

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

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

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

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couple attachments become ruptured, traumatizing both partners as well as their relationship.

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

DEFINING HYPERSEXUAL BEHAVIOR

Although some differences exist among the various theoretical constructs of hypersexuality, many researchers agree that associated symptoms include behavior dysregulation, impaired functioning, maladaptive coping skills, and incongruence with one's values and beliefs. Elsewhere people have labeled this phenomenon using terms such as sexual addiction, sexual impulsivity, and sexual compulsive behavior (e.g., Barth & Kinder, 1987; Goodman, 2001; Kafka, 2001; McCarthy, 1994; Raymond, Coleman, & Miner, 2003; Rinehart & McCabe, 1997; Travin, 1995). Our conceptualization of hypersexual behavior is meant to function as a dimensional term opposite *hypo*sexual desire disorders on a spectrum of dysfunctional sexual behavior. Additionally, hypersexuality is frequently described in medical literature as encompassing dysregulated sexual behavior stemming from origins not traditionally considered in the sexual addiction literature, such as neurological pathology (e.g., traumatic brain injury, temporal lobe epilepsy). Ultimately, it is conceivable that the construct of hypersexuality could have several subtypes. In the context of this article, we define hypersexual behavior as difficulty in regulating (e.g., diminishing or inhibiting) sexual thoughts, feelings, or behavior to the extent that negative consequences are experienced by the self or others. The behavior causes significant levels of personal or interpersonal distress and may include activities that are incongruent with personal values, beliefs, or desired goals. The behavior may function as a maladaptive coping mechanism (e.g., used to avoid emotional pain or used as a tension-reduction activity) and may coincide with other psychopathology or neurological impairments.

An vast array of problems is associated with hypersexual behavior, including (1) health risks related to unprotected anonymous sex, (2) economic loss related to difficulty with employment (e.g., fired for consuming Internet pornography in the workplace) or excessive financial expenditures associated with perpetuating sexual activities, (3) legal problems related to sexual behavior (e.g., solicitation from commercial sex workers), and (4) impact of undesirable consequences associated with hypersexuality on emotional and

psychological well-being. When an individual is part of a committed relationship, the consequences of choices related to hypersexual behavior are magnified because they also impact the partner and the relationship itself.

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

IMPACT OF HYPERSEXUAL BEHAVIOR ON COUPLE RELATIONSHIPS

Approximately 15–20% percent of marital vitality and satisfaction is attributable to functional sexuality in relationships (McCarthy, 2003). When sex becomes problematic for couples, however, it has a proportionately greater impact on relationship satisfaction. Some self-reports have suggested sexual problems account for 50–70% of distress in relationships (McCarthy, 2003).

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

On average, 70% of individuals who present with hypersexual behavior are ambivalent about their sexual activities (Reid, in press). Like the cocaine addict toward cocaine, many hypersexual individuals develop a love-hate relationship with sex. They become psychologically dependent upon the euphoria associated with neuro-chemical processes activated by sex while remaining aware that their self-destructive behavior is jeopardizing their relationships. They also remain aware of potentially greater consequences such as risks associated with sexually transmitted diseases. One pattern among some individuals with hypersexual behavior appears to suggest that they use

sex as an emotionally avoidant activity (e.g., Adams & Robinson, 2001). The precipitating event that triggers these individuals to act out sexually is often related to times when they feel emotional pain or dysregulation. It is plausible that such individuals may never have developed the ability to process uncomfortable or difficult emotions. For example, such individuals experience difficulty differentiating their emotions from their sense of self. Such individuals may translate "I feel bad" to "I'm worthless." Cognitive distortions like these are amplified when uncomfortable or awkward feelings such as frustration, disappointment, anger, rejection, or inadequacy surface. In order to avoid or escape emotional discomfort, individuals may turn to sex as a way of self-medicating or soothing themselves. Thus, therapists must consider not only the impact of the hypersexual behavior on the relationship but also any accompanying impairments, such as emotional processing deficits like those found in alexithymia (Sifneos, 1972; Taylor, Ryan, & Bagby, 1985). These factors will need to be evaluated in the context of how the couple has been affected.

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

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

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

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

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

When hypersexual behavior is discovered in relationships, the injured partner can feel, among other emotions, deep betrayal, violation, confusion, fear, hurt, and anger. These emotions frequently lead to behaviors such as attacking, criticizing, clinging, controlling, or cold withdrawing, which tend to be very destructive to the relationship (Gottman, 1994; Johnson, 2004). They can also lead to what has been defined as an attachment injury (Johnson, Makinen, & Millikin, 2001) where the foundational beliefs of the relationship are redefined negatively (e.g., "I can't trust him," "He will never be faithful," "He really doesn't love me"). In order to heal this type of injury, it is necessary to create relational dynamics and events that help the injured partner feel safe, loved, and respected.

Hypersexual behavior typically robs the relationship of the emotional energy of at least one partner. The deception, guilt, and shame that accompany hypersexuality distract from accessibility and responsiveness. Additionally, the attention devoted to the hypersexual behavior reduces commitment

and time that could have been devoted to the relationship. Hypersexual behavior can become a type of competing attachment in which the person engages in hypersexual behavior to be soothed or feel safe or important rather than finding safety, soothing, and validation in the primary relationship.

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

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

SEXUALITY IN COUPLE RELATIONSHIPS

There are a wide range of views about sexuality and what healthy sexuality is and is not. Defining healthy sexuality is a daunting task and is outside the scope of this article. However, it is important to identify how the couple and each partner defines healthy or ideal sexuality. If they are unclear, it may be useful to help couples define what they want sexuality to be in their relationship. If treatment is successful, couples will likely want to reconnect at some point, and this is often symbolized through sexual union. Because of the diversity of ideas about sexuality, it is recommended that clinicians become familiar with various theories and models of sexuality (e.g., DeLugach, 1999; Montgomery, 1995; Stratton & Newbold, 1995). Additionally, the field of sexual addiction has been harshly criticized for its emphasis on pathologizing sexual behavior instead of promoting models of healthy sexuality (Todd, 2004), and this trend must be curtailed if our profession is to be taken more seriously among colleagues and other mental health professionals. The social science literature has broadened its perspectives on sexuality, as evidenced by the fact that the number of journals devoted to sexuality has doubled in the last five years. In 2001 there were 19 professional journals devoted to issues of human sexuality (Wiederman, 2001), whereas at the time this article was written we located 42 social science journals on the topic. This increase in literature on sexuality provides a wealth of information to assist therapists in becoming educated so they can be sensitive to the needs of their clients.

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

Regardless of how a couple approaches these issues, healthy sexuality in many relationships is likely to include mutual caring, respect, openness, consent, sharing, safety, and trust (Roscoe, Kennedy, & Pope, 1987). When present, these qualities cultivate emotional intimacy between partners in relationships. Sexuality can be viewed as an attachment behavior that facilitates closeness and creates bonding between two people. When sexuality is safe, it can help create mutual acceptance, affection, and admiration. Several aspects of the sexual experience require risk taking and vulnerability. From an attachment perspective, vulnerability within a reasonably safe environment and relationship deepens emotional intimacy. On the other hand, vulnerability, without a certain degree of safety and loyalty, can result in deep wounds.

These wounds can become emotionally traumatizing to individuals and must be healed at least to some extent if the relationship is to thrive.

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

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

EMOTIONALLY FOCUSED THERAPY FOR COUPLES

Emotionally Focused Therapy (EFT) is a short-term, structured approach to couples therapy formulated in the early 1980s by Sue Johnson and Les Greenberg (Johnson & Greenberg, 1985). EFT is an integration of experiential, humanistic, and family systems approaches to treatment and is firmly rooted in attachment theory, which serves as a theory of love. Research on EFT has been very positive and indicates that 90% of treated couples are able to significantly improve their relationships in comparison to untreated couples, and between 70% and 73% of treated couples recover from relational distress (Johnson, Hunsley, Greenberg, & Schindler, 1999). A two-year follow-up on relationship distress in parents of chronically ill children, a population at high risk for divorce, suggests that many couples, even if faced with stressful events, maintain their gains or continue to improve in the two years following termination of therapy (Cloutier, Manion, Gordon Walker & Johnson, 2002). EFT is described in detail elsewhere (Johnson,

2004; Johnson et al., 2005; Woolley & Johnson, 2005), but the present study warrants a brief review of this approach and why it is being suggested for couples with hypersexuality issues.

EFT is made up of nine steps and three stages (see Appendix). In the first stage, the therapist works to identify the systemic cycle or pattern, which is often characterized by some form of one partner pursuing issues and the other withdrawing. The therapist identifies and accesses the emotions that are both a response to, and an organizer of, the cycle with the intent to deescalate the couple conflict. In the second phase, the therapist then works to reprocess the emotions and to create new, secure bonding experiences, which will lead to new cycles of trust and security. It is emotional experiencing and reprocessing that are the key components in changing negative cycles and creating a safe connection. In the third stage, the therapist helps the couple solidify their changes and resolve any unfinished business.

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

There comes a time in the therapy process where attachment injuries must be addressed in order for the relationship to move forward on the path to healing. The EFT process outlined for addressing an attachment injury can be very effective in guiding the type of relational healing that must take place if the couple is to develop a healthy attachment bond. These processes, which were first articulated by Cloutier and colleagues (Cloutier et al., 2002), are modified and presented here as we conceptualize them applying to repairing an injury resulting from ruptures related to hypersexual behavior. These processes are applied after the couple has gone through the first

phase of EFT and deescalated the conflict in the relationship. Additionally, it is assumed that the hypersexual behavior is in remission or well on its way to recovery. For ease of explanation, we will refer to the hypersexual partner as male and the injured partner as female.

1. The partner who has not engaged in hypersexual behavior is invited by the therapist to articulate the injury and the impact it has had. This injured partner is encouraged to begin risking reconnecting with his partner (now accessible to him through couples therapy). Generally, the injured partner recounts the emotional pain associated with the hypersexual behavior. In describing her experience, she might share feelings of abandonment or helplessness or times when she experienced a violation of trust that damaged her belief in the relationship as a secure bond. Often, the injured partner speaks about this injury in an emotionally reactive manner. Through this account, the injury becomes alive and present rather than a distant or disconnected recollection. The hypersexual partner will often discount, deny, or minimize the incident, and this act trivializes his partner's pain. He subsequently becomes defensive as a way of protecting their fragile sense of self. In many cases, the defensiveness is a manifestation of narcissism desperately trying to protect the broken sense of self.
2. The injured partner begins to integrate the narrative (the story or context in which the events occurred) and the emotions associated with the story. This process accesses the attachment fears associated with the injury. The therapist helps the injured partner remain connected with the pain of the injury and begin to articulate its impact and significance with respect to attachment-related emotions. At this point the identification and expression of painful emotions often elicits new emotions. Anger is translated into clear expressions of hurt, helplessness, fear, and shame. The connection of the injury to present negative patterns in the relationship becomes clear. For example, the injured partner says, "I feel so hopeless. I find myself yelling at him to show him he can't pretend I'm not here. He can't just wipe out my hurt like that. I want him to suffer too."
3. The hypersexual partner develops understanding of the significance of his behavior and acknowledges his partner's emotional pain and suffering. The hypersexual partner, supported by the therapist, begins to hear and understand the impact of his sexual activities in the context of attachment. He reframes the pain of his injured partner as a reflection of her love for him and realizes that her suffering exists because she considers him a person of importance. The ability to give an alternative explanation to his partner's emotional pain empowers the hypersexual individual to let go of beliefs that her protests are personal attacks or a reflection of her own inadequacies. He is invited to continue exploring his injured partner's pain and suffering and elaborate on how the behavior evolved for him.

4. The partner who has been injured moves toward a more integrated articulation of the injury and how it relates to her attachment bond. She expresses the grief and loss involved with the injury and any fears that may exist about the attachment bond (e.g., fears of abandonment, being alone, not being loved, or future betrayal and ruptures of trust). The injured partner, in the safety of the therapist's office, allows her hypersexual partner to witness her vulnerability.
5. The hypersexual partner acknowledges responsibility and empathetically engages in the process of healing the relationship. He becomes more emotionally available as he assumes accountability for his part in the attachment injury. Expressions of empathy, regret, and remorse may be present.
6. The injured partner is invited to express her emotional needs (e.g., I need reassurance, I need to feel loved, I need to feel safe). She may risk by asking for reparative comfort and caring, which were unavailable and inaccessible at the time of the attachment injury.
7. If the hypersexual partner is able to demonstrate the ability to meet the emotional need of the injured partner, a bonding event occurs, creating an antidote to the hurt created by the traumatic experiences associated with the hypersexual behavior. Beliefs about the relationship are redefined (e.g., the relationship can be a safe place), and the couple collaboratively reconstructs a new narrative of the traumatic events. This narrative has order and may include, for the injured partner, clarity about how the hypersexual behavior developed and why her partner made choices that undermined the foundation of their attachment. For the hypersexual partner, he may reconstruct beliefs about his way of coping with stress or emotional pain. He reorganizes his beliefs about the attachment being a safe place where his needs can be met.

These seven processes occur over time. The therapist might consider seeing each partner individually at times during the process if necessary. If one or both partners have individual issues, these may be addressed separately from the couples work. For example, one man who was involved with hypersexual behavior was married to a woman who had a Borderline Personality Disorder. Each of them received individual therapy until they arrived at a place where they could work on the relationship. If the hypersexual partner continues to struggle with sexually acting out, it is important for him to receive individual and possibly group therapy in addition to couples counseling with his partner. In most cases, couples therapy should be suspended until the hypersexual partner has some level of sobriety, especially if the presenting problem was the sexual acting out.

It is not uncommon that one or both partners will have tremendous ambivalence about wanting to stay in the relationship. This is usually a reflection of the deep hurt they have suffered, and unless they both develop some hope that they will not regret the decision to recommit to the relationship, they

will have a hard time risking and being vulnerable with each other. EFT assumes that both partners want to repair the attachment rupture, but it also can accommodate some ambivalence, which is to be expected.

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

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

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

ISSUES EFT SEEKS TO ADDRESS IF THE ATTACHMENT RUPTURE IS TO BE HEALED

As couples work through attachment injuries, both partners will have needs that must be addressed before they will be willing to move forward in the relationship. In particular, the following list represents some of the common denominators we have witnessed in our clinical work where couples have successfully repaired attachment injuries.

- The hypersexual partner needs to develop the ability to regulate and process his own feelings and respond to his partner's emotional needs.
- Core maladaptive beliefs about self and partner need to be transformed to healthy adaptive beliefs.
- A road map for restoring trust needs to be established.
- The injured partner needs to feel that her partner understands the impact of his choices to engage in hypersexual behavior.
- The couple needs to have some experiential evidence that they will not regret their decision to recommit to the relationship.
- Forgiveness for unhealthy choices needs to occur.
- Both partners need to reorganize their feelings and beliefs about their sexual relationship.
- New patterns and rituals for accessing, connecting, and responding to each partner's emotional and physical needs must be established.

The following case example is intended to provide a snapshot of EFT and represents some portions of the beginning stages of working with a couple and their attachment injury. It is not intended to exemplify a comprehensive overview of EFT. Additionally, in this case, as in many others, it was assumed that the couple has an agreement of monogamy.

CASE EXAMPLE: GREG AND DEBBIE

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

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

The following dialogue occurred as part of a session where Greg was invited to explore the injury Debbie experienced as a result of his hypersexual behavior. The transcript has been modified slightly from the original dialogue to help it flow and to preserve anonymity for the couple. (This couple has consented to have their data be used for research purposes

and for the education of other mental health professionals in workshop and publication venues, provided that identifying information be altered to preserve anonymity.)

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

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

Debbie: I was shocked. [Pause] I sat there reading this letter from the court that said he needed to appear for some hearing and I saw the charges and I initially thought he had tried to have sex with a child or something like that. I couldn't even finish reading the letter [starts crying; therapist leans forward in chair focusing on Debbie] because my eyes welled up with tears and I couldn't see anymore. [Greg is looking at the floor as she is speaking]. Then this really sick feeling came over me [crying escalates] and my stomach felt like it was twisted in a thousand knots. I just sat there and couldn't stop crying. I felt like I could hardly breathe and my head started to hurt. Part of me was saying to myself, "My God, this can't be happening to me. There must be some mistake," but something told me this was no mistake.

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

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

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

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

Greg: That's not true.

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

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

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

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

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

Debbie: [Facial expression of disbelief]

Therapist: [speaking softly] You feel bad.

Greg: Yeah.

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

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

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

Greg: Yeah. I know I should feel something.

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

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

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

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

Therapist: [Speaking softly] Greg, you're fighting those tears right now. Those are important tears. I'm wondering if you could let those tears speak for you. [Therapist attempts to have Greg lean into his emotions.] What do

your tears say? [Debbie has stopped crying at this point and is intently focused on what's happening with Greg.]

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

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

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

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

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

Therapist: You're afraid he'll never understand, but it's important to you that he does. [Therapist reflects and validates.]

Debbie: I don't think he gets it. I don't even know if he's capable of getting it.

Therapist: How did you feel yourself reacting after he initially told you he felt bad? [Therapist checks Debbie's reaction to him.]

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

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

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

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

Debbie: He never shares feelings like that.

Therapist: You want him to share his feelings.

Debbie: Of course.

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

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

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

Debbie: [Turns to Greg] I'm tired of the lies. I can't be lied to anymore. I just want you to tell me the way it is. If this is going to work, you have to start

being completely honest with me no matter what. [Greg nods affirmatively, agreeing with Debbie's request.]

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

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

SUMMARY

Hypersexual behavior can have a devastating impact on couple relationships. There are numerous issues that affect the relationship dynamics. EFT can be a very powerful intervention in repairing attachment injuries, provided couples are willing to risk and be open to identifying and sharing their emotions. Additionally, therapists who desire to implement an EFT approach with couples need to feel comfortable using strong emotion to create new emotional experiences that change relationships. We hope that through outlining and introducing some of the principles of EFT as they relate to attachment injuries caused by hypersexual behavior, the reader will see the potential in using EFT with couples impacted by these presenting problems. Clinicians interested in investigating EFT will discover numerous articles in the literature as well as opportunities to receive training and supervision as they acquire the skills

necessary to become competent and effective EFT therapists. As therapists are able to cultivate a safe environment where emotionally charged situations can be processed and resolved, we believe they will discover that EFT is a powerful approach to helping couples repair and reconcile attachment injuries associated with hypersexual behavior.

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APPENDIX

The 3 Stages and 9 Steps of EFT

Stage 1: Assessment and Cycle De-escalation

1. Create an alliance and identify the conflict issues.
2. Identify the negative interaction cycle, and each partner's position in that cycle.
3. Access unacknowledged primary emotions underlying interactional positions.
4. Reframe the problem in terms of underlying emotions, attachment needs, and the negative cycle.

Stage 2: Engagement: Changing Interactional Positions and Creating Bonding Events

5. Promote identification with disowned needs and aspects of self, and integrate these into relationship interactions.
6. Promote acceptance of the other partner's experiences, aspects of self, and new interaction patterns.
7. Facilitate the expression of needs and wants to restructure the interaction, and create emotional engagement.

Stage 3: Consolidation

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