

An Emotionally Focused Approach to Sex Therapy

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Sex is a Bonding Behavior: The Emotionally Focused Approach to Healing Sexual Issues

A strange thing has happened to sex and sexuality. It is increasingly portrayed, as psychologist Leonore Tiefer (2010) suggested and critiqued, as purely a physical process similar to *digestion*. As such, sexual problems are “medicalized” (Leiblum & Rosen, 2000), much as problems in digestion are. For the clinician who sees partners together, however, it is clear that sexuality is best viewed as a reciprocal *dance* that occurs in a particular interactional context (Tiefer, 2010). In fact, I would argue that, even in solo sex acts, such as masturbation, sex occurs in the context of our primary relationships because such relationships shape our perceptions of our body; our orientation to our needs; and our ability to engage fully with and integrate our emotional experience of self, as well as others. We are social animals who live, even when we are physically alone, lives that are saturated with constant images of, models of, and inner conversations with others. As an attachment-oriented researcher and clinician, taking sexuality out of a relational context is clearly, in my view, a major mistake in terms of understanding how sex works, what healthy sex is, and how to treat sexual problems. This attachment perspective involves more than recognizing that “sex therapy is ... inextricably tied to relationship issues and psychological functioning” (Leiblum & Rosen, 2000, p. 11). It implies that relational issues are primary; they are the defining context for sexual functioning. The quality of our attachments—our emotional connection with key others—is seen as irrevocably shaping the other elements of a relationship, namely care-taking and sexuality (Johnson & Zuccarini, 2010).

This chapter will examine the emotionally focused approach to dealing with sexual problems and the implications of this attachment-oriented perspective for our understanding of sexuality, sexual health, sexual dysfunction, and the treatment of sexual issues. It will present an overview of “emotionally focused couples therapy” (EFT), a well-validated approach to relationship distress (Johnson, 2004; Lebow, Chambers, Christensen, & Johnson, 2012). EFT is the only couple intervention that is systematically grounded in a consistently validated, developmental, relational theory of personality and human functioning—namely, attachment theory (Bowlby, 1988; Mikulincer & Shaver, 2007). As part of this overview, the attachment orientation to sexual health and dysfunction will be outlined. EFT interventions that address sexual functioning will be described and examples given. Conclusions will be drawn from attachment theory and research and EFT practice as to the nature of sexuality and the best path to the remediation of sexual difficulties.

The Attachment Perspective on Adult Love and Sexuality

As stated above, EFT is based on an understanding of romantic love as an emotional bond. The nature of this bond is outlined by the last 15 years of adult attachment theory and research (Mikulincer & Shaver, 2007). The attachment framework not only offers a procedural template for understanding relationship distress and remediating it, but also offers a particular view of sexuality (Johnson & Zuccarini, 2010, 2011).

An attachment bond is characterized by the seeking of physical and emotional proximity, particularly at times of uncertainty or stress; the creation of a safe haven connection that regulates emotion, especially fear; the shaping of a secure base with a loved one that supports exploration and autonomy; and separation distress responses when emotional contact with an attachment figure is lost. These distress responses—the intensity and nature of which will vary depending on the level of felt security or connection in the relationship—include protest, clinging, and despair, finally culminating, if no renewal of connection occurs, in numbing and detachment. Attachment bonds prime the release of oxytocin, which increases the ability to tune into others, down-regulate fear, and stimulates the production of reward hormones such as dopamine (Johnson, 2008, 2013).

In adults, these bonds are more reciprocal than between parent and child, and they can be accessed through mental representations when the other person is absent; adults think of loved ones when under stress and so find comfort and strength. Physical proximity and comfort also expand into a sexual bond in adulthood. Bowlby (1969), the father of attachment theory, considered that, of the three behavioral systems active in close relationships (attachment, caregiving, and sexuality), it is the attachment bond—with its core associations with safety and survival—that is primary. Attachment then structures the other two behavioral systems: caregiving and sexuality.

A secure emotional bond, characterized by accessibility and responsiveness, optimizes healthy sexuality in that, by its nature, such a bond fosters the ability to play, to put aside defenses and trust bodily responses, to tune into another person, to express sexual desires and needs, and to deal with sexual differences and problems. Safety allows for all of one's attention and mental and physical resources to be directed to and used in the service of sexuality. In a reciprocal feedback loop, secure attachment, with its accessibility and responsiveness, potentiates adult sexuality, and secure sexuality, in turn, promotes emotional connection and bonding. Conversely, insecure attachment, in which partners are anxious and vigilant for cues of rejection or abandonment, or in which they shut down attachment needs and actively avoid contact with others when vulnerable, constrains the experience and expression of sexuality.

Secure attachment and optimal couple sexuality

As stated above, secure attachment offers a secure base from which individuals can explore their universe and adaptively and flexibly respond to internal and external cues. It allows partners to be attuned to each other, sensing each other's inner state and intention and responding to each other's shifting states of arousal in the same way that an empathic mother is attuned to her baby (Stern, 2004). Non-verbal cues—sighs, gaze, and touch—carry exquisitely coordinated signals. The resulting sense of deep rapport creates a “synchrony” in which emotional, physical, and sexual cues can be integrated into the dance with a lover. In a secure relationship—marked by emotional accessibility and responsiveness—attachment, caregiving, and sexuality are integrated in such a manner that emotional and physiological responsiveness, tender touch, and erotic playfulness can all come together. With the integration of attachment, caregiving, and sexuality, lust and passion can flow into affection and intimacy. Eastwick and Finkel (2008) persuasively defined passion as the uniting of attachment longing with erotic connection.

As Heiman (2007) suggested, sexuality is an affect-oriented interaction. Ways of regulating and expressing emotion constitute our ways of engaging others. Thus, emotional safety shapes physical synchrony, and physical synchrony embodies emotional safety (Johnson, 2009). One of the most basic elements of sexuality—touch—integrates the language of sexuality and of attachment. Touch arouses, and it also soothes and comforts. Sexual thrill and eroticism in a secure attachment arise from the partners' openness to moment-to-moment connection and fully-engaged presence. Sexual exploration is also more possible with an engaged partner, who is able to surrender to sensation without reserve or caution. It is also the case that, with secure attachment, partners can tolerate shifts in sexual focus between one's own and the other's attachment and sexual pleasure goals without experiencing fears of abandonment or rejection, as one person risks sharing their sexual needs and longings with the other. Secure partners can then flexibly tolerate variations in a partner's needs, including the passionate, emotional, and physical aspects of sexuality. As a result of this attunement, securely attached partners can achieve a sense of connection and closeness in the sexual realm, which is a primary reason for engaging in sex (Davis, Shaver, & Vernon, 2004; Schachner & Shaver, 2004).

There is, however, much confusion in the couples therapy field as to what healthy sexuality looks like. This tends to hinder any effective integration of sex therapy and couples therapy, and it confuses clinicians. Some commentators suggest that the most functional sex arises when partners do not depend upon each other, but maintain clear personal boundaries and a sense of individuation or differentiation from each other. This conceptualization arises from Bowen's (1978) theory of family therapy, developed many years ago to address schizophrenia in a family context. The concept is that, to be arousing, one must be emotionally separate and different (Schnarch, 1997). This is tied to the idea that what is thrilling inevitably arises out of constant novelty and foreignness. It follows from this perspective that security diminishes desire and sexual boredom is the key problem in long-term relationships. Couples then have to spice up their sexuality, for example, by playing the role of the stranger, prostitute, or adulterous lover (Perel, 2007). The leap is then sometimes made into the argument that monogamy is essentially unnatural, and that it, in fact, kills eroticism. There is little research to support any of these views. The best survey research in the US (Laumann & Michael, 2001) suggested that happy long-term couples have more and better sex than those in uncommitted or short-term relationships. Even as adolescents, those with an orientation toward secure attachment—who feel confident that they can reach for and rely on others—report fewer erotophobic responses (i.e., fewer negative affective-evaluative responses to sexual cues and more positive and passionate emotions during sex) compared with those with a less secure attachment orientation. Expressing love and affection is also one of their main motivations for having sex, and those with a secure orientation prefer sex in committed relationships rather than casual relationships (Brennan & Shaver, 1995; Tracy, Shaver, Albino, & Cooper, 2003). In adulthood, they also have more positive sexual self-schemas than those with a less secure orientation (Cyranski & Anderson, 1998). Attachment research supports the idea that secure connection fosters sexual satisfaction.

From an attachment viewpoint, the focus on sensation and performance that saturates the alternative novelty- and thrill-orientated approach to sex, as described above (Perel, 2007; Schnarch, 1997), sounds much like the operation of avoidant attachment (discussed later in the chapter). Avoidantly attached lovers, who are uncomfortable with closeness, are more likely to state that their motivation for sex is oriented to sensation, stress control, and self-image aggrandisement or prestige with peers. They also report less frequent sex and less satisfaction in their sexual relationships (Bogaert & Sadava, 2002; Davis *et al.*, 2006; Schnachner & Shaver, 2004). Compared with securely attached individuals, avoidant individuals endorse more positive attitudes toward emotion-free and recreational sex and more dislike of the bonding aspects of sex such as cuddling (Gillath & Schnachner, 2006). This constricted view of sexuality does not lend itself to foreplay or afterplay and generally seems foreign to the

process of secure bonding or a rich sex life. If emotion is viewed as the music of the dance, sex without emotional engagement might be compared to dancing without music.

An attachment-oriented perspective suggests that, in fact, it is emotional safety rather than novelty and unfamiliarity that offers the best platform for passion and ongoing arousal in a long-term couple relationship. Paradoxically, a felt sense of safety allows sex to be an adventure, in which risk and exploration can occur. As deep emotional engagement occurs, the awareness of the innate “otherness” and the ultimate unknowable-ness of another person become clear, so the capacity for exploration is infinite. Sex and bonding are also natural bedfellows; they share the same chemistry in that they are both associated with dopamine and oxytocin. Interestingly, oxytocin also interacts with dopamine to block habituation to reward effects in drug studies. It is possible that it may have a similar effect in bonding interactions. Attachment researchers such as Gillath, Mikulincer, Birnbaum, and Shaver (2008) found that, if men and women are subconsciously primed with erotic stimuli, then they also respond more positively to questions about bonding responses, for example, about their willingness to make sacrifices for a relationship, their desire for closeness, and their ability to find caring ways to resolve conflict.

There is evidence that, especially for women, emotional and physical safety and security are key ingredients in the experience of sexual arousal. Given the extent of the attunement and coordination necessary for good sex and the constricting nature of anxiety, it certainly makes sense that this would be true for sexual satisfaction as well. In one study, the prefrontal cortex and other areas involved in making judgments became activated in women’s brains when they were exposed to subliminal and explicit sexual primes (Gillath & Canterbury, 2012). This response was not found for men. The researchers suggested that women naturally pair safety concerns with lust, and indeed, this seems functional given how vulnerable women are during sex. In couples therapy, men also typically talk of how criticism and anger from their partner turn on anxiety and turn off their sexual response. In clinical situations, both men and women typically identify a lack of safe emotional connection with their primary partner, rather than lust for another partner, as the trigger for extramarital sexual involvement.

The impact of attachment insecurity on sexuality

Sexuality is experienced, expressed, and enacted differently by those in relationships characterized by secure versus insecure attachment (Diamond & Blatt, 2007; Mikulincer & Shaver, 2007). A couple’s sexual connection may be a source of insecurity or a resource that builds and maintains greater attachment security.

Insecure forms of attachment with their unique forms of affect regulation and relationship strategies have been classified in over 50 years of research into three styles—namely, *preoccupied anxious*, *dismissing avoidant*, and *fearful avoidant or disorganized* attachment. Anxious attachment, which arises in the context of inconsistent caregiving where a child has to intensify attachment signals to get a caregiver’s attention, shows up in adult relationships in terms of unremitting attempts to elicit responsiveness from a partner and to find proof of love. For example, Bruce tells his wife:

So what if we have been married for 25 years. How do I know you really love me? If you made love to me twice a day and showed that I pleased you by having multiple orgasms then maybe I would believe it. And I don’t want you to look at other guys at parties.

Abandonment and rejection sensitivities complicate all aspects of sexuality for an anxiously attached individual such as Bruce. The anxiously attached person’s sexual interactions could be termed “solace sex” because sex is mostly about relieving fears of rejection rather than eroticism or pleasure (Johnson, 2008).

Dismissing avoidant attachment occurs when loved ones have been unresponsive or even dangerous and so needs for connection have been shut off and any form of dependency is shunned. This shows up in adult relationships in the form of mechanical and emotionally dissociated sex. For example, Andrew tells his wife,

So what if I watch porn all the time. It's just to get off. It's easier than doing all that talking and cuddling that you want to do if we make out. And I want more intense sex than you do—more charge.

Andrew's conversation about sex is filled with references to sensation and specific performance concerns about needing sex to be "hot" and wanting his wife to dress in "hot" clothes to turn him on. This could be labeled "sealed-off" sex, in that the longing for love and connection are removed from the sexual act.

The partner caught in a fearful avoidant style has usually been abused by attachment figures, and this often includes sexual abuse. For such people, sexuality is then a paradoxical mix of desire, longing for comfort in a dangerous and chaotic world, and fear of connection that may lead to violation and betrayal. These individuals often flip between anxious, desperate clinging and dissociated, defensive distancing in bed and out of it. EFT is the only couples therapy in which an outcome research study has been conducted specifically with this population (Macintosh & Johnson, 2008), and case studies can be found in the couples therapy for trauma survivors literature (Johnson, 2002).

In general, in insecure attachment, the sexual dance is inevitably impacted by one's own or a partner's self-protection strategies, such as anxious pursuit or reactive numbing, employed to manage attachment distress. With attachment insecurity, partners struggle to manage frustrations, failures, and differences in each partner's desire and arousal. All couples face the inevitable waxing and waning of desire, arousal, and orgasm capacities throughout their history together. How these changes and possible frustrations are dealt with and how they impact the relationship as a whole will be influenced by a couple's attachment security. Desire, arousal, orgasm, and satisfaction will be impacted by each partner's level of security and associated attachment strategies (Birnbaum, 2007; Birnbaum, Reis, Mikulincer, Gillath, & Orpaz, 2006).

Perhaps the greatest strength of an intervention based on attachment is that this perspective offers an integrated model of relational and sexual health in terms of optimal development, as well as dysfunction. This gives both couples therapists and sex therapists—two roles that are becoming more and more intertwined (Leiblum, 2007)—a clear direction for intervention that goes beyond simply the reduction of general relationship distress or the alleviation of sexual symptomatology.

For many couples, sexual problems arise as a result of relationship breakdown and wane when the relationship is restored, although both positive and negative sexual experiences tend to have more impact on relationship interactions for insecurely attached partners than for securely attached ones. For example, anxiously attached partners use such sexual interactions as a barometer for the viability of the relationship as a whole and as a sign of how much or how little they are valued by their partner (Birnbaum *et al.*, 2006). For some partners, however, sexuality and sexual issues are front and center and have to be addressed in a relationship therapy in a more systematic and deliberate manner, rather than simply as a side-bar in the general process of relationship repair (Johnson & Zuccarini, 2011). The remainder of this chapter will consider the EFT model of couples intervention and the addressing of sexual issues in the context of EFT.

The EFT Model of Couple Therapy

Theoretically, EFT draws on a synthesis of humanistic/experiential and systemic assumptions (e.g. Minuchin & Fishman, 1981; Rogers, 1951), both of which are evident in EFT's dynamic use of reprocessed and "new" emotional experiences to engage partners in the enactment of

more adaptive relational patterns. Shortly after Johnson and Greenberg's (1985) promising initial outcome study on EFT and the sudden growth of the literature on adult attachment (e.g. Hazan & Shaver, 1987), EFT began to contribute to the integration of attachment concepts into couples therapy (Johnson, 1986). The approach became more and more explicitly focused on strengthening a couple's bond through increased mutual emotional accessibility and responsiveness.

The primary treatment manual for EFT (Johnson, 2004) described this brief, systematic approach (8–20 sessions). EFT combines a shared focus on interpersonal interaction patterns and intrapsychic processes, which are understood in terms of adult attachment theory (Mikulincer & Shaver, 2007). The therapist serves as a process consultant, focused on facilitating in-session experiences of interactive and inner experiential emotional cycles. To facilitate access to the underlying aspects of a client's emotional experience, the therapist builds a safe and collaborative therapeutic alliance. This alliance enables couples to engage and explore their habitual emotional responses, and provides a felt sense of security as each partner takes steps to restructure their negative patterns and to address unmet needs for secure connection. The approach assumes that couples have mutual goals and a workable commitment to changing their relationship. EFT is not meant for use with violent partners or with couples demonstrating incompatible relationship goals (Johnson, 2004).

In this model, a distressed couple's problem is not seen as a lack of communication skill, an inability to negotiate differences, or a propensity for conflict. Disagreements and conflict occur in every relationship. Distress instead is seen as the result of chronic emotional disconnection without reliable repair. Partners continually trigger each other's fears of rejection and abandonment and then protest or try to "fix" their lack of safe haven connection. The usual pattern is that one partner blames and demands, while the other shuts down to try to regulate their emotions and prevent escalation. This dance of disconnection takes over the relationship and leaves both partners hurt, and in what emotion researcher Jaak Panksepp (1998) described as *attachment panic*. This panic is viewed as a specific form of fear that is wired into the mammalian brain, reflecting the fact that mammals are born helpless and require connection with others to survive. Emotional isolation is encoded as a danger cue or a threat to survival in much the same way as extreme thirst or hunger. In a secure relationship, partners are able to reach for each other and repair rifts; this process helps each to find emotional balance. In terms of sexuality, the experience of fear and the task of regulating survival-oriented emotions interferes with processes necessary for satisfying sex—such as engaged sexual arousal and attunement to and coordination with the other's physiological and emotional state. In couples who do not present with specific sexual problems, the EFT therapist assumes that, once this relational block or insecurity is addressed and safe emotional connection restored, then the door opens to positive sexuality. A recent study showing that EFT increased relationship satisfaction and the security of the emotional bond between distressed partners also found that sexual satisfaction increased in these partners' relationships (Elliott, Wiebe, Johnson & Tasca, 2016).

In EFT, the therapist attempts to create safety in the session and then constantly cycles through five key interventions. These interventions are intrapsychic/experiential and interpersonal/systemic. The description of these interventions offers an overview of the EFT model.

First, the therapist reflects the process that occurs in the present moment in the session, *between* members of the couple or *within* the emotional experience of the partners. For example, the therapist might comment:

I notice that you talk about many issues where you disagree. But, Ann, when the fact that you seem to have lost the closeness and sexuality in your relationship comes up, you get very agitated, and you try to get Jerry to see how you experience him as "difficult and cold." You sound angry. Jerry, you turn your chair away and sigh. You say, "Not this again. There is no point in talking to you," and go silent. This dance of "I-push-you-to-open-up-and-look-at-how-distant-we-still-are"

followed by “I-step-back-and-close-down-because-we-will-just-get-into-a-‘pointless’-struggle-with-no-good-outcome” seems like it leaves you both so discouraged. And the more you, Anne, demand to be heard, the more you, Jerry, step back because it seems kind of hopeless to talk?

Anne and Jerry agree and help the therapist to refine this description, which offers a meta-perspective of their self-perpetuating interactional dance. They also each learn how the dance impacts the other emotionally.

Second, the therapist focuses on the inner emotional experience of each partner and how this emotion is constructed and regulated, using empathic reflection and evocative questions. The therapist might say, “Anne, right now, as you use the word ‘cold’, your voice goes soft and your face changes. What is happening for you?” Anne tunes in and finds that she suddenly feels sad rather than angry, and with the therapist’s help, she formulates this feeling in terms of “desperate-aloneness”. The therapist has deepened Anne’s engagement with her emotions and helped her to order and articulate them in a clear and specific way.

Third, the therapist invites each person to coherently shape this newly-formulated emotion into a new message to his or her partner. She distills Anne’s experience and asks, “So can you turn to Jerry right now and share with him these feelings of desperation and loneliness that hit just before you get mad? These feelings of having lost him?” The therapist supports Anne to do this, perhaps by helping her, first, to talk about how hard this is to do and how worried she is about Jerry’s response. New emotions are shaped into new signals that are crafted to engage the other partner emotionally and evoke empathic responsiveness. Anne shares her desperation and admits that, although showing anger is easier than showing her desperation, it still leaves her feeling all alone.

Fourth, the therapist processes these new steps in the dance—this new enactment—with both partners, asking Anne what it was like to share (she says it was scary but good) and asking Jerry what it was like to hear this message. Jerry confides that he feels confused, and he says that he is so focused on monitoring his wife’s anger that he never considers she might feel scared or worried about losing him. He turns his chair more towards her. She begins to cry, and he puts his hand on her knee. She then shares that the most painful part of this is that she worries he no longer desires her because she has put on weight. Jerry seems to uncoil from his cool reserve, and he leans forward and tells her that he feels lots of desire but loses it when she becomes “dangerous.”

Fifth, the therapist takes this new experience and new interaction and contrasts it with the couple’s regular pattern of responding. In doing so, the therapist encapsulates and reviews the new interaction to build confidence and hope and to help each partner to integrate it into their model of self and other. The therapist notes, “Look what you just did here. [She recaps the moves each made.] That is amazing.” Helping partners change how they engage emotionally and see the impact of this change creates a sense of competence that motivates them to continue to explore and learn.

In order to deepen clients’ exploration of their emotions, the EFT therapist continuously uses focused empathic reflection, evocative process questions (e.g., “How does your body feel as you talk about this?”; “What do you say to yourself as this happens?”), small interpretations at the leading edge of a client’s experience where that experience is unformulated or vague, and validation that emotions and habitual interactional moves make legitimate sense. All of this occurs while the therapist’s ordering of the process helps the couple stay in emotional balance. Therapy then becomes a safe adventure. The therapist also creates enactments that slowly move partners towards the safe, congruent emotional connection that characterizes a secure emotional bond. The map of relatedness provided by attachment theory also allows the therapist to create therapeutic reframes; for example, the problem in the relationship can be reframed as the dance of disconnection that has captured the couple and holds them in its thrall, rather than as a personal inadequacy on the part of the partners. Another reframe is that withdrawn partners shut down, not out of indifference, but because they are so overwhelmed by and care so much

about the messages coming from their lover. All of the above five moves and interventions are well articulated and demonstrated in the many chapters and training DVDs on EFT (available from www.iceeft.com).

These moves and interventions span the whole of course of therapy, but they may differ in intensity and directiveness across the three stages of EFT.

- 1 In the *de-escalation stage*, the negative cycle of disconnection is outlined and contained so that the partner is no longer viewed as a danger cue but as a fellow victim of the negative relational pattern. Primary emotions that have gone unacknowledged, such as deep loneliness and fears of inadequacy and rejection, are now explicated. The couple now has, in attachment terms, a secure base upon which to stand. This enables them to risk engaging at a deeper level. In a couple in which this distress has undermined sexual connection, this sexual connection usually begins to return at the end of this de-escalation stage, when the couple feels safer and has more hope that positive change can occur.
- 2 In the *restructuring attachment stage*, the therapist guides each person into owning their attachment needs and fears and expressing these in a manner that primes empathy and responsiveness in the other. This stage ends with powerful bonding conversations that have been found in nine studies to be associated with success in therapy, relationship recovery, and long-term relationship satisfaction (Greenman & Johnson, 2013).
- 3 In the *consolidation stage*, the changes the couple has made are reviewed and integrated into the models of self, other, and relationship, and visions of the future are shared.

EFT has been extensively empirically validated. The most rigorous older studies find that 70–73% of couples move out of distress by the end of therapy, and 86–90% report significant improvement in distress levels (Johnson, Hunsley, Greenberg, & Schindler 1999). Factors such as the pre-treatment level of distress or traditionality (i.e., the couple's level of adherence to traditional gendered marriage roles) do not seem to significantly impact outcome; the level of engagement in the tasks of therapy and the perceived relevance of the tasks set up by the therapist seem to be more important (Johnson & Talitman, 1996). EFT has been implemented with depressed and traumatized couples with good success; it has also been found to lead to improvement in both individual depression and trauma symptoms (Dalton, Greenman, Classen & Johnson, 2013; Denton, Burelson, Clark, Rodriguez, & Hobbs, 2000), both of which are known to impact sexuality. One older study, which looked at the impact of 12 sessions of EFT specifically on distressed couples' sexuality, found only weak evidence of any positive results (McPhee, Johnson, & van der Veer, 1995). However, as mentioned previously, a more recent study (Elliott *et al.*, 2016), in which 20 sessions by more experienced therapists were offered to couples facing relationship distress and insecurity, did find that EFT was associated with an increase in sexual satisfaction.

EFT researchers have concluded that the large effect sizes and the stability of these effects arise from the active utilization of the most powerful unconditioned human drive: the longing for a secure bond with another human being. In any short-term intervention, focus is key, and as an intervention, EFT is on target from the point of view of attachment theory and research. It is also consonant with the psychotherapy literature that suggests that emotional engagement is the core active ingredient in successful psychotherapy, and collaborative rather than coaching models attain this kind of engagement most effectively (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Coombs, Coleman, & Jones, 2002).

The 10 principles for addressing sexual problems from an EFT perspective

Principle 1 Sexuality is never addressed as purely an individual problem; the partner's responses are always viewed as part of any sexual issue. Sexual disconnection is placed in the context of a couple's negative cycles of interaction that undermine safety and intimacy.

Depressed, emotionally withdrawn partners, for example, may actually occasionally seek positive engagement in the area of sexuality, but their already-alienated partners cannot respond to these overtures. Even if a partner comes into a relationship with a serious sexual problem—for example, a lack of desire and emotional numbing as a result of previous sexual abuse—interactions with the partner will potentiate or block healing (Johnson, 2002). Therapy always begins, then, with an assessment of a couple's patterns of emotional engagement and disengagement, and the patterns of sexual interaction are viewed in this context.

Principle 2 When specific sexual complaints are central to relationship distress, the therapist will, in the individual sessions that are part of the assessment process in EFT, conduct a sexual functioning assessment, including querying cultural and family scripts about sexuality; physiological functioning; childhood trauma; current medical treatments; and mental health issues, such as anxiety and depression, that undermine positive sexuality. Consultation with an expert professional specializing in sexual dysfunction also may be sought. A relational perspective is still maintained, however, with a focus on the details of present sexual interactions. Couples' problems are often mutually sustaining; for example, a woman's arousal difficulties may prime her husband's premature ejaculation and vice versa.

Principle 3 In general, partners are guided to de-escalate conflict and distancing strategies (the main focus of the first stage of EFT) and to slowly shape safe touch and emotional connection before addressing sexual issues. If attempts at sexual relations prime escalating negative interactional cycles, then the therapist encourages the couple to set aside attempts at intercourse for a period of time until they can create a secure base to explore the blocks to positive sexuality and until they are capable of wooing and supporting each other. The attachment narrative around disappointments in sex is explored; such disappointments are often experienced as shaming and trigger catastrophic expectations of rejection and abandonment. EFT is a collaborative therapy so the above process is all conducted with the active participation of both partners. EFT therapists talk about how they are conducting therapy as they do it, so at the end of Stage 1 of EFT, both general interactional cycles that impact sexuality and specific cycles of sexual disconnection are clear. At that point, the couple has a meta-perspective on how both types of cycles trap them in a state of emotional and sexual starvation. Partners also begin to see how they can collaborate to name these cycles as they occur, understand how the cycles trigger each other's pain, and help each other to curtail the power of such cycles to take over the relationship and demoralize them both.

Principle 4 Sexual responses are placed in an attachment frame. For example, Terry's inability to keep an erection since his wedding is placed in the context of his sudden sense of risk and vulnerability related to his awareness that Amanda now has the power to "devastate" him because he committed to her as a partner and now "depends" on her so much. Similarly, Claire's rage at her husband's apparent lack of desire is linked to her silent terror that, since her mastectomy, he inevitably finds her to be "ugly and deformed."

Principle 5 Once a couple can begin to create a secure base in the session and at home, the active shaping of more engaged emotional accessibility and responsiveness—the key ingredients of a secure bond—begins. Each partner is supported to engage with, actively explore, distill, and express attachment fears and specific needs in powerful re-engagement and softening conversations. These conversations, in which soft emotions, such as sadness, shame, and fear, are owned and shared and longings then articulated, are also called Hold Me Tight conversations. In couples with specific sexual issues, these conversations, and the deeper exploratory processes leading up to them, often focus on the sexual issue, or if not, these are repeated

later with the sexual issue as the focus. For example, Mary and Ryan begin their Stage 2 conversations with Ryan re-engaging fully from a withdrawn position and sharing his sense of inadequacy around sharing emotions and his terror of being found wanting by Mary. He is able to own this terror and ask for Mary's reassurance and forgiveness concerning his detachment from her. This process is then repeated with reference to his numbed-out sexuality and apparent desire problem, which are perpetuated by Mary's frantic and increasingly angry attempts to get him to respond to her.

Principle 6 Positive links between sexuality and moments of security and bonding are explored so that partners understand them. For example, the therapist focuses on how David's new tender holding of his wife after lovemaking, which he dismisses as incidental, impacts her sense of him as a partner, her continuing desire, and her felt sense of secure connection in the relationship.

Principle 7 As part of the sexually-oriented bonding conversations, sexual experience is tracked and made explicit. The couple is then encouraged to risk sharing erotic cues and sexual longings and desires. Once the couple is tuned in and coordinated on an emotional level, the goal is to create a similar synchrony in the bedroom.

Principle 8 If in the processes described above, sexual cues spark past traumatic cues that block physical connection, the safe alliance with the therapist offers a safe haven to explore such cues and reprocess them on an emotional level. For example, Danielle is able to tell her husband, Jim, for the first time, that the way he kisses her neck spirals her back to a rape she experienced earlier in her life and makes her feel "crazy." The therapist can help Jim hear this and support his wife rather than moving into his own fears of personal rejection. They can then share ways to prevent this triggering and ways that Jim can comfort Danielle and help her calm down when she is triggered. They decide she can tell him, "The shadow has come for me again," and he can then support her by remaining silent but holding her in a certain way and just breathing with her in a synchronized fashion. When she is able to do this, she takes control of her trauma flashbacks, and he feels both unique to and needed by his partner.

Principle 9 In the consolation stage of EFT, emotional, physical, and sexual connection are reviewed, and the couple's achievements are celebrated. The process of how exactly they helped each other move into these new levels of engagement is outlined, offering them a prototype of relationship recovery that they can use in the future. Partners are encouraged to take a meta-perspective and view themselves in the continuous dance of emotional and sexual synchrony, mis-attunement, loss of connection, re-attunement, and recovered connection. In other words, they view themselves as able to make and remake their emotional and sexual bond. As McCarthy and McCarthy (2003) concluded, "Sex works best when each spouse is open and receptive" (p. 32). Partners are helped to articulate explicitly how they can each help each other step into and maintain this state.

Principle 10 Last, but not least, in all of the above, the EFT therapist offers education concerning sex and normalizes each partner's response—for example, by telling Elizabeth that her sexual functioning is normal and that most women cannot reach orgasm simply from penetration, and by actively countering her shame about her masturbation. The therapist also offers an alternative point of view to the compartmentalization and objectification of sex that is found in our culture, offering a more whole and integrated view of sexuality and adult love.

A Case Example: The Lover Who Got Married

James and Carol were referred to our clinic by Carol's doctor, who felt that Carol's marriage was bringing her to the edge of a breakdown. Carol was a 48-year-old stay-at-home mother. Her son had just gone off to high school, and she was studying for business school entrance exams. Her husband, James, 54, was a consummately successful businessman.

This couple presented with an extremely volatile interactional cycle of loud, angry attacks on Carol's part followed by urbane justification, evasion, and withdrawal on the part of her husband. He came to therapy after she had told him that she was moving out of the family home because she believed he was gay. Carol came from a home where her father was alcoholic and her mother was permanently depressed and unavailable, and she had been involved with several very unhappy love relationships before meeting James. James, who was handsome and charming and who described himself as being an "expert at compartmentalization," did not want to discuss his past. However, he did mention that, before he met his wife, he had, for many years, successfully courted and bedded a large number of "beautiful" women, with whom he would stay until they "fell in love" with him, at which point he would immediately end the relationship. Shortly after their wedding, Carol had been diagnosed with Crohn's disease and had also become pregnant. Her son was born with severe health issues. After this child's birth and her own lengthy medical treatment, James had withdrawn from her physically to the point of not touching her at all, stating that he had no sexual desire. He then completely immersed himself in his work. Their child's and Carol's own health problems had consumed much of the next decade, but as these issues stabilized, her belief that her husband was simply stressed and would eventually return to making love with her changed to a conviction that he had deceived her all these years and was, in fact, gay. He completely denied this, stating that he loved his wife, and attempted to minimize their emotional and sexual problems.

EFT begins with two couples sessions in which the members of the couple meet together with the therapist and are asked to talk about their relationship strengths and problems and give a relationship history. The therapist also observes and sets up interactions between partners to begin to grasp the couple's habitual interactional patterns, styles of communication, and ways of regulating emotion. This couple presented with an extremely escalated cycle of outraged accusation and blaming by Carol, followed by defensive justifications and withdrawal by James. He stated that he deeply loved his wife and, in fact, that she was the only woman with which he had ever fallen in love. She seethed in response. He was very supportive in many ways, offering to support his wife in her studies and future dreams and stating that he did not want her to leave him.

In the two individual assessment sessions (one per partner) that followed the joint sessions (this is typical procedure in EFT), Carol painted a picture of very volatile and unsupportive family-of-origin relationships and early romantic connections in which her needs were dismissed and denied. Her anxious attachment and pain at her partner's lack of desire and physical affection were palpable. The only way she could understand this was as a wholesale deception regarding his sexual orientation.

James, in his individual session, painted a picture of his lonely childhood in a Hungarian village dominated by his randomly abusive and fanatically religious mother and his always drunken father. He also described his childhood love of books and desire to escape to North America. He reported that he thought of his wife in sexual fantasies and occasionally looked at sexy magazines and masturbated to them. He had not made advances to her or to any other woman in the last 12 years. When asked about his physical distance from his wife, he became very silent. The therapist asked him what happened to him when his wife ran her hand along his back in bed, as she described she used to do. He winced and replied that he could not breathe and wanted to run away. This reaction began after his marriage and at the same time that his wife became physically ill and then preoccupied with a sick child. When asked very pointedly about sexual abuse as a child, he began to speak with great difficulty about being abused continually in the church school where he had been educated from ages 4 to 18. He had tried once to confide this to his mother, who then berated him

as being sinful and evil. He also noted that he had succeeded in putting “this all aside” when he moved to Canada and became a lady’s man, having very brief affairs with many women whom he expertly seduced but with whom he never became emotionally involved. He was filled with deep shame about his abuse, and the therapist referred him for additional individual therapy that ran concurrently with the couples sessions. Both therapists—his individual therapist and the couples therapist—conferred together. The link between his traumatic past and his avoidant attachment to his wife was clear.

I will now replay some key moments in the change process, as they occurred in Stage 1 (de-escalation) and Stage 2 (restructuring attachment) of EFT with this couple. In Session 3, the therapist actively intervened, with empathic reflection, soothing validation, interpretation, and reframing to calm Carol and help both partners see the negative cycle of abandonment followed by angry blaming. It was explained that this cycle triggered evasion and distancing in James and maintained emotional and physical disconnection.

CAROL: I don’t believe anything you say. The only thing that makes sense is that you have been gay all along and you lied to me.

THERAPIST: This is the only way you have been able to make sense of James’s “sudden shut down” of his sexuality. It has caused such pain for you. It has left you so alone and feeling so undesired. So it’s hard to let it in when he says that he loves you and desires you but that he blocks out these feelings and stays at a safe distance. This is so disorienting that you get angry. Then you look even more dangerous to him, and he withdraws further; it confirms his fears that emotional and physical connections are not safe.

JAMES: Yes. It doesn’t feel safe, so I kind of numb out. Somehow, before you, those other women never got to me. I never needed them. It was such a risk to love you, and then you kind of disappeared into the kid and into all the medical stuff, and my brain just freaked out. I kept thinking this would all just go away, but ...

THERAPIST: Connection was scary just because you DID love her—because you let yourself need her. And that was the first time you let yourself need or be vulnerable. But when the fear came out, it was overwhelming? [He nods.] So you tried to hold onto her and keep the fear at bay, too—you held onto her and shut her out at the same time? What is happening as I say this, James?

JAMES: I don’t feel well. [The therapist leans forward with a questioning look on her face.] I have a pain here. [He touches his chest.] It does feel like fear. That is ridiculous. But I freeze up. Feels like I am a kid at home with my crazy mother ranting at me or all alone in that church... [He tears up.]

CAROL: What does this have to do with you never making love to me? Tell me that! [She smacks her hand on her other hand.]

THERAPIST: I am going to stop you, Carol. Can you hear him say that it is fear that has him shut down and shut you out? And what comes up are images of his mother—with whom needing or longing for closeness was totally dangerous and filled with pain—and images of being vulnerable and being abused.

JAMES: I could make love to women who never touched me here [touches his heart], but ... suddenly it’s like I knew I needed you but ... you were sick, and you were miles away, it seemed. And all this got all caught up in the abuse stuff that I had never taken out of the closet—even with you.

THERAPIST: Can you feel the fear now? [He nods.] Can you tell her what it feels like in your chest and when it comes up at home? Then we will look at the terrible thoughts that come with it.

JAMES: Yes. [To Carol:] It hurts—like I can’t breathe. Frozen up. I am six-years-old and back in that dark church. You put your hand on my back when we are in bed, and I just freeze up. And I know it hurts you. Some part of me wants to run; it seems like, if I stay, I will shatter. No control. I can’t breathe and then ... [The therapist comments on the sadness in his face.] Yes, if I stay, I will fall apart, weep forever ... and if I don’t stay... It’s black no matter what I do.

THERAPIST: Right. So can you tell her, “It’s desperate aloneness and blackness to lose you, but also to let you in feels like terror and brings back the hurt of the past?” You stay but keep her at a distance. You can’t lose her and can’t be this vulnerable. Is that it?

- JAMES: *Like she says. [He laughs.] ... It's like anything I do feels bad so that I just freeze; then I don't feel. Anything. No desire or anything. [Carol looks sad but confused.]*
- THERAPIST: *What is this like to hear, Carol? Confusing? It is new? Your man isn't indifferent or deceiving you, he is afraid and dodging the ghosts of the past.*
- CAROL: *[To James:] This is about that past stuff—the abuse stuff? You made it seem like no big deal when you spoke about it. This is really fear? [He nods.] But then you go and leave me all alone—untouched.*
- JAMES: *I know. I am ashamed that I let you down. I didn't know what else to do. I don't want to lose you.*

The therapist summarized the negative cycle of Carol's anger and James's numbing and how each now triggers the other. The therapist also outlined again how James's trauma shaped needing and loving into a threat. She also linked James's shame and fear to his total sidelining and numbing out of his sexuality. As moments like this occur, the partners saw their negative coping cycle and the "dragons" of James's past hurts as the problem. This cycle was normalized and framed as an "enemy" they could stand together and face. The therapist, of course, also worked in a similar fashion with Carol's sense of rejection and her fears that she "disgusted" her husband because she was in ill health or simply not attractive enough. During this time, the therapist framed safe connection as a necessary prerequisite for any kind of sexual advance and encouraged sharing soft emotions but not expecting physical touch. As a result of these actions, Carol calmed down and stopped exploding and threatening to leave if her husband didn't come on to her sexually. After 16 sessions, this couple had a secure base to explore their emotional bond on a deeper level and begin to explore how to renew their physical connection.

Later in therapy, James was able to explicate and share the link between closeness, needing, and his traumatic responses, and he was also able to ask Carol's forgiveness for leaving her so alone. He was able to offer her touch and physical comfort when she expressed her hurt and her fears around her apparent inability to spark desire in him. She became much more open and less volatile. The therapist encouraged James to initiate safe touch and comforting moves, and James began to share his positive images of their early sexual life, which he kept in his mind and "held on to." Each partner was able to move into their deeper vulnerabilities and ask the other for comfort and care. James could tell Carol, for example:

I feel safer with you, and I want you to give me the chance to walk back through my fears and find you—find us—again. It really helps when I can tell you that "the shame shadow has come for me" and you are there for me. I am less numbed out. I want us to be sexual with each other, but I have to do it in small steps. So I want you to give me the chance to do that.

Once Carol was able to see James as a trauma survivor for whom love and vulnerability were tied to old, but still raw, wounds of shame and fear, she was able to frame his physical withdrawal from her in a more acceptable way and to begin to empathize with him. The therapist framed James as a virgin when they married, in that the relationship with Carol was the first time he had tried to meld his sexuality with an open heart. The therapist also helped Carol to explore how her anger at her "abandonment" by James had created ever more hostile interactions that continued to trigger James's fear. The therapist helped Carol move to sharing her own fears, namely that she was deeply flawed, unlovable, and at fault for her own illness.

The interactions that occurred at this point constituted a "softening event," in which a previously hostile and blaming partner can share core fears and ask for contact and comfort in a manner that pulls their partner towards them. Key statements made by Carol in this softening event included:

- *I guess I have been so angry for so long. I just never understood why you stayed so distant. It felt deliberate. So I got into threatening and berating you. I didn't know what else to do. I was so hurt and lonely.*

- *It was like we suddenly became roommates, and even after my illness and the baby was well, it didn't change. I was trying to change you. It has hurt so much to feel rejected. I just died inside. Never mind sex, I just needed you to hold me. It's been so long. [She weeps and James reaches and holds her hand.] I need physical closeness. I want to feel desired. It helped when you said you always fantasized about holding and making love to me ... felt like I still mattered then—like I was still your wife.*
- *The worst was when I decided that all of this was because I was disgusting—flawed. That was like falling down a deep hole. The anger kept me from staying there. I am afraid that you don't desire me—that you don't want me as a partner in bed.*

With the therapist's help, James was able to help Carol with this latter fear and reassure her that, to him, she was beautiful and perfect and that he wanted to learn to risk coming close. He told her:

I need lots of reassurance here. I know we need to make what is called a "safe haven" and take things slow. But I need to know that you want lovemaking too, and I need you to touch me and be there if I get lonely and scared.

All through these kinds of events, the therapist reflected and ordered the clients' experience, validated their struggle, asked simple questions to keep them on track, and gently helped them move out of blocks to openness and connection. The therapist also structured the sharing of fears in a simple distilled form; facilitated clear requests for connection; and encouraged supporting the other spouse to respond.

Once this couple had a secure base of emotional confiding, increased faith in their relationship, and the ability to soothe each other with physical affection, then they directly addressed how to change their sexual relationship, and how to "woo" and "court" each other into lovemaking. Carol admitted that, after more than a decade, it was scary for her, as it was for James, to begin to be openly sexual. The therapist encouraged them to share their images of what small sexually-tinged encounters would look like and how they would feel, as well as how to invite each other into them. Gradually this couple moved from holding and affection to foreplay to intercourse. As James said in the last session, "I didn't need help to be sexual; I needed help to clear my fears and old emotions out of the way so I could love and make love at the same time." As this couple made love more often, this also strengthened their emotional bond.

Leiblum (2007) noted that there has been increasing recognition of the need for an integrated approach to the treatment of sexual disorders and complaints. A focus on relationship context is essential. The success of more traditional, graduated sexual stimulation techniques, such as sensate focus exercises, seems to be largely determined by a couple's ratings of communication prior to treatment (Hawton, Catalan, & Fagg, 1992); in other words, poor relationship attachment decreases the effectiveness of traditional sex therapy interventions. Thus, a secure bond is the perfect context for the development and maintenance of rich, satisfying, and functional sexuality. It is also the most relevant context for sexual healing.

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