *Journal of Marital and Family Therapy, 25*, 291–312.

Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. New York: Basic Books.

Bowlby, J. (1980). *Attachment and loss: Vol 3. Loss*. New York: Basic Books.

Bowlby, J. (1988). *A secure base*. New York: Basic Books.

Cassidy, J., & Shaver, P. (Eds.). (1999). *Handbook of attachment: Theory, research, and clinical applications*. New York: Guilford Press.

Coiro, M., & Gottesman, I. (1996). The diathesis and/or stressor role of EE in affective illness. *Clinical Psychology: Science and Practice, 3*, 310–322.

Davila, J., & Bradbury, T. (1999). *Attachment security in the development of depression and relationship distress*. Paper presented at the 33rd Annual Convention of the Association for Advancement of Behavior Therapy, Toronto.

Denton, W. H., Burleson, B. R., Clark, T. E., Rodriguez, C. P., & Hobbs, B. V. (2000). A randomized trial of emotion focused therapy for couples in a training clinic. *Journal of Marital and Family Therapy, 26*, 65–78.

Dessaulles, A. (1991). *The treatment of clinical depression in the context of marital distress*. Unpublished doctoral dissertation, University of Ottawa.

de Shazer, S. (1991). *Putting difference to work*. New York: Norton.

Dutton, D. G. (1995). *The batterer: A psychological profile*. New York: Basic Books.

Feeney, J. A., Noller, P., & Callan, V. J. (1994). Attachment style, communication and satisfaction in the early years of marriage. In K. Bartholomew & D. Perlman (Eds.), *Advances in personal relationships: Vol. 5. Attachment processes in adulthood* (pp. 269–308). London: Jessica Kingsley.

Fisch, R., Weakland, J. H., & Segal, L. (1982). *The tactics of change: Doing therapy briefly*. San Francisco: Jossey-Bass.

Fonagy, P., & Target, M. (1997). Attachment and reflective function: Their role in self-organization. *Development and Psychopathology, 9*, 679–700.

Goldner, V. (1999). Morality and multiplicity: Perspectives on the treatment of violence in intimate life. *Journal of Marital and Family Therapy, 25*, 325–336.

Goleman, D. (1995). *Emotional intelligence*. New York: Bantam Books.

Gordon-Walker, J. (1994). *A marital intervention program for couples with chronically ill children*. Unpublished doctoral dissertation, University of Ottawa.

Gordon-Walker, J., Johnson, S. M., Manion, I., & Clothier, P. (1997). An emotionally focused marital intervention for couples with chronically ill children. *Journal of Consulting and Clinical Psychology, 64*, 1029–1036.

Gottman, J. M. (1979). *Marital interaction: Experimental investigations*. New York: Academic Press.

Gottman, J. M. (1994). *What predicts divorce?* Hillsdale, NJ: Erlbaum.

Gottman, J. M., Coan, J., Carrere, S., & Swanson, C. (1998). Predicting marital happiness and stability from newlywed interactions. *Journal of Marriage and the Family, 60*, 5–22.

Green, R. J., Bettinger, M., & Zacks, E. (1996). Are lesbian couples fused and gay male couples disengaged? In J. Laird & R. J. Green (Eds.), *Lesbians and gays in couples and families* (pp. 185–230). San Francisco: Jossey-Bass.

Greenberg, L. S., & Johnson, S. M. (1988). *Emotionally focused therapy for couples*. New York: Guilford Press.

Greenberg, L. S., & Paivio, S. (1997). *Working with emotions in psychotherapy*. New York: Guilford Press.

Greenberg, L. S., Watson, J. C., & Goldman, R. (1998). Process experiential therapy of depression. In L. S. Greenberg, J. C. Watson, & G. Lietaer (Eds.), *Handbook of experiential psychotherapy* (pp. 227–248). New York: Guilford Press.

Greenberg, L. S., Watson, J. C., & Lietaer, G. (Eds.). (1998). *Handbook of experiential psychotherapy* New York: Guilford Press.

Guerney, B. (1994). The role of emotion in relationship enhancement marital/family therapy. In S. M. Johnson & L. S. Greenberg (Eds.), *The heart of the matter: Perspectives on emotion in marital therapy* (pp. 124–150). New York: Brunner/Mazel.

Gurman, A. (2001). Brief therapy and family/couple therapy: An essential redundancy. *Clinical Psychology: Science and Practice, 8*, 51–65.

Haddock, S., Schindler Zimmerman, T., & MacPhee, D. (2000). The power equity guide: Attending to gender in family therapy. *Journal of Marital and Family Therapy, 26*, 153–170.

Hammen, C., Burge, D., Daley, S., Davila, J., Paley, B., & Rudolph, K. (1995). Interpersonal attachment cognitions and prediction of symptomatic responses to interpersonal stress. *Journal of Abnormal Psychology, 104*, 436–443.

Hazan, C., & Shaver, P. (1987). Conceptualizing romantic love as an attachment process. *Journal of Personality and Social Psychology, 52*, 511–524.

Hazan, C., & Zeifman, D. (1994). Sex and the psychological tether. In K. Bartholomew & D. Perlman (Eds.), *Advances in personal relationships: Vol. 5. Attachment processes in adulthood* (pp. 151–180). London: Jessica Kingsley.

Herman, J. (1992). *Trauma and recovery*. New York: Basic Books.

Hoffman, L. (1998). Setting aside the model in family therapy. *Journal of Marital and Family Therapy, 24*, 145–156.

Jackson, D. D. (1965). The study of the family. *Family Process, 4*, 1–20.

Jacobson, N. S., & Addis, M. E. (1993). Research on couples therapy: What do we know? Where are we going? *Journal of Consulting and Clinical Psychology, 61*, 85–93.

Jacobson, N. S., Follette, W. C., & Macdonald, D. (1982). Reactivity to positive and negative behavior in distressed and non-distressed married couples. *Journal of Consulting and Clinical Psychology, 50*, 706–714.

James, P. (1991). Effects of a communication component added to an emotionally focused couples therapy. *Journal of Marital and Family Therapy, 17*, 263–276.

Johnson, S. M. (1986). Bonds or bargains: Relationship paradigms and their significance for marital therapy. *Journal of Marital and Family Therapy, 12*, 259–267.

Johnson, S. M. (1996). *The practice of emotionally focused marital therapy: Creating connection*. New York: Brunner/Mazel.

Johnson, S. M. (1998b). Emotionally focused marital therapy: Using the power of emotion. In F. M. Dattilio (Ed.), *Case studies in couple and family therapy* (pp. 450–472). New York: Guilford Press.

Johnson, S. M. (1998a). Listening to the music: Emotion as a natural part of systems theory. *Journal of Systemic Therapies, 17*, 1–17.

Johnson, S. M. (1999). Emotionally focused couple therapy: Straight to the heart. In J. M. Donovan (Ed.), *Short-term couple therapy* (pp. 13–42). New York: Guilford Press.

Johnson, S. M. (in press). An antidote to post-traumatic stress disorder: The creation of secure attachment. In L. S. Atkinson (Ed.), *Attachment and psychopathology* (Vol. 2). Cambridge, England: Cambridge University Press.

Johnson, S. M. (2002). *Emotionally focused couple therapy with trauma survivors: Strengthening attachment bonds*. New York: Guilford Press.

Johnson, S. M., & Boisvert, C. (2002). Humanistic couple and family therapy. In D. Kane (Ed.), *Humanistic psychotherapies* (pp. 309–338). Washington, DC: American Psychological Association.

Johnson, S. M., & Greenberg, L. S. (1985). The differential effects of experiential and problem solving interventions in resolving marital conflict. *Journal of Consulting and Clinical Psychology, 53*, 175–184.

Johnson, S. M., & Greenberg, L. S. (1988). Relating process to outcome in marital therapy. *Journal of Marital and Family Therapy, 14*, 175–183.

Johnson, S. M., & Greenberg, L. S. (Eds.). (1994). *The heart of the matter: Perspectives on emotion in marital therapy*. New York: Brunner/Mazel.

Johnson, S. M., & Greenberg, L. S. (1995). The emotionally focused approach to problems in adult attachment. In N. S. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of couple therapy*, (pp. 121–141). New York: Guilford Press.

Johnson, S. M., Hunsley, J., Greenberg, L., & Schlinder, D. (1999). Emotionally focused couples therapy: Status and challenges. *Journal of Clinical Psychology: Science and Practice, 6*, 67–79.

Johnson, S. M., & Lebow, J. (2000). The "coming of age" of couple therapy: A decade review. *Journal of Marital and Family Therapy, 26*, 23–38.

Johnson, S. M., Maddeaux, C., & Blouin, J. (1998). Emotionally focused family therapy for bulimia: Changing attachment patterns. *Psychotherapy, 35*, 238–247.

Johnson, S. M., Makinen, J., & Millikin, J. (2001). Attachment injuries in couple relationships: A new perspective on impasses in couples therapy. *Journal of Marital and Family Therapy, 27*, 145–155.

Johnson, S. M., & Talitman, E. (1997). Predictors of success in emotionally focused marital therapy. *Journal of Marital and Family Therapy, 23*, 135–152.

Johnson, S. M., & Whiffen, V. (1999). Made to measure: Adapting emotionally focused couple therapy to partners attachment styles. *Clinical Psychology: Science and Practice, 6*, 366–381.

Johnson, S. M., & Williams-Keeler, L. (1998). Creating healing relationships for couples dealing with trauma: The use of emotionally focused marital therapy. *Journal of Marital and Family Therapy, 24*, 227–236.

Jordan, J. V., Kaplan, A. G., Miller, J. B., Stiver, L. P., & Surrey, J. L. (1991). *Women's growth in connection: Writings from the Stone Center*. New York: Guilford Press.

Kennedy-Moore, E., & Watson, J. (1999). *Expressing emotion: Myths, realities, and therapeutic strategies*. New York: Guilford Press.

Kobak, R., & Cole, H. (1991). Attachment and meta-monitoring: Implications for autonomy and psychopathology. In D. Cicchetti & S. Toth (Eds.), *Disorders and dysfunctions of the self* (pp. 267–297). Rochester, NY: University of Rochester Press.

Kobak, R., & Hazan, C. (1991). Attachment in marriage: Effects of security and accuracy of working models. *Journal of Personality and Social Psychology, 60*, 861–869.

Koerner, K., & Jacobson, N. (1994). Emotion and behavioral couple therapy. In S. M. Johnson & L. S. Greenberg (Eds.), *The heart of the matter: Perspectives on emotion in marital therapy* (pp. 207–226). New York: Brunner/Mazel.

Knudson-Martin, C., & Mahoney, A. (1999). Beyond different worlds: A post gender approach to relationship development. *Family Process, 38*, 325–340.

Lebow, J. (1997). The integrative revolution in couple and family therapy. *Family Process, 36*, 1–17.

MacPhee, D. C., Johnson, S. M., & van der Veer, M. C. (1995). Low sexual desire in women: The effects of marital therapy. *Journal of Sex and Marital Therapy, 21*, 159–182.

Mahoney, M. (1991). *Human change processes*. New York: Basic Books.

Main, M., & Hesse, E. (1990). Parents' unresolved traumatic experiences are related to infant disorganized attachment status. In M. Greenberg, D. Cicchetti, & E. M. Cummings (Eds.), *Attachment in the preschool years* (pp. 161–182). Chicago: University of Chicago Press.

Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood and adulthood: A move to the level of representation. In I. Bretherton & E. Waters (Eds.),

Growing points of attachment theory and research. *Monographs of the Society for Research in Child Development, 50*(1–2, Serial No. 209), 66–104.

Martin, J., & Sugarman, J. (2000). Between modern and postmodern. *American Psychologist, 55*, 397–406.

McFarlane, A.C., & van der Kolk, B. A. (1996). Trauma and its challenge to society. In B. van der Kolk, A. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress* (pp. 24–46). New York: Guilford Press.

McLeod, J., Kessler, R., & Landis, K. (1992). Speed of recovery from major depressive episodes in a community sample of married men and women. *Journal of Abnormal Psychology, 101*, 277–286.

Mesquita, B., & Frijda, N. (1992). Cultural variations in emotions: A review. *Psychological Bulletin, 112*, 179–204.

Mikulincer, M. (1995). Attachment style and the mental representation of self. *Journal of Personality and Social Psychology, 69*, 1203–1215.

Mikulincer, M. (1997). Adult attachment style and information processing: Individual differences in curiosity and cognitive closure. *Journal of Personality and Social Psychology, 72*, 1217–1230.

Mikulincer, M. (1998). Adult attachment style and individual differences in functional versus dysfunctional experiences of anger. *Journal of Personality and Social Psychology, 74*, 513–524.

Millikin, J., & Johnson, S. M. (2000). Telling tales: Disquisitions in emotionally focused therapy. *Journal of Family Psychotherapy, 11*, 75–79.

Minuchin, S., & Fishman, H. C. (1981). *Family therapy techniques*. Cambridge, MA: Harvard University Press.

Neimeyer, R. (1993). An appraisal of constructivist psychotherapies. *Journal of Consulting and Clinical Psychology, 61*, 221–234.

Orlinsky, D., Grawe, K., & Parks, B. (1994). Process and outcome in psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 270–376). New York: Wiley.

Palmer, G., & Johnson, S. M. (2002). Becoming an emotionally focused couple therapist. *Journal of Couple and Relationship Therapy, 3*, 1–6.

Perls, F., Hefferline, R., & Goldman, P. (1951). *Gestalt therapy*. New York: Dell.

Roberts, T. W. (1992). Sexual attraction and romantic love: Forgotten variables in marital therapy. *Journal of Marital and Family Therapy, 18*, 357–364.

Rogers, C. R. (1951). *Client-centered therapy*. Boston: Houghton Mifflin.

Salovey, P., Rothman, A. J., Detweiler, J. B., & Stewart, W. T. (2000). Emotional states and physical health, *American Psychologist, 55*, 110–1421.

Satir, V. (1967). *Conjoint family therapy*. Palo Alto, CA: Science & Behavior Books.

Schore, A. (1994). *Affect regulation and the organization of self*. Hillsdale, NJ: Erlbaum.

Schwartz, R., & Johnson, S. M. (2000). Does couple and family therapy have emotional intelligence? *Family Process, 39*, 29–34.

Shapiro, V. (1996). Subjugated knowledge and the working alliance. *In Session: Psychotherapy in Practice, 1*, 9–22.

Simpson, J. A., & Rholes, W. S. (1994). Stress and secure base relationships in adulthood. In K. Bartholomew & D. Perlman (Eds.), *Advances in personal relationships: Vol. 5. Attachment processes in adulthood* (pp. 181–204). London: Jessica Kingsley.

Simpson, J. A., Rholes, W. S., & Nelligan, J. S. (1992). Support seeking and support giving within couples in an anxiety provoking situation: The role of attachment styles. *Journal of Personality and Social Psychology, 62*, 434–446.

Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and the Family, 38*, 15–28.

Sprenkle, D., Blow, A., & Dickey, M. H. (1999). Common factors and other non-technique variables in marriage and family therapy. In M. Hubble, B. Duncan, & C. Miller (Eds.), *The heart and soul of change* (pp. 329–359). Washington, DC: American Psychological Association.

Teichman, Y., & Teichman, M. (1990). Interpersonal views of depression: Review and integration. *Family Psychology, 3*, 349–367.

Tomkins, S. (1962). *Affect, imagery and consciousness* (2 vols.). New York: Springer.

van der Kolk, B., Perry, C., & Herman, J. (1991). Childhood origins of self-destructive behavior. *American Journal of Psychiatry, 148*, 1665–1671.

van Ijzendoorn, M. H., & Sagi, A. (1999). Cross-cultural patterns of attachment: Universal and contextual dimensions. In J. Cassidy & P. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 713–734). New York: Guilford Press.

Vatcher, C. A., & Bogo, M. (2001). The feminist/emotionally focused therapy practice model. *Journal of Marital Family Therapy, 27*, 69–84.

von Bertalanffy, L. (1956). General system theory. *General Systems Yearbook, 1*, 1–10.

Watzlawick, P., Beavin, J., & Jackson, D. (1967). *Pragmatics of human communication*. New York: Norton.

Weeks, G. R., & L'Abate, L. (1979). A compilation of paradoxical methods. *American Journal of Family Therapy, 7*, 61–76.

Weinfield, N. S., Sroufe, L. A., Egeland, B., & Carlson, E. A. (1999). The nature of individual differences in infant–caregiver attachment. In J. Cassidy & P. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 68–88). New York: Guilford Press.

Weissman, M. M. (1987). Advances in psychiatric epidemiology: Rates and risks for major depression. *American Journal of Public Health, 77*, 445–451.

Whiffen, V., & Johnson, S. (1998). An attachment theory framework for the treatment of child bearing depression. *Clinical Psychology: Science and Practice, 5*, 478–493.

Whisman, M. (1999). Marital dissatisfaction and psychiatric disorders: Results from the National Comorbidity Survey. *Journal of Abnormal Psychology, 108*, 701–706.

Whisman, M., & Jacobson, N. S. (1990). Power, marital satisfaction and response to marital therapy. *Journal of Family Psychology, 4*, 202–212.

Wile, D. B. (1995). The ego-analytic approach to couple therapy. In N. S. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of couple therapy* (pp. 91–120). New York: Guilford Press.