Using Emotionally Focused Therapy for Couples to Resolve Attachment Ruptures Created by Hypersexual Behavior

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ABSTRACT: Hypersexual behavior can have a devastating impact on attachments between couples in committed relationships. An array of emotions are activated by these attachment ruptures including feelings of betrayal, confusion, frustration, hopelessness, and abandonment. Repairing these ruptures can be a delicate, and challenging, part of helping couples restore trust and forgiveness in their relationships. This article describes the process of using Emotionally Focused Therapy for couples as an intervention to facilitate the process of healing damage caused by hypersexual behavior.

Hypersexual behavior can have a devastating impact on attachments between couples in committed relationships. In addition to sexual infidelity that often accompanies hypersexual behavior, many partners report being equally disturbed by dishonesty, lies, and secrets frequently associated with patterns of hypersexuality (Corley and Schneider, 2002; Corley, 1998). If children exist, concerns about their risk of being prematurely exposed to activities associated with a caregiver’s hypersexual behavior may be present. In some cases, hypersexual individuals attempt to sexually manipulate their partners creating tension around physical intimacy in the relationship. The constellation of issues impacts each couple differently but in most cases, one partner feels insecure leading to distrust that jeopardizes the foundation of the relationship. (Blow and Hartnett, 2005; Gordon, Baucom, and Snyder, 2004). When hypersexual behavior is present, couple attachments become ruptured, traumatizing both of the partners as well as the relationship.

Despite the host of issues that threaten the relationship, couples can recover from the impact of hypersexual behavior. Of course, like every journey to recovery, there is a price to be paid that involves sacrifice, risk, and hard work. This article outlines the impact of hypersexual behavior on couple relationships and proposes that repairing attachment ruptures can be greatly enhanced and facilitated using Emotionally Focused Therapy (EFT) for couples.
Defining Hypersexual Behavior

Although some differences exist among the various theoretical constructs of hypersexuality, many researchers agree that associated symptoms include behavior disregulation, impaired functioning, maladaptive coping skills, and incongruence with ones values and beliefs. Elsewhere, people have labeled this phenomenon using terms such as sexual addiction, sexual impulsivity, and sexual compulsive behavior (e.g. Barth and Kinder, 1987; Raymond, Coleman, and Miner, 2003; Goodman, 2001; Kafka, 2001; McCarthy, 1994; Travin, 1995; Rinehart and McCabe, 1997). Our conceptualization of hypersexual behavior is meant to function as a dimensional term opposite hyposexual desire disorders on a spectrum of dysfunctional sexual behavior. Additionally, hypersexuality is frequently described in the medical literature as encompassing disregulated sexual behavior stemming from some origins not traditionally considered in the sexual addiction literature such as neurological pathology (e.g. traumatic brain injury, temporal lobe epilepsy, etc.). Ultimately, it is conceivable that the construct of hypersexuality could have several subtypes. In the context of this article, we define hypersexual behavior as:

Difficulty in regulating (e.g. diminishing or inhibiting) sexual thoughts, feelings or behavior to the extent that negative consequences are experienced by self or others. The behavior causes significant levels of personal or interpersonal distress and / or functional impairment and may include activities that are incongruent with personal values, beliefs, or desired goals. The behavior may function as a maladaptive coping mechanism (e.g. used to avoid emotional pain or used as a tension-reduction activity) and may be subsumed or coincide with other psychopathology or neurological impairments.

An vast array of problems are associated with hypersexual behavior including 1) health risks related to unprotected anonymous sex, 2) economic loss related to difficulty with employment (e.g. fired for consuming Internet pornography in the workplace) or excessive financial expenditures associated with perpetuating sexual activities, 3) legal problems related to sexual behavior (e.g. solicitation from commercial sex workers), and 4) the impact on emotional and psychological well-being from the undesirable consequences associated with hypersexuality. When an individual is part of a committed relationship, the consequences of choices related to hypersexual behavior are magnified because they also impact the partner and the relationship.

Complicating the clinical picture, hypersexuality is often comorbid with psychopathologies such as substance-related disorders, anxiety, emotional regulation problems, and adult attention difficulties (Black et al., 1997; Kafka and Hennen, 2002; Kafka and Prentky 1994, 1998; Raymond and Coleman, 2003). Additionally, many of these individuals report childhood experiences of sexual, physical, and emotional abuse (Carnes, 1991; Courtois, 1979; Gold & Heffner, 1998; McCarthy, 1994; Stoller, 1975, 1985; Timms & Connors, 1992). This landscape of issues makes it difficult to determine correlations related to attachment ruptures due to hypersexuality verses any attendant psychopathologies or other problems. Consistent with best practices, a comprehensive clinical and diagnostic assessment for both partners will be an important part of treatment in order to ensure that issues of hypersexuality do not eclipse other important factors that may be affecting the relationship.

Impact of Hypersexual Behavior on Couple Relationships

Approximately fifteen to twenty percent of marital vitality and satisfaction are attributable to functional sexuality in relationships (McCarthy, 2003). However, when sex becomes problematic for couples, it has a proportionately greater impact on relationship
satisfaction. Some self reports have suggested sexual problems account for fifty to seventy percent of distress (McCarthy, 2003).

When relationships are impacted by hypersexual behavior, usually both partners have suffered injuries. Therapists may be inclined to marginalize the pain of the individual who has engaged in hypersexual behavior and privilege the issues and concerns of the non-offending partner. However, this ignores the underlying issues that might have precipitated the sexual activities. Addressing the trauma of both partners is a delicate balancing act for the therapist that will need to be well orchestrated if the relationship is to heal.

On average, seventy percent of individuals who present with hypersexual behavior are ambivalent about their sexual activities (Reid, in press). Like the cocaine addict toward cocaine, many hypersexual individuals develop a love-hate relationship with sex. They become psychologically dependent upon the euphoria associated with neuro-chemical processes activated by sex while remaining aware that their self-destructive behavior is jeopardizing their relationships. They also remain aware of potentially greater consequences such as risks associated with sexually transmitted diseases. One pattern among some individuals with hypersexual behavior appears to suggest that sex is being used as an emotionally avoidant activity (e.g. Adams and Robinson, 2001). The precipitating event that triggers these individuals to act out sexually is often related to times when they feel emotional pain or disregulation. It's plausible that such individuals may never have developed the ability to process uncomfortable or difficult emotions. For example, such individuals experience difficulty differentiating emotions from a sense of self. Such an individual may translate “feeling bad" to "I'm worthless." Cognitive distortions like these are amplified when uncomfortable or awkward feelings such as frustration, disappointment, anger, rejection, or inadequacy surface. In order to avoid or escape emotional discomfort, individuals may turn to sex as a way of self-medicating or soothing themselves. Thus, one must not only consider the impact of the hypersexual behavior on the relationship, but also accompanying impairments, such as emotional processing deficits like ones found in alexithymia (Sifneos, 1972; Taylor, Ryan, & Bagby, 1985). These factors will need to be evaluated in the context of how the couple has been affected.

As a side note, it is interesting that attempts to separate sex from emotions might be futile. Sex itself is an emotional experience as evidenced in studies investigating the neurobiological processes underlying sexual behavior. These studies, using functional MRI, have implicated several brain regions with sexual activity, including the amygdala, that are widely understood to be correlated with emotional arousal and processing (e.g. Aron, et al., 2005; Arnow, et al., 2002; Hamann, S., 2005; Karama et al., 2002). These neurological findings may also explain the pattern among individuals with hypersexual behavior where unwanted emotional states are replaced with the mood altering states activated by the biological and chemical processes associated with sexual arousal, fantasy, and satiation.

Another impact of hypersexual behavior is that it undermines the foundation of healthy sexuality by threatening the emotional and physical intimacy within couple relationships. For example, one form of hypersexual behavior, unprotected anonymous sex with multiple partners, may lead to the forfeiture of bonding experiences that link people together in intimate ways, because people who engage in such behavior often disconnect their emotions from the sexual process in which they participate. These individuals perceive little risk of being emotionally hurt by “one night stands." This perceived lack of risk stems in part from the absence of commitment and the ability to leave at any time. Additionally, anonymous sex without emotional attachment, allows individuals to keep private those aspects about themselves that may expose their vulnerabilities. Ironically, in their attempts to minimize emotional risk and vulnerability, their sexual activities with multiple anonymous partners increases their risks rather than lessening
them. They risk contraction of sexual transmitted diseases and they jeopardize intimate relationships in which their needs might be met in meaningful ways.

There are also pragmatic consequences for hypersexual behavior that may further stress relationships. Sometimes relationships suffer public humiliation (e.g. a partner arrested for solicitation of sex), or economic hardship when employment is terminated because of inappropriate sexual activities in the workplace. Financial difficulties also occur when excessive amounts of money are used to perpetuate the hypersexual behavior (e.g. commercial sex workers, patronizing sexually oriented business establishments, consumption of pornography, etc.). Some individuals lose church fellowship privileges (e.g. excommunication). Time pursuing sex results in lost productivity and neglect of responsibilities. Sometimes these consequences are severe enough that therapy stops and the clinician assumes a case management role in order to restore the couples environment or personal circumstances to a point where therapy can be resumed.

Paramount above the couple relationship should be concern for any children that may be part of the family system. Clinicians should be mindful of possible consequences to children in a home where one or both partners are engaged in hypersexual behavior. A possible duty to report may exist if children are being exposed to any activities associated with hypersexual behavior. Be aware, that partners will often dissolve relationships if they feel their children are at risk, even though these same individuals will not be assertive about their own suffering related to hypersexuality.

The disclosure or non-disclosure of sexual activities is another significant factor of hypersexual behavior that can impact the severity of an attachment rupture. Partners may be more disturbed when they discover behavior that has been kept from them. They may wonder how long the hypersexual partner would have continued in their behavior and maintained secrecy and lies. They may wonder what else is being hidden or kept from them. Serious questions about trust and safety begin to emerge (Gordon, Baucom, and Snyder, 2004).

When hypersexual behavior is discovered in relationships, the injured partner can feel deeply betrayed, violated, confused, afraid, hurt and angry. These emotions frequently lead to behaviors such as attacking, criticizing, clinging, controlling, or cold withdrawal, which tend to be very destructive to the relationship (Johnson, 2004; Gottman, 1994). They can also lead to what has been defined as an attachment injury (Johnson, Makinen, & Millikin, 2000) where the foundational beliefs of the relationship are redefined negatively (e.g. “I can’t trust him,” “he will never be faithful,” “he really doesn’t love me”). In order to heal this type of an injury, it is necessary to create relational dynamics and events that help the injured partner feel safe, loved, and respected.

Hypersexual behavior typically robs the relationship of emotional energy of at least one partner. The deception, guilt, and shame that accompanies hypersexuality distracts from accessibility and responsiveness. Additionally, the attention that is devoted to the hypersexual behavior reduces commitment and time that could have been devoted to the relationship. Hypersexual behavior can become a type of competing attachment, where the person engages in hypersexual behavior to be soothed or feel safe or important rather than finding safety, soothing, and validation in the primary relationship.

In discussing the impact of hypersexual behavior, it would be a gross oversimplification to blame all couple problems of an impacted couple exclusively on the hypersexual behavior. Such an approach might lead clinicians to focus on symptoms rather than root causes of the distress. People who treat eating disorders know that focusing exclusively on food and calories would be less effective than a comprehensive approach that considers all the facets involved with disregulated consumption of food (Spangler, et al., 2004). Similarly, focusing exclusively on sex
is highly unlikely to resolve marital discord when a couple’s presenting problem is an attachment rupture associated with hypersexual behavior. It is probable that individuals who developed hypersexual behavior had preexisting conditions predisposing them to such behavior, possibly long before the initiation of their couple relationships. It’s conceivable that couples impacted by hypersexual behavior may have been affected from the onset of the relationship. If individuals had preexisting issues with hypersexual behavior or were predisposed to such activities, they may have sought insecure or ambivalent attachments because of comorbid issues (e.g. anxiety, loneliness, maladaptive shame, depression, etc.) related with their own mental health. In some cases, these traits may have influenced the hypersexual partner to select someone who would interact with them in a way that did not require them to engage in emotionally threatening ways (e.g. being emotionally vulnerable). Subsequently, a relational dynamic might have been created that fostered a climate in which the trajectory of hypersexual behavior was easily perpetuated.

The constellation of issues related to hypersexual behavior that negatively impact couple relationships should not be seen to be limited to those areas we have illuminated here. We echo what others have noted in the literature, that hypersexual behavior is the antithesis of healthy sexuality and can threaten the foundation of couple relationships (e.g. Irons, 1994, Elbaum, 1981). Ultimately, if both partners are not given some reassurance or hope that recovery is possible, the relationship will be volatile and increasingly susceptible to being dissolved. This vulnerability mandates that the therapist have a sense of what direction to take a couple, especially when so many issues can make moving forward in any particular direction challenging. It is imperative that the clinician have a theory that gives clarity to where the relationship must go if it is to survive the attachment rupture. The template we propose in this article is that 1) the therapist should have a working model of some traits associated with healthy sexuality, and 2) we postulate a model using theory derived from EFT to address the attachment injuries the relationship has suffered in conjunction with the hypersexual behavior.

**Sexuality in Couple Relationships**

There are a wide range of views about sexuality, and what healthy sexuality is and is not. Defining healthy sexuality is a daunting task outside the scope of this article. However, it is important to identify how the couple or each member of the couple defines healthy or ideal sexuality. If they are unclear, it may be useful to help couples define what they want sexuality to be in their relationship. If treatment is successful, couples will likely, at some point, want to reconnect and this is often symbolized through sexual union. Because of the diversity of ideas about sexuality it is recommended that clinicians become familiar with various theories and models of sexuality (e.g. DeLugach, 1999; Montgomery, 1995; Stratton and Newbold, 1995). Additionally, the field of sexual addiction has been harshly criticized for its emphasis on pathologizing sexual behavior instead of promoting models of healthy sexuality (Todd, 2004) and this trend must be curtailed if our profession is to be taken more seriously among colleagues and other mental health professionals. There are 19 professional journals devoted to issues of human sexuality (Wiederman, 2001), that contain wealth of information to assist therapists in becoming educated so they can be sensitive to the needs of their clients.

Clinicians should also take time to explore religious and cultural beliefs that may inform or govern sexual relations (e.g. prohibitions of premarital sex) and how each partner views their personal beliefs in the context of their religion or culture. This can be sensitive territory requiring respect from the clinician. Curiosity in this domain is always an asset and assumptions should be made with caution. For example, a person may hold membership in a particular subculture but not subscribe to the tenants and beliefs of that group. Sometimes, issues around hypersexual
behavior stem from inner conflict between externally derived and internally derived belief systems related to culture or faith.

Regardless of how a couple approaches these issues, healthy sexuality in many relationships is likely to include mutual caring, respect, openness, consent, sharing, safety, and trust. When present, these qualities cultivate emotional intimacy between partners in relationships. Sexuality can be viewed as an attachment behavior that facilitates closeness and creates bonding between two people. When sexuality is safe, it can help create mutual acceptance, affection, and admiration. Several aspects of the sexual experience require risk taking and vulnerability. From an attachment perspective, vulnerability within a reasonably safe environment and relationship deepens emotional intimacy. On the other hand, vulnerability, without a certain degree of safety and loyalty, can result in deep wounds. These wounds can become emotionally traumatizing to individuals and must have some level of resolution if the relationship is to thrive.

For couples seeking to cultivate healthy sexuality in their relationship, such a journey is not without its challenges. In fact, developing healthy sexuality usually requires both partners to have open dialogue about their sexual thoughts and feelings. Naturally, this elicits different perspectives which can feel threatening to one or both partners. Despite the undesirable consequences of hypersexual behavior in relationships, many couples report that issues that surfaced as a result of hypersexuality forced both partners to develop more effective communication skills, abilities in validating and being empathic towards each other, and problem solving strategies in the midst of conflict and emotionally charged situations. These abilities ultimately benefit most couples, although the majority would have preferred to acquire such relational skills without suffering the consequences of hypersexual behavior.

As couples work toward establishing healthy sexuality, the greater context should be a development of healthy attachment that will empower the couple to thrive and grow. Healthy attachment evolves in relationships as partners become accessible and responsive to each other and share the intimacies of their lives together. Consistent accessibility and responsiveness to various needs in the relationship creates the safety, security, and context for emotional vulnerability and engagement to occur. In order to be accessible and responsive, each partner has to focus on the other person, accurately understand each others needs, and respond to those needs in a manner consistent with traits that cultivate intimacy. In this greater context, many couples report satisfying and meaningful sexual relations (McCarthy, 2003; Lessin, et al., 2005).

**Emotionally Focused Therapy for Couples**

EFT is a short term, structured approach to couples therapy formulated in the early 1980's by Sue Johnson and Les Greenberg (Johnson & Greenberg, 1985). EFT is an integration of experiential, humanistic, and family systems approaches to treatment and is firmly rooted in attachment theory, which serves as a theory of love. Research on EFT has been very positive and indicates that 90% of treated couples are able to significantly improve their relationship when compared to untreated couples, and between 70% and 73% of treated couples recover from relational distress (Johnson, Hunsley, Greenberg, & Schindler, 1999). A two-year follow-up on relationship distress in parents of chronically ill children, a population at high risk for divorce, suggests that many couples, even if faced with stressful events, maintain their gains or continue to improve in the two years following termination from therapy (Cloutier, Manion, Walker & Johnson, 2002). EFT is described in detail elsewhere (Johnson, 2004; Woolley & Johnson, 2005; Johnson, et al. 2005), but a brief review of this approach, and why it is being suggested for couples when there is hypersexuality, is warranted.
EFT is made up of nine steps and 3 phases (see Table 1). In the first phase, the therapist works to identify the systemic cycle or pattern, which is often characterized by some form of purse-withdraw. The therapist identifies and accesses the emotions that are both a response to, and an organizer of, the cycle. The therapist then works to reprocess the emotions and to create new, secure bonding experiences, which lead to new cycles of trust and security. It is emotional experiencing and reprocessing that are the key components in changing negative cycles and creating a safe connection.

The attachment theory roots of EFT are particularly important in the treatment of couples where there has been hypersexual behavior. Attachment theory (Bowlby, 1988; Sperling and Berman, 1994) posits that most problematic behavior is the result of past or present threats to secure attachment, and that fear and uncertainty activate attachment needs and behaviors. Hypersexual behavior almost always results in a threat to secure attachment, both by the person engaging in hypersexual behavior (because of the fear, guilt, shame), and especially the partner (because of the sense of betrayal, violation, abandonment, and injury). Hypersexual behavior often creates relational traumas that redefine the relationship and the other partner. For example a wife who learns that her husband has had multiple affairs, may not only feel deeply betrayed, wounded and afraid, she may also question her basic assumptions about who he is and what the relationship is about. When wounds are deep enough that they lead to the redefinition of the relationship, they are identified in EFT as attachment injuries (Johnson, Makinen & Millikin, 2001). Attachment injuries are usually “violations of human connection” (Herman, 1992) that take the form of abandonment’s or betrayals in areas of vulnerability or at times of crucial need. In many ways, they are relational traumas that come alive when people are asked to risk engaging and being vulnerable, and consequently block couples from reengaging.

There comes a time in the therapy process where attachment injuries must be addressed in order for the relationship to move forward on the path to healing. The EFT process outlined for addressing an attachment injury can be very effective in guiding the type of relational healing that must take place if the couple is to develop a healthy attachment bond. These steps, which were first articulated by Johnson (Johnson et al., 2002) are reviewed here as they apply to repairing an injury resulting from ruptures related to hypersexual behavior.

1. The injured partner is invited by the therapist to articulate the injury and the impact it has had. The injured partner is encouraged to begin risking reconnecting with their partner (now accessible to them through couple’s therapy). Generally, the injured partner recounts the emotionally pain associated with the hypersexual behavior. In describing their experience, they might share feelings of abandonment, helplessness, or times when they experienced a violation of trust that damaged their belief in the relationship as a secure bond. Often, the injured partner speaks about this injury in an emotionally reactive manner. Through this account, the injury becomes alive and present rather than a distant or disconnected recollection. The hypersexual partner will usually discount, deny, or minimize the incident and this act trivializes their partner’s pain. The hypersexual partner subsequently becomes defensive as a way of protecting their fragile sense of self. In many cases, the defensiveness is a manifestation of narcissism desperately trying to protect the broken sense of self.

2. The injured partner begins to integrate the narrative (the story or context in which the events occurred) and the emotions associated with the story. This
process accesses the attachment fears associated with the injury. The therapist helps the injured partner remain connected with the pain of the injury and helps the partner begin to articulate its impact and significance with respect to the attachment related emotions. The identification and expression of painful emotions often elicits new emotions at this point. Anger is translated into clear expressions of hurt, helplessness, fear, and shame. The connection of the injury to present negative patterns in the relationship becomes clear. For example, the injured partner says, “I feel so hopeless. I find myself yelling at him to show him he can’t pretend I’m not here. He can’t just wipe out my hurt like that. I want him to suffer too.”

3. The hypersexual partner develops understanding of the significance of their behavior and acknowledges their partners emotional pain and suffering. The hypersexual partner, supported by the therapist, begins to hear and understand the impact of their sexual activities the context of the attachment. They reframe the pain of their injured partner as a reflection of their partners love for them and realize that their partners’ suffering exists because the hypersexual individual is considered a person of importance. The ability to give an alternative explanation to the emotional pain of their partner empowers the hypersexual individual to let go of beliefs that the protests of their partner are personal attacks or a reflection of their own inadequacies. They are invited to continue exploring the injured partners pain and suffering and elaborate on how the behavior evolved for them.

4. The partner who has been injured moves toward a more integrated articulation of the injury and how it relates to their attachment bond. They express the grief and loss involved with the injury and fears that may exist about the attachment bond (e.g. fear of abandonment, being alone, not being loved). The injured partner, the safety of the therapist’s office, allows the hypersexual partner to witness their vulnerability.

5. The hypersexual partner acknowledges responsibility and empathically engages in the healing process. They become more emotionally available as they assume accountability for their part in the attachment injury. Expressions of empathy, regret, and / or remorse may be present.

6. The injured partner is invited to express their emotional needs (e.g. I need reassurance, I need to feel loved, I need to feel safe, etc...). They may risk by asking for reparative comfort and caring which were unavailable and inaccessible at the time of the attachment injury.

7. If the hypersexual partner is able to demonstrate the ability to meet the emotional need of the injured partner, a bonding event occurs creating an antidote the hurt suffered by the traumatic experiences associated with the hypersexual behavior. Beliefs about the relationship are redefined (e.g. the relationship can be a safe place). The couple collaboratively reconstructs a new narrative of the traumatic events. This narrative has order and may include, for the injured partner, clarity about how the hypersexual behavior...
developed and why their partner made choices that undermined the foundation of their attachment. For the hypersexual partner, they may reconstruct beliefs about their way of coping with stress or emotional pain. They reorganize their beliefs about the attachment being a safe place where their needs can be met.

These steps are part of a process that occurs over time. The therapist might consider seeing each partner individually at times during the process if necessary. If one or both partners have individual issues these may be addressed separately from the couples work. For example, one man who was involved with hypersexual behavior was married to a woman who had a Borderline Personality Disorder. Each of them received individual therapy until they arrived at a place where they could work on the relationship.

In some cases, it is not uncommon that one or both partners will have tremendous ambivalence about wanting to stay in the relationship. This is usually a reflection of the deep hurt they have suffered and unless they develop some hope that recommitment to the relationship is a decision they will not regret, they will have a hard time risking and being vulnerable with each other. EFT assumes that both partners want to repair the attachment rupture but it can also accommodate some ambivalence which is often to be expected.

Another important feature of EFT is the assumption that partners are capable of emotionally engaging with each other. Because individuals who participate in hypersexual behavior are often intolerant of and lack patience for their emotional pain they will likely take this “quick-fix” approach in attempting to repair the attachment injury. For example, one client asked his spouse “Why do we have to keep revisiting this. I said I’m sorry. What else do you want from me?” This response was obviously invalidating and dismissive of his wife’s suffering but is also a reflection of his desire to avoid emotional pain. He was being asked to explore pain and suffering created by his choices and this was too overwhelming for him.

This pattern of avoidance is especially true for individuals who are narcissistic (Solomon, 1989). For them, a broken sense of self is threatened by the possibility of accepting responsibility for one more thing “wrong” with themselves and so they reject responsibility and accountability for their choices in order to preserve their fragile inner self. In these cases, some individual work with the hypersexual partner around issues of emotional regulation might be helpful.

As part of the preparatory work, a clinician might consider working with the hypersexual partner so they can speak the language of emotion such as giving them a list of adjectives that describe feeling states (e.g. sad, frustrated, hurt, confused, numb etc…) and helping them identify, describe, and express their emotional experiences. These skills will empower them with language that will enable them to emotionally engage with their partners during the healing process. For example, techniques as simple as guiding clients in expressing their emotions when they begin to express thoughts can assist a client in focusing on their emotions. For instance, when clients begin to describe feelings using phrases such as “I feel that” or “I feel like” they are in fact beginning to express thoughts, not feelings. The therapist might consider saying “A feeling is one word. I feel happy, frustrated, sad, etc…” and subsequently encourage clients to use language describing their feelings, not their thoughts.

**Issues EFT Seeks to Addressed if the Attachment Rupture is to be Healed**

As couples work through attachment injuries, each will have needs that must be addressed before they will be willing to move forward in the relationship. In particular, the following list represents some of the common denominators of issues among many couples who work through attachment injuries.
1. Hypersexual partner needs to develop the ability to regulate and process their own feelings and respond to their partner’s emotional needs.
2. Core maladaptive beliefs about self and partner need to be transformed to healthy adaptive beliefs.
3. A road map for restoring trust needs to be established.
4. The injured partner needs to feel that the other partner understands the impact of choices to engage in hypersexual behavior.
5. The couple needs to have some experiential evidence that their decision to recommit to the relationship will not be regretted.
6. Forgiveness for unhealthy choices needs to occur.
7. Both partners need to reorganize their feelings and beliefs about their sexual relationship.
8. New patterns and rituals for accessing, connecting, and responding to each partner’s emotional and physical needs must be established.

**Case Example: Greg and Debbie**

Greg and Debbie, a Caucasian couple in their mid-thirties, presented for treatment after Debbie discovered that Greg had been arrested while traveling on business for soliciting sex from a prostitute. When she confronted Greg, he had at first denied the incident and told Debbie he was asking the “woman” for directions, and that the entire incident was a misunderstanding. Debbie however, was not convinced and after pressing Greg, he told her the truth. Although Debbie initially threatened divorce, she agreed to stay together if Greg would seek counseling.

As Greg’s history slowly unraveled, Debbie learned that his sexual activities began during his high school years with compulsive masturbation, excessive pornography use, and unprotected sex with multiple girlfriends. During his college years, this behavior escalated and Greg would patronize strip clubs once or twice a month. This eventually led to excessive sexual activities with club dancers and multiple occasions when Greg used escort services to satisfy his sexual desires.

The following dialogue occurred as part of a session where Greg was invited to explore the injury Debbie experienced as a result of his hypersexual behavior. The transcript has been modified slightly from the original dialogue to help it flow and in order to preserve anonymity for the couple. *

This dialogue is intended to illustrate elements of EFT applied to a specific context in which a couple has experienced an attachment injury. In this dialogue, Debbie explains the trauma of learning about Greg’s hypersexual behavior, and how it completely changed her view of Greg and their marriage. As Greg hears her, he is numb, and the therapist works to access and heighten his pain to make him more available to her.

**Therapist:** So Debbie, I’m wondering if you might be willing to share what it was like for you when you discovered some of the things that had been occurring while Greg was away on business.

**Debbie:** I was shocked. [Pause] I sat there reading this letter from the court that said he needed to appear for some hearing and as I saw the charges and I initially though he had tried to have sex with a child or something like that. I couldn’t even finish reading the letter [starts crying and therapist leans forward in chair focusing on Debbie] because my eyes swelled up with tears and I

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* Couple has consented to have their data be used for research purposes and for the education of other mental health professions in workshop and publication venues provided identifying information be altered to preserve anonymity.
couldn’t see anymore. [Greg is looking at the floor as she is speaking]. Then this really sick
feeling came over me [crying escalates] and my stomach felt like it was twisted in a thousand
knots. I just sat there and couldn’t stop crying. I felt like I could hardly breath and my head
started to hurt. Part of me was saying to myself “My God this can’t be happening to me there
must be some mistake” but something told me this was no mistake.

Therapist: You wanted to believe this wasn’t happening but your gut was telling you this is for
real.

Debbie: [nods in acknowledgement of the therapists reflection] That’s exactly what it was like
but I knew it was for real and I felt like someone had just dropped me in a black hole without a
bottom.

Therapist: Say more about what it was like for you in the black hole. [Here the therapist works
to expand or heighten her experience]

Debbie: My entire world was erased and everything I believed about my marriage disappeared
and I closed my eyes and just wept in my pillow. [Greg gives her some tissue from the box
sitting beside him on the table; Debbie comments about this gesture from Greg] He just wants
me to wipe the tears away and pretend nothing has happened.

Greg: That’s not true.

Debbie: Don’t put on some façade for the therapist.

Therapist: Debbie, I can see this is incredibly painful for you to revisit. I appreciate your
willingness to share… [Therapist refocuses her on her pain and validates her suffering.]

Debbie: You have no idea. Unless someone has been in my shoes they’ll never fully appreciate
what it’s like.

Therapist: You’re right I don’t have any idea. I can’t even imagine what it was like for you.
[Pause] Greg as you hear Debbie describe her experience what is happening for you?

Greg: [Looks at Debbie for a second then turns towards the therapist] I feel bad.

Debbie: [Facial expression of disbelief]

Therapist: [Softly spoken] You feel bad.

Greg: Yeah.

Therapist: [Leaning toward Greg, speaks softly and slowly] Greg, when I hear you say that I
wonder if you’re saying it because it seems like it’s the correct thing to say but inside it doesn’t
really capture what’s happening for you as you hear Debbie share how devastating this is for her.
[Greg gives puzzled look]. Greg, I’m going to risk at guessing something, and I may be
completely wrong, but some guys hear their wives talk about how painful things have been and
they just feel numb, they don’t feel anything, but they’re afraid to say that’s what’s going on.
[Greg looks down at floor again; Therapist makes what in EFT is called an empathic conjecture or interpretation in order to help Greg access his deeper emotions.]

Greg: [Long pause; Greg looks up] You’re right. I don’t feel anything [Debbie gasps] but it bothers me that I can just sit here and watch her suffer because I f—d up and then not care that she’s hurt.

Therapist: So you’re feeling numb and it bothers you because somehow you think you should feel something else as you listen to Debbie. [Therapist works to expand Greg’s experience]

Greg: Yeah. I know I should feel something.

Therapist: What’s that like Greg? To sense that somehow you should be connecting to what’s going on but instead its like you’re feeling…. [Therapist offers facial expression that invites Greg to finish the sentence with a feeling word; Again therapist is working to expand his experience]

Greg: I don’t know. I just feel disconnected and I don’t know why. [Debbie is looking at Greg with a facial expression that seems to communicate feeling hurt that Greg doesn’t understand her pain but curious about the direction the dialogue is headed]

Therapist: [Looking at Greg] You hesitated when I invited you to be more emotionally open about your reaction to Debbie’s experience. Were you afraid of what might happened if you expressed what you were really feeling?

Greg: Of course. What kind of a monster sits here and watches his wife crying and doesn’t feel anything. [Greg starts to become emotional but he’s fighting some tears that are trying to flow].

Therapist: [Speaking softly] Greg, you’re fighting those tears right now. Those are important tears. I’m wondering if you could let those tears speak for you. [The therapist attempts to have Greg lean into his emotions] What do your tears say? [Debbie has stopped crying at this point and is intently focused on what’s happening with Greg]

Greg: [Tears start but Greg continues to resist them] I don’t know what to say. I don’t know why I’m this insensitive after everything I’ve done. I should be in the black hole, not Debbie. [Here Greg acknowledges her pain, an import beginning in healing attachment injuries.]

Therapist: It’s painful for you to see Debbie suffering.

Greg: It is. I know it doesn’t show and somehow I think that’s even worse.

Therapist: [Turns to Debbie] What’s it like for you to hear how Greg really feels?

Debbie: It hurts. I don’t understand and I want him to feel what I’ve felt for the past several weeks but I’m not sure that will ever happen.

Therapist: You’re afraid he’ll never understand but it’s important to you that he does. (Therapist reflects and validates)
Debbie: I don’t think he gets it. I don’t even know if he’s capable of getting it.

Therapist: How did you feel yourself reacting after he initially told you he felt bad? (Therapist checks her reaction to him.)

Debbie: I didn’t believe it. He can’t even stay focused on my s—t long enough to feel bad. He runs away.

Therapist: You’re right. I think Greg struggles when it comes to sharing his feelings or connecting with you about emotionally uncomfortable things. [Pause] So when he shared what was really going on was that believable?

Debbie: Well, it wasn’t what I wanted to hear but I could tell he was being honest with me. It’s more believable than telling me he feels bad when he doesn’t.

Therapist: I’m sure it wasn’t at all what you hoped for or needed. I couldn’t help but notice that you almost seemed surprised when he started shared his real feelings.

Debbie: He never shares feelings like that.

Therapist: You want him to share his feelings.

Debbie: Of course.

Therapist: Even if what he shares isn’t pleasant to hear? [Here the therapist heightens the importance of sharing where he really is].

Debbie: I just want the truth regardless of what the truth is. What could be worse than what’s already happened?

Therapist: I’m wondering if you could turn to Greg and look at him while you repeat what you just said. I think it’s important that he hears that coming from you. [Again the therapist works to heighten the importance of Greg being honest and open with her]

Debbie: [Turns to Greg] I’m tired of the lies. I can’t be lied to anymore. I just want you to tell me the way it is. If this is going to work you have to start being completely honest with me no matter what. [Greg nods affirmatively agreeing with Debbie’s request]

In this short segment, the therapist helps Debbie express the life altering devastation she experienced because of his hypersexual behavior. The therapist then expands Greg’s numbness into pain and fear and is able to access those emotions enough for Debbie to witness them. The therapist then validates her pain about his numbness, but then heightens and reframes this for Debbie in order to give her some hope that Greg is capable of honestly expressing his real feelings. The therapist then helps her solidify the importance of Greg's emotional honesty and has her communicate with him directly about this in order to emphasize how critical it is for Greg to be emotionally open in the relationship.

This dialogue draws upon the first three of the seven steps outlined earlier and illustrates how an EFT therapist works to repair an attachment injury. This session was a turning point for
Debbie in helping her develop hope that a recommitment to the relationship would be worth the risk and pain she would experience while attempting to repair the marriage. Through this dialogue and subsequent sessions, Greg learns a paradoxical phenomenon about taking emotional risks. He realizes that when he's willing to risk and be emotionally vulnerable he will become more, not less, attractive to Debbie. This couple ultimately learned to express emotion more honestly and openly in the relationship. A few months after this experience, Greg was able to demonstrate an increased ability to connect emotionally with Debbie and identify and respond to her feelings with impressive accuracy. Through this process, Debbie slowly began to soften and trust Greg again. Greg also received some individual counseling related to his hypersexual behavior and periodically, Debbie would join these individual sessions to observe and witness his process of change.

Summary

Hypersexual behavior can have a devastating impact on couple relationships. There are numerous issues that affect the relationship dynamics. EFT can be a very powerful intervention in repairing attachment injuries provided couples are willing to risk and be open to identifying and sharing their emotions. Additionally, therapists who desire to implement an EFT approach with couples need to feel comfortable with using strong emotion to create new emotional experiences that change relationships. It is hoped that through outlining and introducing some of the principles of EFT as they relate to attachment injuries caused by hypersexual behavior, that the reader will see the potential in using EFT with couples impacted by these presenting problems. Clinicians interested in investigating EFT will discover numerous articles in the literature as well as opportunities to receive training and supervision as they acquire the skills necessary to be a competent and effective EFT therapist. As therapists are able to cultivate a safe environment where emotionally charged situations can be processed and resolved, we believe they will discover that EFT is a powerful approach to helping couples repair and reconcile attachment injuries associated with hypersexual behavior.
REFERENCES


Reid, R.C. and Woolley, S.R 16


**Table 1**

**The 3 Stages and 9 Steps of EFT**

*Stage 1: Assessment and Cycle De-escalation*
1. Create an alliance and identify the conflict issues.
2. Identify the negative interaction cycle, and each partner’s position in that cycle.
3. Access unacknowledged primary emotions underlying interactional positions.
4. Reframe the problem in terms of underlying emotions, attachment needs, and the negative cycle.

*Stage 2: Engagement: Changing Interactional Positions and Creating Bonding Events*
5. Promote identification with disowned needs and aspects of self, and integrate these into relationship interactions.
6. Promote acceptance of the other partner’s experiences, aspects of self, and new interaction patterns.
7. Facilitate the expression of needs and wants to restructure the interaction, and create emotional engagement.

*Stage 3: Consolidation*
8. Facilitate the emergence of new solutions to problematic interactions and old relationship issues.
9. Consolidate new positions and new cycles of attachment behaviors