



Journal of Couple & Relationship Therapy: Innovations in Clinical and Educational Interventions

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/wcrt20>

Emotionally Focused Family Therapy: Facilitating Change Within a Family System

Katherine Stavrianopoulos ^a , George Faller ^b & James L. Furrow ^c

^a Department of Counseling, John Jay College , City University of New York , New York , New York , USA

^b New York Center for Emotionally Focused Therapy and Ackerman Institute for the Family , New York , New York , USA

^c Fuller Graduate School of Psychology , Pasadena , California , USA
Published online: 30 Jan 2014.

To cite this article: Katherine Stavrianopoulos , George Faller & James L. Furrow (2014) Emotionally Focused Family Therapy: Facilitating Change Within a Family System, *Journal of Couple & Relationship Therapy: Innovations in Clinical and Educational Interventions*, 13:1, 25-43, DOI: [10.1080/15332691.2014.865976](https://doi.org/10.1080/15332691.2014.865976)

To link to this article: <http://dx.doi.org/10.1080/15332691.2014.865976>

PLEASE SCROLL DOWN FOR ARTICLE

Taylor & Francis makes every effort to ensure the accuracy of all the information (the "Content") contained in the publications on our platform. However, Taylor & Francis, our agents, and our licensors make no representations or warranties whatsoever as to the accuracy, completeness, or suitability for any purpose of the Content. Any opinions and views expressed in this publication are the opinions and views of the authors, and are not the views of or endorsed by Taylor & Francis. The accuracy of the Content should not be relied upon and should be independently verified with primary sources of information. Taylor and Francis shall not be liable for any losses, actions, claims, proceedings, demands, costs, expenses, damages, and other liabilities whatsoever or howsoever caused arising directly or indirectly in connection with, in relation to or arising out of the use of the Content.

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-licensing, systematic supply, or distribution in any form to anyone is expressly forbidden. Terms &

Conditions of access and use can be found at <http://www.tandfonline.com/page/terms-and-conditions>

Emotionally Focused Family Therapy: Facilitating Change Within a Family System

KATHERINE STAVRIANOPOULOS

Department of Counseling, John Jay College, City University of New York, New York, New York, USA

GEORGE FALLER

New York Center for Emotionally Focused Therapy and Ackerman Institute for the Family, New York, New York, USA

JAMES L. FURROW

Fuller Graduate School of Psychology, Pasadena, California, USA

Adolescent transition to adulthood is often challenged in families with high levels of anxiety, distress, and emotional conflict. Attachment theory offers a robust developmental model for conceptualizing emotional distress and symptomatic behavior as an adaptive response to emotional insecurity in parent–child relationships. Recent developments in emotionally focused family therapy (EFFT) and attachment-based family therapy demonstrate promising empirical support for the application of attachment theory to the treatment of childhood disorders and family distress. However, few resources exist that demonstrate the practice of EFFT and its conceptual approach to facilitate family change. The authors demonstrate the successful application of EFFT to a parent–adolescent problem and examine key moments in the process of change from an attachment perspective.

KEYWORDS *emotionally focused family therapy, adolescence, attachment*

Address correspondence to Katherine Stavrianopoulos, Department of Counseling, John Jay College, CUNY, 524 W. 58th Street, Room L.68.12, New York, NY 10019, USA. E-mail: stavros@jjay.cuny.edu

INTRODUCTION

Resilient families adapt to the changing developmental needs of family members. These changes often create practical and emotional demands that require families to respond with increasing flexibility while affirming access and investment in the emotional ties that are central to family life (Walsh, 1998). The transition to adulthood presents common challenges for couples and families as developmental tasks shift and demands change within the family system.

Families with adolescent children must adjust to the separation–individuation for the adolescent to gain autonomy while, at the same time, maintaining an ongoing connection with her or his parents (Allen & Land, 1999). Families who have developed and maintained secure emotional bonds are best able to weather the storm and successfully move through the conflicts typically associated with this uniquely challenging phase. Unfortunately, families whose emotional attachments are tenuous at best are likely to find themselves engaged in severe conflictual relationships, ultimately turning to family mental health professionals for assistance to cope with their relationship distress (Aquilino, 1999).

Attachment theory offers a promising approach to treating families caught in reactive patterns associated with these predictable periods of adjustment. Increasingly, clinical approaches are considering ways to conceptualize and treat youth caught in negative patterns of hostility, criticism, and emotional overinvolvement. There have been some emerging attachment-based family interventions with adolescents (Mackey, 2003; Moretti & Holland, 2003) and younger children (Hughes, 2007). However, there are only two family therapy models demonstrating promising empirical support for the application of attachment theory to the treatment of childhood disorders and family distress. These are attachment-based family therapy (ABFT; Diamond, Siqueland, & Diamond, 2003) and emotionally focused family therapy (EFFT; Johnson & Lee, 2000; Johnson, Maddeaux, & Blouin, 1998). Currently, however, few resources exist that demonstrate the practice of EFFT and its conceptual approach to change.

This article provides an overview of EFFT and illustrates the successful treatment of family distress linked to parental efforts to help their symptomatic adolescent son. The case focuses on two primary change events that demonstrate the therapist's use of emotion to promote change. Previous case examples (Johnson, 2004; Johnson et al., 1998) illustrate the therapist focus on parent–child dyadic interaction, whereas the examples in this case demonstrate the therapist setting up change events in a triad between parents and the identified patient. This article illustrates how an EFFT therapist remains flexible and creative in engaging the family and promoting increased accessibility and responsiveness across the family system.

ATTACHMENT AND ADOLESCENCE

Adolescence typically brings profound changes in the parent–child relationship (Aquilino, 1997, 1999; Bucx & van Wel, 2008). As youth attempt to shed parental dependencies conflict amplifies between them and their parents, compromising emotional accessibility and responsiveness and hindering attachment security. Attachment needs for security, contact, and protection are more intense in times of transition and crisis when the responsiveness of the other is most important. Securely attached individuals are able to turn to their attachment figures for comfort and support (Shaver & Mikulincer, 2002). Insecurely attached adolescents tend to heighten expressions of anxious response and demand reassurance or disengage and avoid expressions of distress, particularly in the moments they need support (Bowlby, 1973; Johnson, 2002; Kobak, 1999).

Attachment anxiety and avoidance can be viewed as natural responses to the lack of confidence in the parents' emotional availability. When a parent appropriately responds to the child's need for connection, the child generally develops a secure attachment (Bowlby, 1988; Gillath, Selcuk, & Shaver, 2008; Waters & Cummings, 2000). However, when a child's attachment needs are not effectively met they develop strategies to cope with separation distress. These strategies are described in two main dimensions: anxiety and avoidance (Ainsworth et al., 1978; Brennan, Clarke, & Shaver, 1998; Crowell, Fraley, & Shaver, 2008). In the anxious–clinging pattern the attachment system becomes hyperactivated and behaviors are characterized by anxious clinging and pursuit; angry attempts to obtain a response from the attachment figure escalate. In the detached–avoidance strategy, the attachment system is deactivated (Cassidy & Kobak, 1988), and the attachment needs are suppressed.

Drawing from attachment theory, EFFT therapists conceptualize distress in terms of attachment dilemmas in which ineffective responses to attachment needs drive family communication problems, creating parenting dysfunctions and exacerbating symptoms associated with individual psychopathology (Johnson et al., 1998). For the EFFT therapist an “acting-out” adolescent is perceived as one who is struggling with an individual need for autonomy and a continuing need for emotional connection to his parents (Palmer & Efron, 2007).

In EFFT the therapist must obtain a clear understanding of the adolescent's symptomatic behavior that produces distress in the family and then systematically move to evaluate the quality of the relationship between adolescent and parent(s). The therapist evaluates the parent(s) availability and the adolescent's confidence in their availability. Observations of parent–adolescent interactions provide the therapist with information for assessing attachment quality.

Secure attachment is evident when a parent is able to empathize with and understand the adolescent's goals, directly communicate appropriate parental concerns, and flexibly negotiate conflicts (Allen & Land, 1999; Kobak & Duemmler, 1994). Insecure attachment is evident in severe restrictions of the parent's capacity for empathy (Fonagy & Target, 1997). When feelings of anxiety and anger take precedence, the parent's view of the youth shifts to that of a hostile individual. The parent's frustration with the adolescent further reduces mental freedom for exploring alternative views, perspective taking, and problem solving (Bugental, 1992). As a result, the parent(s) will often adhere to a view of the adolescent as negativistic, uncooperative, and hostile and have difficulty perceiving the underlying sources of the adolescent's fear, rage, or sadness—often identifying the adolescent as the one with the problem (Kobak & Mandelbaum, 2003).

The EFFT therapist links the adolescent's symptoms to perceived threats to the caregiver's availability and responsiveness as well as other sources of insecurity in the child's life. When communication is difficult between adolescent and parent, it fosters the perception of the parent being unavailable. These perceptions increase a child's anxiety, anger, and defensive behavior that contribute to the adolescent's presenting problems (Bowlby, 1973; Miccuci, 1998). The EFFT therapist frames the problem in attachment terms and normalizes the family's distress as arising out of attachment-related distress (Johnson et al., 2005).

OVERVIEW OF EFFT

EFFT offers a specific approach to facilitating change in family patterns of emotional distress often related to problematic behaviors or psychological symptoms of children (Johnson et al., 1998). Negative cycles of emotional reactivity mutually reinforce patterns of insecurity in parent-child and sibling relationships (Johnson, 2004). The interruption of parental accessibility and responsiveness decreases a family's ability to cope and respond to the emotional demands that are often symptom related. EFFT guides parents and children to reengage in a more secure emotional bond through accessing, expanding, and engaging their primary emotions and attending to unmet attachment needs (Johnson, 2004; Johnson & Lee, 2000).

The EFFT therapist uses attachment theory as a map for organizing the patterns of emotional dysregulation common to distressed families (Johnson et al., 2005). Family patterns of distress increase in both their rigidity and influence as parents and children move to more complementary positions through escalating efforts to force a change or through withdrawing from the interaction altogether (Kobak & Mandelbaum, 2003). Family conflicts are seen as relational dilemmas rooted in the unmet and often unexpressed attachment needs of family members (Furrow & Palmer, 2007).

The therapeutic goals of EFFT are to change the distressing cycles of interaction that magnify conflict and undermine the potentially secure connection between parents and adolescents; it also aims to increase accessibility and responsiveness, thus helping the family create a secure base for youth to grow in and leave from (Johnson, 2004). Secure attachment is defined as the degree of confidence a family member has that other family members will provide support, comfort, and protection and will remain emotionally available (Johnson et al., 2005).

THE PROCESS OF EFFT

The EFFT therapist begins treatment with one or two family sessions focused on the presenting problem and assessing dynamics with relevant family members. The therapist builds an alliance with family members through inviting each person's view regarding the presenting problem and how the family tried to resolve their distress. The therapist proves accessible and responsive to family members through reflecting and validating each person's experience of the family and her or his presenting concerns (Johnson, 2004). As family members discuss how they each perceive their concerns, reactive emotional responses are expressed or suppressed, thus allowing the therapist to witness the negative interaction pattern firsthand. The therapist tracks and reflects the behaviors that elicit the negative response and begins to identify the family pattern that is associated with the problem (Johnson, 1996, 2004).

Often the therapist engages different family subsystems, usually in dyads or triads, to explore the impact of the negative family patterns on those subsystems. These family dyads or triads include the parental subsystem, sibling subsystem, identified patient (adolescent), mother and adolescent, father and adolescent (Johnson, 2004). These subsystem sessions enable the therapist and family to refine impressions of the family's interactional patterns and the specific emotions that drive them. The therapist's goal is to make explicit the relationship of the patterns of emotional response to the presenting problem (Johnson et al., 1998). The therapist reframes the family problem as one arising out of an attachment crisis and thus normalizes family difficulties without blaming anyone (Palmer & Efron, 2007).

Family patterns are highlighted with specific attention given to the positions parents and children take in periods of heightened distress. It is similar in this regard to emotionally focused therapy for couples; family members tend to react to insecurity in the family through predictable responses to emotional distress (Johnson, 2004). These may include: withdrawing, pursuing, blaming, or placating. Underlying these responses are attachment strategies of avoidance and anxiety that represent adaptive attempts to correct for insecurity that is experienced in the family system (Kobak & Mandelbaum, 2003). Rigid patterns emerge as efforts to control or coerce change and are

met with responses of withdrawal or heightened defensiveness. The EFFT therapist reframes maladaptive or secondary emotional responses as part of a broader negative interactional pattern that organizes the family around insecurity rather than vulnerability. The therapist helps family members access underlying emotions and attachment needs (Johnson, 2004). Accessing primary emotions such as fear, hurt, and sadness creates empathy among family members, facilitates responsiveness, and helps the family deescalate (Johnson et al., 2005).

In the second stage of EFFT, the therapist facilitates the restructuring of the reactive family patterns identified in stage one. Typically the focus of Stage Two is on accessing and expanding the unmet attachment needs of children and youth as well as promoting parental accessibility and responsiveness to children's experienced underlying emotions and needs (Johnson, 2004). The change event in stage two involves the therapist facilitating the enactment of children reaching out to their parents with these underlying needs (Johnson et al., 1998). This shift is premised on the parent(s) responsiveness to both the child's vulnerability and direct request for care, contact, or comfort. As Bowlby (1988) recognized, fear may block a child from making bids for attachment. During stage two the therapist recognizes the need to support both children and parents in working through the fears often associated with the vulnerability experienced in distressed family relationships and reengaging new patterns of availability and responsiveness (Johnson, 2004).

The final stage of EFFT focuses on consolidation of the changes families have made in stage two. At the end of this stage, the family is able to integrate the new ways of engaging discussions and investing in greater security (Johnson et al., 2005). Discussions are characterized by more openness, responsiveness, and engagement among family members. It is imperative for the family to learn how to repair failed attempts to connect outside of session. Before termination, the therapist wants to see the family handle old problems by going underneath and resolving the issues in new ways. The therapist also wants to help the family amplify their vision to include more mindfulness of positive affect, vulnerable reaching, and the benefits of connection.

The following case example illustrates the successful treatment of distress in a family with an adolescent. The case focuses on two primary change events in the treatment: deescalation and shaping of new patterns of family accessibility and responsiveness.

CASE EXAMPLE

Joseph and Jenna, a couple in their 40s, were married for 20 years and had four sons; Stephen (17 years old), Tony (14), Michael (12), and Ben

(10). The presenting problem described by the parents focused on their son Tony, whose negative behaviors disrupted family cohesion. EFFT therapists typically meet first with the entire family and then with family subsystems (Johnson, 1998). In this case, the therapist first met with the parents, then in the second session with all four siblings, and finally with the entire family. The parents organized their concern around Tony's increasing oppositional behavior. He frequently argued with his brothers, was disrespectful to his parents, acted out with peers, and obtained poor grades. Joseph and Jenna found Tony's efforts to individuate increasingly difficult for the family and felt at a loss as to how to best manage his growing independence. Tony had been treated previously for attention-deficit/hyperactivity disorder and was prescribed medication as a part of his course of treatment. Both parents were supportive and loving towards each other and loved Tony; however, they felt helpless in dealing with his behavior. In the sibling session all of the brothers were motivated to get along better and fight less but were skeptical that Tony could change.

In the family session, it was clear to the therapist that all members were caught in a reactive pattern of defensiveness, which escalated with increasing anger and frustration. The family attempted to resolve conflicts by getting into content details and attempting to prove each other wrong. A typical escalation would include their initial attempts to stop the arguing and yelling; then dad and two of the brothers (Stephen and Ben) would withdraw, whereas mom, Tony, and Michael would continue to engage angrily in conflicts that were rarely resolved. The impact of these fights only reinforced the tension and disconnection that increasingly defined the family's experience.

KEY EVENTS IN THE PROCESS OF CHANGE

Stage One: Cycle Deescalation

After the initial three sessions, the therapist met with the whole family for sessions four and five. Snapshots of sessions below capture significant elements of the change process occurring in the first two stages of EFFT. The first excerpt illustrates therapist involvement in reflecting the present patterns by following the process of interaction between family members, focusing on the relationship between Stephen and Tony. The therapist explores and expands the processing of attachment-related emotions and uses her or his experience to set up interactional tasks that enact and thus clarify the present interactional positions.

THERAPIST: Last time we talked about the different ways people learn to protect themselves when they feel threatened. Some of us try to go away to avoid further threat while others actively force the issue. I realize we

all do some of both but I'm trying to get a feel for the predominant way each one of you protects yourself during a fight or when you are stressed. (*Therapist assessing family members' awareness of their predictable secondary, emotional responses*).

MICHAEL: Well, Stephen, Ben, and Dad all go to their rooms when they are mad. Mom and Tony usually start yelling at everyone, and I try to keep the peace by talking it out.

TONY: Yeah, right! You cause just as much trouble as me. You cause most of our fights by stealing my stuff; it's just that everyone blames me.

MOM: Hey, quit it you two. We are not here to fight.

One minute into the session and the therapist can already see the negative cycle taking off; Mom, Tony, and Michael jump into the conversation while Dad, Stephen, and Ben stay out.

THERAPIST: Stephen, I noticed when Tony and Michael were arguing you rolled your eyes and looked away. What happens for you when they fight? (*Therapist asks evocative question highlighting possible body reaction and secondary emotional response*).

STEPHEN: It is so stupid. All they do is argue and neither one is listening to the other. I wish they both could grow up.

TONY: Sure, you are Mr. Mature, Mr. Cool Guy. You are a big loser!

STEPHEN: Like I was saying just before Tony the troublemaker jumped in. Always . . .

THERAPIST: Hold on a second, Stephen, I just want to slow this down a little bit. What just happened now as Tony jumped in, saying "Mr. Cool Guy the big loser"? (*Evocative question focusing on emotional trigger leading to a secondary emotional response*).

STEPHEN: I get frustrated and I want to get back at him, but what's the point?

THERAPIST: Right, so what happens if you say something to get back at Tony?

STEPHEN: It only makes it worse. Tony doesn't listen to anyone. I just go away to stop the fighting and get out.

THERAPIST: So, if talking only makes it worse then it makes sense why you don't engage. Correct me if I'm wrong, but it is almost like there is nothing you can do when these fights happen but leave. (*Therapist reflects and validates the action tendency to withdraw and conjectures about underlying helplessness*). Do you feel like there is nothing you can do when the fighting starts?

STEPHEN: There's nothing. I feel that I can't make any kind of change. My only choice is to avoid the argument.

THERAPIST: So, you get away because you feel that you can't stop the fight. That makes sense to me. What do you think it will be like to tell your brother Tony that the reason you leave is because you don't know what to say to make a difference? (*Therapist validates his secondary response and evokes a new level of experience by asking Stephen to engage with his brother in a discussion about his tendency to withdraw*).

STEPHEN: That would be weird. He heard me say it to you.

THERAPIST: It certainly would be weird. Most families do not know how to talk about their feelings. You are doing a terrific job describing how anyone would feel when they are feeling stuck and don't know what to do. The reason it's important is because your brother only sees you walking away and is left not knowing what is happening. I think this is a big step in showing your entire family how to speak in a different way. What do you think, can you try? If it feels too weird we can skip it. (*Therapist validates Stephen's experience and provides support for the proposed enactment*).

STEPHEN: Okay, I'll give it a shot. (*Looking at Tony and smiling*) When I walk away it's because I feel I can't do anything to stop the fighting. I don't want to fight and I don't know what else to do.

TONY: (Makes a confused look with his face).

THERAPIST: Tony, I noticed a look on your face—surprised or confused. What is happening for you? (*Therapist uses an evocative question to draw out Tony's response*).

TONY: Wow, I never knew he didn't know what to do. I just assumed he didn't care and didn't want to bother. (*Enactment was successful. Tony has a new understanding regarding his brother's behavior and they both share in the new experience of staying engaged*).

THERAPIST: So WOW, you are discovering something new about Stephen. That's pretty cool. What is that like? (*Therapist asks evocative question focused on positive emotion*).

TONY: I don't know. He never hangs around. He doesn't care. All he does is go away on his own. (*Tony is not able to stay in the positive affect of wow. He exits into the familiar mistrust of the negative interaction cycle. This escalation from primary emotion to reactive secondary responses is a common response of protection characteristic in Stage 1.*)

THERAPIST: Right, and when it seems to you he doesn't care by walking away what happens to you? (*Therapist asks evocative question focused on possible negative emotion.*)

TONY: I get pissed. I hate it when he walks away. I usually follow him and let him know he's a jerk. Brothers should care about each other, not stay in their own world.

THERAPIST: So, of course you would get angry. I guess I'm curious about what it feels like when you think Stephen doesn't care about you? (*Therapist validates the defensive anger and follows with an evocative response focused on the attachment theme of "do I matter?"*).

TONY: It feels unfair. It feels bad. I want him to care (*looking down at the floor*).

THERAPIST: We all want our family to care about us. Of course it feels bad. You want to spend time with your big brother and it feels sad when it seems like he doesn't? (*Therapist validates and reflects possible emerging underlying emotion.*)

TONY: Yeah (*still looking at the floor*).

THERAPIST: I notice Tony you looking at the floor. This is tough to talk about. Like Stephen, you are doing a great job talking in a different way. What do you think it would be like to tell Stephen that underneath the anger you feel bad because you think he doesn't want to be around you? (*Therapist validates, reflects possible underlying emotion, and invites a possible enactment.*)

TONY: (*Still looking at the floor but talking to Stephen*) It feels like you never want to be around me, like I'm too annoying and you don't like me.

STEPHEN: I do care about you I just don't want to be around the fighting. I don't want you to feel bad and I don't want to feel bad either.

Tony wanted to be around Stephen but often something happened that triggered Stephen to think a fight was imminent. He immediately pulled

away and retreated to avoid the argument. When he disengaged Tony felt rejected and believed Stephen did not like being around him. Tony then got frustrated; this reinforced Stephen's disengagement, thus confirming Tony's fears of rejection. Both positions the brothers take in this interaction make sense but, when put together, each brother's response perfectly reinforces the other boy's underlying attachment fears (Stephen—helplessness/failure, Tony—rejection). Neither one is able to talk about his underlying feelings, leaving only arguments and disengagement to organize their relationship.

Deescalation occurs as family members identify and experience the secondary responses they use to control and avoid negative experiences, the underlying attachment needs that fuel these responses, and how their defensive responses to unmet attachment needs trigger further protection in others. To change the cycle the therapist needs all members to understand their part in the pattern and how their attachment-driven behaviors trigger predictable responses in other family members. This awareness is crucial to shifting the family members' stance from blaming and avoiding to working together. Although Tony and Stephen at the end of this stage may not know how to change their pattern, they recognize each other's underlying attachment needs and how their defensiveness strengthens their quandary. Reframing the problem as the interplay between their defenses, not the essence of each person, is movement toward uniting against an external problem to create greater security. This shift constitutes the first EFFT change event, cycle deescalation.

The deescalation was evident following the shift in Tony and Stephen's interaction. The brothers opened up a doorway to sharing their vulnerability, offering the family hope that the brothers did share concern for each other and that their relationship mattered. Their mutual efforts to express and respond at a primary level provided other family members with a new opportunity to respond. In the session Jenna responded to her own vulnerable feelings by sharing how she felt sad for her sons, which demonstrated her attunement to their experience and a new position in relation to the boys fighting.

Everyone in the session experienced a positive outcome to a conversation that characteristically ends in negativity and greater distance. Witnessing the conversation between their sons, both parents experienced a new, expansive awareness of their children's needs; this reduced the parents' reactivity and anxiety while increasing their gratefulness and hope for the family. Their narrow position of seeing Tony as the "troublemaker" changed to a more open stance that views his behavior as protection against unmet needs. This transition toward calmness and an eagerness to engage in a different way is an indication the family is primed for the restructuring of stage two.

Stage Two: Shaping New Cycles of Responsiveness and Accessibility

In the sixth session the therapist met with the parents to further assess the family's progress and awareness of the family's negative interactional cycle. Both were more hopeful and accepted accountability for how their own defensive responses often fueled family escalations and their own fears and concerns. They wanted a chance to repair with Tony, although all their previous attempts had failed. Both parents identified how their reactive positions blocked their best efforts to express care to Tony. Jenna described her criticism and anger as protection for her underlying feelings of shame and failure. Her angry approach typically resulted in Tony's withdrawal. Joseph often expressed frustration at not being able to "fix" Tony and tried to talk Tony out of his experience, further increasing Tony's withdrawal. When the parents tried to discuss Tony's behavior, they often entered their own problem cycle with Jenna blaming and Joseph defending. These arguments reinforced Tony's withdrawal and fears of being the "problem child." This shift in the parents' stance from defensive blaming to curiosity about Tony's underlying experience signaled their desire to engage their son in a different way; their desire to be more responsive and accessible to his concern held promise for a secure level of care giving.

The therapist scheduled the seventh session between Tony and his parents to help the parents take a new position of engagement toward Tony's needs. The therapist started the session by validating and "leaning into" Tony's anger and frustration instead of trying to talk him out of his experience. Giving permission for Tony's anger and mistrust became an essential first step toward lowering his defensiveness and accessing his underlying emotions of sadness and fears related to not being good enough. As Tony's parents began to attune to his attachment hurt, the opportunity arose for Tony and his parents to come together around this pain. The following excerpt is from the seventh session.

THERAPIST: So, it feels like you never fit in with your family, which must be pretty annoying. If you try to fix the problem and talk about it, it leads to more fighting, and if you go away you get the message that is also wrong. Either way you are stuck. That must be really frustrating. (*Therapist tracks and validates secondary emotion*).

TONY: The point is that everyone else sees me as the problem. Even though they might not admit it, they look at me different. Even if they think that I don't see it—it's so stupid—cause I do see it.

THERAPIST: That must feel pretty terrible. I guess I'm curious—how do you think Ben would feel if everyone saw him as the problem? (*Therapist reflects and heightens underlying emotion by focusing on imagined experience of Tony's brother*).

TONY: He would be dead. I don't think he would want to live and he would kill himself. If anyone understood my pain they would do something to fix it, they would understand me and they would treat me so much better. But no one understands it because no one is in the position I am. *(This is first time Tony has ever mentioned his pain; previously he just expressed anger and indifference. Therapist assesses for suicidal ideation before continuing).*

THERAPIST: It's pretty amazing how you have been able to survive with all that pain. *(Therapist validates and acknowledges how Tony has been carrying this pain).*

TONY: I try not to think about it.

THERAPIST: And then, when you think about it and try to talk about the terrible pain, what happens? No one hears it or responds? *(Therapist is giving permission for the protection; if no one responds to our needs then we learn not express them).*

TONY: No one understands. Even if they think they are listening nothing is ever done. There is never any understanding because the change that needs to be made is not made. I can't even explain it . . . it sounds crazy.

THERAPIST: It's not crazy at all. I think the way you describe it with Ben . . . that was really touching for me to hear, the extent of how often you grapple and struggle with this pain . . . how often you block these feelings because it doesn't seem like anyone can hear them. The only thing you have is your anger to protect you from this pain and sadness. If I had a choice between feeling all this terrible pain and being angry, I would choose the anger too. It's a terrible place for you to be. *(Therapist normalizes Tony's story and uses self-disclosure to let Tony know that his emotional experience impacts the therapist).*

Tony looks down holding back tears. Mom reaches over to touch him and he pulls his arm away and asks her to stop, rejecting her attempt to comfort him.

TONY: Don't touch me. I'm sick of being the one seen as different, as your project. Everyone is waiting for me to change while they do nothing differently.

THERAPIST: Right. This is hard for you. You feel that something is wrong with you, that you need to change. What I think makes this hard is when you get to the heart of the matter and you have tears in your eyes and you talk about this terrible place and the pain you are in. When your mom sees that and your dad sees that, they feel bad and they want to do it differently and they want to reach to you, and yet your body says "No, I

can't trust this" and pushes it away. (*Therapist reflects present interaction and normalizes Tony's mistrust*).

TONY: Because it's not the first time they tried and they are doing it because they don't want anyone to fight but they don't understand that it doesn't just end like that for me.

MOM: (*tears in her eyes*). This is why we are here to figure out a new way. Help me . . . help us understand what is going on for you.

Pause.

THERAPIST: Tony, do you hear your mom? She wants to know. She wants to know about your hurt. Do you think you can let her in? Can you tell her what it is like for you when you go to that alone place where no one seems to understand you? (*Therapist is trying to access Tony's primary emotion underneath the mistrust and shift his focus from his mom to himself*).

TONY: (*looking down*) Since I was little, I have felt that there was something wrong with me. No matter what I did or wanted it was not right and you had to fix it or change my mind about it. It was like I was your "forever project." Now, I feel that I'm not good enough, and when you get upset with me, I just tell you I don't care. I can never get it right and make you proud of me and, if I ever get close to it, your standards immediately go up. And I just give up."

THERAPIST: That's awful for you and it must be so difficult to be in that place. Trying so hard, not being seen for getting it right. (*Therapist is reflecting Tony's attachment dilemma and using empathy to help Tony stay in his vulnerability*).

MOM: Tony, it pains me that I can't reach you the way you want me to reach you and listen to you. I don't want you to feel that there is something wrong with you and that I want to fix you or change you. I don't want you to give up on me, and I want to learn how to be supportive." (*Mom is now wiping tears*).

TONY: (*in a low voice*) I was telling you what was wrong, but no one listened, and the best option for you was to put me on medication, take me to the hospital, and in therapy.

DAD: When we started to worry about you—that you weren't happy, we had to do something. We began to worry as parents do . . . they worry about their kids all the time and we didn't know what to do and we sought advice. And it took us down the path that you lived and experienced and has taken you to this awful place. I never knew how

painful it was for you. And in hindsight we were wrong. We were wrong. Wrong to not listen to you more closely even though you were only in fifth grade. We were wrong about the medication. We . . . needed help and we didn't know what to do and we still don't. In all that we did we were driven by one motive only, our love for you. And (*he begins to cry*) I'm sorry if the things we did were wrong. And I'm sorry that it caused you so much pain. (*Mom is now wiping her tears as she reaches over and touches her husband's shoulder and they both embrace. Both weep as they hold each other for a few long moments. Tony glances over at his parents*).

THERAPIST: What is happening to you, Tony, as you see your mom and dad crying?

TONY: (*hesitating*) Well, it's really good to hear that and for them to say that the therapy and medication were wrong to do without asking me, but I'm not sure what to say. (*Tony's emerging reaction is hesitant and unformulated*).

THERAPIST: That seems like a pretty big deal for them to see your position. What's it like to see your dad so sad because he touched a place where he feels so bad for all that hurt you experienced? (*Therapist sharpens the focus and heightens Tony's emotional response to his father's more responsive position*).

TONY: It's good to see that they understand me.

THERAPIST: It feels like your dad finally understands that painful place where you feel so different? (*Therapist provides empathic conjecture about father's response to son's attachment affect*).

TONY: It's the first time in my life where I hear him accept that he made a decision that wasn't exactly the best one. I think he is seeing my point of view for the first time ever. I never thought he'd ever understand.

THERAPIST: That is pretty cool. To finally be seen and understood.

DAD: (*holding his wife's hand*) Everything we did we did together for you; we share in the mistakes and in the things that we've done better. I want you to know that . . . (*Tears are running down his face. Mom reaches over to put her arm on Tony's shoulder and this time Tony allows her to leave it on his shoulder. Dad gets up from the couch where he was sitting next to his wife and moves to a chair next to Tony. He reaches over and embraces him with a big hug*).

DAD: I'm so sorry. (*He rubs the back of his son's head. Tony allows the affection*).

Mom, crying, gets up and kneels down next to Tony; she reaches out to rub his leg.

MOM: I'm so, so, sorry . . . I love you so much. I never knew you were in so much pain. We will do it differently now that we understand. I get how hard this has been, why you have so much doubt and mistrust. You will not be alone in that place anymore. (*Tony's body relaxes as he leans into his Dad's hug and his Mom's comfort*).

This session provides a powerful example of the power of a family's attachment bonds and how restructuring can bring about healing and transformation. It was the first time Joseph apologized and showed his vulnerability to Tony by crying. Typically Joseph justified his reasons and minimized Tony's complaints. In session, Joseph took Tony's experience seriously and risked joining him in his pain. Tony was able to go underneath his angry protests and share his previously unformulated attachment pain and need for understanding, in response to his parent's comfort and level of emotional engagement. This powerfully illustrates two parents working together to respond to the attachment needs of their son. The ability to keep focused on Tony and connect with him around his hurt was crucial. Often parents can't empathize because they get caught up in their own secondary responses of fear in relation to parenting and fail to support one another in responding to the source of their fears.

Joining Tony in his vulnerability enabled both parents to get a felt sense of how Tony's problematic behaviors were intrinsically related to the family's negative interactional pattern, that pushed all members into deeper levels of emotional distress and especially isolated Tony in his pain and fear without means of relational support. Tony turned against himself and, sadly, self-contempt and shame were predictable outcomes of his isolation.

EFFT is so promising because it helps families engage these negative symptoms, patterns, and emotions differently by providing comfort, care and connection—the antidotes to isolation (Johnson, 2004). Tony's parents responded with empathy and care, which enabled Tony to return to his developmental pathway by means of secure attachment with his family (Byng-Hall, 2000). With increased mutuality and the resultant attachment security, Tony's individuation is no longer viewed as a threat to the family but rather as healthy development. The EFFT process unleashes the power of connection to positively shift views of self and other (Johnson et al., 2005). In the love of his parents' understanding and responding, Tony could relax his defenses, engage more positive emotions, and use his freed up energy toward expanding and thriving.

SUMMARY AND TREATMENT IMPLICATIONS

The preceding case demonstrates two EFFT change events with a family navigating the attachment issues and developmental issues of adolescence. The case illustrates how family relationships are critical attachment-related resources to the primary caregiving alliance found between children and their parents. The EFFT therapist fosters deescalation of family distress through accessing the attachment bonds of sibling brothers. This enables the family to see not only the negative pattern playing out between the brothers but also the reactive positions other family members had to the increasing pain and insecurity in the family system. Similarly, the second change event highlights how a couple's responsiveness in their own relationship can strengthen their individual parental responses to their child's emerging attachment needs. Both provide clear examples of the equifinality of EFFT and the various ways a therapist may promote felt security to transform family patterns.

Families present with distress as a result of attachment insecurity, which is typically evident in a child's or adolescent's inability to get their attachment needs met. Family members have little awareness or skill in expressing their attachment needs and protect themselves in consistent ways. Developmental changes add new stress on families. In attachment terms, these changes can threaten accessibility and responsiveness of parent/child relationships. Insecurity may be experienced in other subsystems as well. Accessing underlying attachment-related emotions and the needs associated with these emotions opens the family to address family needs in new ways (Johnson, 2004). Finding predictable ways to mitigate distress and advance connection is the requisite challenge of our times. The therapist possessing a map to make sense of these attachment dilemmas provides guidance and hope. The family doing the work of risking sharing their needs and taking in the response of another member is the clear path of security and thriving.

Although the clinical relevance and initial clinical trial supports EFFT's effectiveness (Johnson et al., 1998), the model as a robust model of family therapy remains unexplored. Changing key interactions with loved ones is a powerful and efficient way to create change, but the multiplicity and complexity of relationships in families makes organizing the dynamics challenging (Johnson et al., 2005). EFFT promises a model sensitive to the developmental changes families face and a robust theoretical approach for directing therapists to a family's resources and needs. Building on almost 30 years of research on Emotionally Focused Couple Therapy, EFFT promises therapists a practical and powerful model for strengthening family resilience and the resources found in its most important relationships.

REFERENCES

- Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the Strange Situation*. Hillsdale, NJ: Erlbaum.
- Allen, J. P., & Land, D. (1999). Attachment in adolescence. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 319–335). New York, NY: The Guilford Press.
- Aquilino, W. S. (1997). From adolescent to young adult: A prospective study of parent-child relations during the transition to adulthood. *Journal of Marriage and the Family*, *59*, 670–686.
- Aquilino, W. S. (1999). Two views of one relationship: Comparing parents' and young adult children's reports of the quality of intergenerational relations. *Journal of Marriage and the Family*, *61*, 858–870.
- Bowlby, J. (1973). *Attachment and loss: Vol. 2. Separation*. New York, NY: Basic Books.
- Bowlby, J. (1988). *A secure base: Clinical applications of attachment theory*. London, England: Routledge.
- Brennan, K. A., Clarke, C. L., & Shaver, P. R. (1998). Self-report measurement of adult romantic attachment: An integrative overview. In J. A. Simpson & W. S. Rholes (Eds.), *Attachment theory and close relationships* (pp. 46–76). New York, NY: The Guilford Press.
- Bucx F., & van Wel, F. (2008). Parental bond and life course transitions from adolescence to young adulthood. *Family Therapy*, *35*, 109–126.
- Bugental, D. (1992). Affective and cognitive processes within threat-oriented family systems. In I. E. Sigel, A. V. McGillicuddy-DeLisi, & J. J. Goodnow (Eds.), *Parental belief systems: Psychological consequences for children* (2nd ed., pp. 219–248). Hillsdale, NJ: Erlbaum.
- Byng-Hall, J. (2000). Diverse developmental pathways for the family. *Journal of Family Therapy*, *22*, 264–272.
- Cassidy, J., & Kobak, R. (1988). Avoidance and its relation to other defensive processes. In J. Belsky & T. Nezworski (Eds.), *Clinical implications of attachment* (pp. 300–323). Hillsdale, NJ: Erlbaum.
- Crowell, J. A., Fraley, R. C., & Shaver, P. R. (2008). Measurement of individual differences in adolescent and adult attachment. In J. C. Cassidy & P. R. Shaver (Eds.), *Handbook of Attachment: Theory, research, and clinical applications* (pp. 599–634). New York, NY: The Guilford Press.
- Diamond, G. S., Siqueland, L., & Diamond, G. M. (2003). Attachment-based family therapy: A program of treatment development. *Clinical Child and Family Psychology*, *6*, 107–127.
- Fonagy, P., & Target, M. (1997). Attachment and reflective function: Their role in self-organization. *Development and Psychopathology*, *9*, 679–700.
- Furrow, J. L., & Palmer, G. (2007). EFFT and blended families: Building bonds from the inside out. *Journal of Systemic Therapies*, *26*, 44–58.
- Gillath, O., Selcuk, E., & Shaver, P. R. (2008). Moving toward a secure attachment: Can repeated security priming help? *Social and Personality Psychology Compass*, *2*, 1651–1666.

- Hughes, D. A. (2007). *Attachment-focused family therapy*. New York, NY: Norton.
- Johnson, S. M. (1996). *The practice of emotionally focused marital therapy: Creating connection*. New York, NY: Brunner/Mazel.
- Johnson, S. M. (2002). *Emotionally focused couple therapy with trauma survivors: Strengthening attachment bonds*. New York, NY: The Guilford Press.
- Johnson, S. M. (2004). *The practice of emotionally focused couple therapy: Creating connection* (2nd ed.). New York, NY: Brunner-Routledge.
- Johnson, S. M., Bradley, B., Furrow, J., Lee, A., Palmer, G., Tilley, D., & Wooley, S. (2005). *Becoming an emotionally focused couple therapist: The workbook*. New York, NY: Brunner-Routledge.
- Johnson, S. M., & Lee, A. (2000). Emotionally focused family therapy: Restructuring attachment. In C. E. Bailey (Ed.), *Children in therapy: Using the family as a resource* (pp. 112–136). New York, NY: Norton.
- Johnson, S. M., Maddeaux, C., & Blouin, J. (1998). Emotionally focused family therapy for bulimia: Changing attachment patterns. *Psychotherapy, 35*, 238–247.
- Kobak, R. (1999). The emotional dynamics of disruption in attachment relationships: Implications for theory, research, and clinical intervention. In J. Cassidy & P. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 21–43). New York, NY: The Guilford Press.
- Kobak, R., & Duemmler, S. (1994). Attachment and conversation: Toward a discourse analysis of adolescent security. In K. Bartholomew & D. Perlam (Eds.), *Advances in personal relationships: Vol. 5. Attachment processes in adulthood* (pp. 121–149). London, England: Jessica Kingsley.
- Kobak, R., & Mandelbaum, T. (2003). Caring for the caregiver: An attachment approach to assessment and treatment of child problems. In S. Johnson & V. Whiffen (Eds.), *Attachment process in couple and family therapy* (pp. 144–164). New York, NY: The Guilford Press.
- Mackey, S. K. (2003). Adolescence and attachment: From theory to treatment implications. In P. Erdman & T. Caffery (Eds.), *Attachment and family systems: Conceptual, empirical, and therapeutic relatedness* (pp. 79–113). New York, NY: Brunner-Routledge.
- Miccuci, J. A. (1998). *The adolescent in family therapy: Breaking the cycle of conflict and control*. New York, NY: The Guilford Press.
- Moretti, M. M., & Holland, R. (2003). The journey of adolescence: Transitions in self in the context of attachment relationships. In S. M. Johnson & V. Whiffen (Eds.), *Attachment processes in couple and family therapy* (pp. 234–257). New York, NY: The Guilford Press.
- Palmer, G., & Efron, D. (2007). Emotionally focused family therapy: Developing the model. *Journal of Systemic Therapies, 26*, 17–24.
- Shaver, P. R., & Mikulincer, M. (2002). Attachment-related psychodynamics. *Attachment and Human Development, 4*, 133–161.
- Walsh, F. (1998). *Strengthening family resilience*. New York, NY: The Guilford Press.
- Waters, E., & Cummings, E. M. (2000). A secure base from which to explore close relationships. *Child Development, 71*, 164–172.