

Emotionally Focused Couple Therapy and Addiction

MARTIN LANDAU-NORTH, SUSAN M. JOHNSON,
AND TRACY L. DALGLEISH

INTRODUCTION

Relationship problems and addiction go hand in hand. Addictions are toxic for relationships and negative relationships make individuals vulnerable to stress and less functional coping styles and thus more likely to turn to addictive substances and behaviors. Distressed relationships are also predictive of a poor prognosis in alcohol and drug abuse programs (Fals-Stewart, Birchler, & O'Farrell, 1999, 2003). Reviews of the best evidence-based treatment approaches to substance disorders indicate that most of them emphasize a focus on family or social networks as a key "active ingredient" of successful therapy (Miller & Wilbourne, 2002).

In spite of the fact that EFT practitioners report working successfully with couples who struggle with addictions, there is a paucity of material on the use of EFT with these couples. This chapter represents a modest start in addressing the growing use of EFT in the context of addictions. The word "addiction" comes from the Latin *addictionem*, the literal meaning of which is "a devoting." It appears to have been first used in its negative modern sense in the early nineteenth century to describe the opium addict's obsession with this drug. Romantic love has also been called an "addiction" (Fisher, 2004), although recent research has found that when this love lasts, the obsession or infatuation aspect that we might most associate with addictions disappears (Acevedo & Aron, 2009).

Stated similarities between romantic love and addiction hinge on the power of love as a motivating force, the “hunger” generated for contact with the beloved, and the distress that arises when this hunger is not satisfied. The exploration of the neurochemical correlates of love, especially the discovery that romantic love turns on dopamine, the brain’s reward system, has also been used to link it to addiction. Viewing a photograph of a deeply loved partner seems to create brain activation patterns similar to those seen after an infusion of cocaine or opiates (Bartels & Zeki, 2000). The process of affect regulation does indeed appear to be inherent in an attachment view of romantic love and in the process of addiction; one man turns to images of contact with his wife for comfort while another turns to cocaine.

Thus, perhaps the ultimate goal of the EFT therapist working with an addicted couple is to help the addict substitute an “addiction” to emotional connection with a loved one for his or her attachment to a negative obsession with drugs, alcohol, or activities such as gambling or internet porn. As EFT therapists, we do use this metaphor with couples in reframes. We might say to an addict, “Your wife does get upset with your obsession with poker. It takes you away from her. It’s like poker is your mistress and you put this mistress first. You turn to this mistress for pleasure and comfort.” Metaphors can be useful as communication tools, but it is dangerous to take them literally. Although there are similarities, it seems to us that the addiction label can only seriously be applied to love if we focus on the initial infatuation phases of romantic love and also hold to a pathologizing view of adult dependency.

A more accurate way to place EFT as an attachment-oriented approach into the context of addictions is to suggest that the EFT process can help to address addictions precisely because it offers the opportunity to shape effective dependency (Bowlby, 1969). Addiction is a form of compulsive behavior that involves an ever increasing constriction of a person’s behavioral repertoire (Insel, 2003). Secure, effective attachment involves the promotion of a broad and flexible response set and relationships where individual partners are stronger, more able to make choices, feel better about themselves, and become less focused on regulating negative emotions and more open to learning and growth.

Secure attachment, where individuals can turn to others as a safe haven and to provide a secure base that allows for resilient coping in the world, is the ultimate goal of EFT. This

kind of bond makes us stronger and less vulnerable to becoming caught in the web of addictive substances and activities. Secure attachment fosters a positive and functional way of dealing with our hunger for comfort, positive emotions and sensations, soothing and relief from pain, and a sense of ourselves as valuable and strong. As such, it can perhaps be thought of as an antidote to addiction.

SUGGESTED MODEL FOR EFT PRACTITIONERS

If we take heavy drinking as an example of addiction, it is clear that there is no simple single pathway into addiction (Molnar, Sadava, Decourville, & Perrier, 2010). Some people drink heavily for social reasons, such as to fit into their social group. This main pathway to addictive drinking is, however, an emotional one. People drink to move into positive affect and alleviate emotional distress (Cooper, Agocha, & Sheldon, 2000).

Once the initial motivation leads into habitual addictive ways of regulating negative emotions, the second question becomes, how is this habit maintained, in spite of obvious negative consequences? First, we suggest that rather than focusing on the physical dependence model of addiction (where the pain of withdrawal triggers further use), an alternative positive-incentive theory of addiction (Pinel, 2006) is most useful. Pinel pinpoints the problems associated with the physical-dependence theories of addiction. These theories essentially state that addicts become ensnared in a substance-driven cycle whereby they are either taking drugs or struggling with terrible symptoms of withdrawal, thus having what is called a physical dependence on the drug itself.

However, some drugs, such as cocaine or amphetamines, do not produce severe withdrawal distress. Detoxified addicts, with no drugs in their system and who are no longer undergoing withdrawal, mostly regress to their former addictive behaviors even after long periods of abstinence. Also, addicts often find sufficient "reward" in drug-related cues alone. Alcoholics will fool around with an empty wine bottle, drool over it, and show behaviors that mimic intoxication. Needle addicts have been known to become euphoric by merely inserting empty hypodermics into their limbs even though there is no drug present.

The positive-incentive theory postulates that addicts are first and foremost caught in a web of expectation. This expectation of escape, release, and a positive shift in emotions in reality provides a more intense high than the pleasure

addicts experience when actually drinking or taking a drug. Addictive behaviors are driven by anticipatory pleasure, and thus cravings are disproportionate to the actual pleasure ultimately derived from taking a drug or substance. Robinson and Berridge (1993) emphasize that it is not the pleasure of the drug that is fundamental to addiction. Rather, it is the wanting, the anticipation of a joyful high, or the release and disinhibition of drunkenness.

An example familiar to many may be that of underage binge drinkers. After planning intensively for a week, there is a party organized for a Saturday night. The excitement is palpable. Once at the party, they knock back their beers and after 10 minutes they are "out of it." The day after, they remember very little of what occurred the previous night. The pleasure is in the anticipation of the drinking than in the actual act, which was quick, numbing, and followed by vomiting and an unpleasant hangover. They then swear off ever having another drink, but within days, high on anticipation, they anticipate their next foray into substance abuse.

With pornography addiction, one of the authors of this chapter has found that the planning, secrecy, and anticipation of viewing sexually explicit materials maintains a quasi-persistent state of arousal, which lasts much longer than the actual viewing of pornography or the pornography-induced orgasm. Anecdotally, that author has had six male patients report that the persistent prodromal sexual arousal is, in many instances, more intense than the rapid or spontaneous ejaculation that occurs when the pornography is in fact viewed.

While the physical-dependence model cannot be dismissed in its entirety (withdrawal hurts), there is evidence to suggest that the positive-incentive theories pertaining to drugs, alcohol, and, in the one author's experience, also pornography elegantly capture the primary factor in addiction (Cardinal & Everitt, 2004; Everitt, Dickinson, & Robbins, 2001). In terms of relapse into addiction, the three causes seem to be rising stress, priming (a single exposure to the formerly abused substance), and exposure to environmental cues associated with the addiction.

For the EFT therapist, acceptance of the positive-incentive model leads to productive implications for the role of EFT in treating addictions and ties into an attachment approach to addiction. It emphasizes that it is not just the addictive behavior itself that is problematic for relationships. Once distracted by the anticipatory pleasure, the distracted and addicted

member of the dyad becomes progressively and chronically more emotionally absent. Over time, this absence erodes romantic attachment, and in response the nonaddicted partner, while remaining attached, sends more and more cues of disappointment and anger.

This perspective also stresses that addiction is not just about altering, escaping, or coping with negative emotions; it is about seeking pleasurable mood-enhancing experiences and how the reliable expectation of these can be used as a constant emotional defense and regulator in everyday life, much as a felt sense of secure connection operates in positive relationships. In general, people attribute risk-taking behaviors to conscious efforts to pursue positive emotions and to escape from negative ones (Cooper, Flanagan, Talley, & Micheas, 2006). This implies that any relationship intervention with couples facing addiction has to focus not only on coping and conflict reduction but also on the creation of predictable positive emotional experiences and perhaps on bonding experiences that release pleasurable "cuddle" hormones such as oxytocin (Carter, 1998).

Addiction is also a systemic process—a set of interacting intrapsychic and interpersonal variables that impact and shape each other. As relationships become more negative and the addictive behaviors become more all encompassing, the addicted partner naturally turns more and more to the addiction as a primary predictable source of pleasure and as a reliable escape from his or her sense of alienation. Addicts become more and more disengaged with others as they become obsessed with the release and pleasure of future indulgences. Once the drug has been taken, the alcohol imbibed, or the pornography viewed, the inevitable consequences in the couple when the actual addictive act is discovered create a situation where alternative routes to positive emotion are lessened, negative emotion is heightened, and the addictive behavior gains in incentive value. The addictive substance becomes the only "solution" to negative emotions and a surrogate source of pleasure and soothing.

In key studies of behavioral marital therapy (BMT), this approach, which focuses on teaching communication and problem-solving skills, has been used in combination with individual treatment for drug addiction; this combination has been found to be more effective than stand-alone individual treatments (Fals-Stewart, O'Farrell, & Birchler, 2001). Studies of alcohol-related problems with BMT also show a consistent pattern of more abstinence and happier relationships for clients

who receive BMT rather than only individual treatment (Fals-Stewart et al., 2003).

This behavioral intervention, its proponents note, has not been widely used. They suggest that this may be because it does not subscribe to the dominant disease model of addiction. Any couple approach to the treatment of addiction, while acknowledging the physiological impact of addictive substances and the power of the painful physical withdrawal process to trigger relapse, has also to pinpoint the power of specific relationship factors in the generation and persistence of addiction and the recovery process. EFT has a very specific, rich, and well-researched theory of adult love in the form of attachment theory and this offers a specific perspective on addiction and its treatment in couple therapy.

ADDICTION AS AN ATTACHMENT DISORDER

It is easy to frame addiction in attachment terms (Flores, 2001). Securely attached individuals are more into self-protective health behaviors and therefore less prone to damaging behaviors such as heavy drinking (Brennan & Shaver, 1995; Thorberg & Lyvers, 2006). Attachment is essentially a theory of affect regulation. Addiction can be seen as a consequence of and dysfunctional solution to the absence of satisfying close relationships and particularly as a seeking after comfort and positive emotion in a context of the experience of emotional isolation. The addiction becomes a substitute place of momentary security and pleasure and relief from this pain. Addiction is also associated with a particularly negative and shameful view of self as being inadequate and undeserving (McNally, Palfai, Levine, & Moore, 2003). The drug of choice then functions as a source of self-aggrandizement providing temporary relief from these negative models of self.

Higher levels of attachment anxiety and avoidance in close relationships result in less ability to regulate and manage internal distress and to reach out to others for support (Mikulincer, 1998). In general, anxious and avoidantly attached adults are more likely to use dysfunctional strategies to soothe, distract, and excite, such as engaging in risky sexual activity. For example, avoidant individuals are more likely to choose one-night stands as a sexual strategy (Gillath & Schachner, 2006; Stephan & Bachman, 1999). Anxiously attached adults drink more, explicitly drink to cope, and drink with greater negative consequences (Molnar et al., 2010). Some studies suggest that

the anxiously attached indulge in problem drinking more than secure or avoidantly attached individuals (Kassel, Wardle, & Roberts, 2007; McNally et al., 2003).

Other studies (Cooper, Shaver, & Collins, 1998) find that both avoidant and anxiously attached young people consume more alcohol. It seems that sometimes anxiously attached individuals drink specifically to reduce negative affect and that dismissing individuals drink more to enhance positive affect. Another study (Doumas, Blasey, & Mitchell, 2006) found that anxious and fearful-avoidant attachment (both of which they note are characterized by a negative sense of self) were over-represented in alcoholic and drug-dependent groups.

Attachment theory would predict that those of us who did not experience a safe haven and secure base relationship as children would be more vulnerable to the impact of stress and trauma, less able to cope with this stress by turning to others for support and caring, and thus be more likely to turn to addictive substances and behaviors to regulate emotions. These factors then release a cascading feedback loop where negative relationships forge negative views of self and other and more isolation and more stress result in more addictive coping behaviors, more conflict and distance in the relationship, and more attachment insecurity.

In therapy, a vicious cycle often appears where relationship distress triggers addictive behaviors or relapse into these behaviors and addictive behaviors trigger or maintain alienation and conflict. The addictive substance or activity, rather than the partner, becomes the addict's safe haven and secure base. Partners feel replaced and abandoned as well as betrayed by an addict's use of lies and evasions to hold onto his or her habit. So-called "codependent" responses that accommodate to the addict's habit are attempts by these partners to hold onto the tatters of their attachment bond with the addicted partner.

For example, Louis, in the case example offered later, grew up in a "cold" and extremely reserved and formal family. He could not remember ever being held or even playing in an intimate way with his siblings. Task performance and work were the focus of family life. As part of his adolescent rebellion, he had begun to play cards with boys in his neighborhood. At the card table he felt competent, "powerful," and admired. He won easily. This activity grew into a consummate skill in and obsession with poker and he played poker all through university into his early adulthood. He was a shy, introverted man who had few friends or girlfriends. He married Anne, his first

serious girlfriend, and in the first years of their relationship, he developed his career as an accountant and stopped playing poker altogether.

However, 10 years later, after setbacks in his career, the arrival of twin boys, and growing alienation in his marriage, he joined a local poker club and within a year he was playing poker at tournaments on the weekend, two nights a week at a local club, and on the Internet every night. His wife objected more and more strenuously and they began to fight regularly over this issue. The more they fought, the more he turned to poker. He denied that his love of poker was in any way a problem; he pointed out that he won constantly and made significant money for the family this way and increased his involvement in the game.

The crisis occurred when he was playing on the Internet one night and his son fell down the stairs and knocked his head. Anne was alarmed and called for him to come, to which he replied, "Not now, I am winning!" Later that week, Anne discovered that on a few occasions Louis's poker club had invited a prostitute to come and offer favors at the end of the late-night games. She announced that she was leaving and moved with her sons into her mother's house. Louis's brother confronted him and Louis sought out therapy for his "problem." Two months later, Anne moved back in and they came for couple therapy.

The absence of secure attachment in this dyad triggered a propensity to turn toward addiction as the solution to distress in what Flores (2004) calls a *faux* attachment. This faux attachment also becomes integrated into the individual's self-concept, which then undermines the addicted partner's reengagement in the strengthening of the weakened attachment bonds (Johnson, 2004). This sense that addiction is inextricably tied into attachment bonds has also been noted as one of the reasons that the 12-step programs work. The essence of these programs is a relationship with a group of similarly struggling companions and also with a mentor who offers a form of safe haven and a secure base to the addict.

An attachment orientation to addiction also implies (Flores, 2004) that just as medication or addictive substances can alter neurology and biochemistry, so can the experience of secure attachment (Lewis, Amini, & Lannon, 2000). It is already clear that a felt sense of attachment alters brain responses to threat (Coan, Schaefer, & Davidson, 2006) and triggers the release of the cuddle hormone oxytocin and the sense of calm contentment it elicits.

EFT AND COUPLES STRUGGLING WITH ADDICTION

This chapter will not address the question of whether total abstinence is the only way to address addiction successfully, as is promoted by Alcoholics Anonymous in the 12-step model of treatment, or whether moderation management and controlled substance use can work (Marlatt, 1998). There is evidence that prolonged use of addictive substances alters the production of neurotransmitters and brain functioning and leaves some users unable to use substances nonaddictively (Leshner, 2001) so that nothing less than a commitment to total abstinence is likely to help. We suggest, as in the case of couple therapy with survivors of trauma who show signs of PTSD, that the identified addict needs to take responsibility for the addiction and its consequences.

The best scenario, then, is that the individual addict acknowledges his problem and takes active steps to address his addiction before beginning couple therapy. If this responsibility is absent, then the therapist will not be able to create safety in the couple session or encourage the nonaddicted partner to increase his or her engagement in the relationship. The level and chronicity of the abuse also need to be taken into account in terms of the feasibility of couple therapy. The EFT therapist also needs to be clear about the nature of the treatment that the addicted partner is engaging in for his or her addiction so that conflicts with EFT are minimized.

The EFT therapist is a process consultant, so if the addiction is denied or not seen as an issue by the addict, the EFT therapist has to offer the perspective that couple therapy is unlikely to offer any benefit, that the compulsive attachment to the addiction is undermining the relationship in very specific ways and will continue to do so, and that the couple's relationship is, in essence, caught in the jaws of the addiction. Along with this "I don't think this will work" message, it is also possible to offer hope in the form of images of what a positive relationship looks like, how it might offer more effective solace and satisfaction, and what would have to happen for the couple to begin this journey.

There is also a need with addicted partners for added vigilance on the part of the therapist in the assessment phase of EFT regarding issues of violence and anger problems and issues of depression and self-harm. The individual sessions provide a place where the therapist can ask explicit questions about these issues and apply the practice principles laid down

in EFT (Johnson, 2004) regarding criteria for excluding couples on the basis of violence. The therapist uses the fear level of the less aggressive partner as the benchmark for whether it is possible to create safety in sessions and thus implement EFT. As with a partner suffering from PTSD (Johnson, 2002), the therapist may set up a contingency containment plan with the couple so that if issues of aggression or self-harm arise, there is a clear way of dealing with them and protecting partners from harm. There is evidence that couple therapy is indeed effective with couples who exhibit mild to moderate physical aggression but want to preserve the relationship and end the aggression (Simpson, Atkins, Gattis, & Christensen, 2008).

For an attachment-oriented approach to addiction issues in a humanistic intervention such as EFT, the principles that add to and expand how this model is implemented are the following:

- The therapist takes a person-centered rather than a problem-centered approach (Rogers, 1951) and accepts that the addicted partner has good reasons for his or her addiction. Many of these reasons will involve problematic attachments and, as Bowlby suggests, in this context a person's less than functional attempts to deal with emotions and the dilemmas of connection and disconnection are "perfectly reasonable." At the same time, the therapist pinpoints the toxic impact of the addiction on the addicted person, the partner, and the relationship. It is worth noting that those who struggle with addictions are more likely to report having parents who were addicted and that the children of such parents report high levels of attachment insecurity with romantic partners (Brennan, Shaver, & Tobey, 1991; Kelley et al., 2005). This attachment perspective offers a specific bridge between a family history of alcoholism and impaired relationships that then renders the next generation vulnerable to addictions. This also reminds us as therapists that most addicts have never seen the kind of secure connection that they wish for and try (without any blueprint) to create with their partner. The speed with which they fall into hopelessness in relationships is then understandable.
- In Stage 1 of EFT, the therapist places problematic compulsive responses and patterns in the context of the recurring spirals of negative interaction patterns such as demand-withdraw that continually confirm

attachment insecurities and often trigger turning to addictive substances. An addiction is both cause and effect for relationship distress; both the addiction and relationship distress trigger and maintain each other. The addiction is framed as part of a couple's negative cycle and, like that cycle, as the enemy in the couple's relationship that they can best defeat together. Specific effects of the addiction, such as the partner's vigilance for cues that the addiction is still present, are outlined and put into a couple's general cycle of distress.

- The validation of the need for emotional safety as the essential foundation for emotional openness and responsiveness is key. Negative behaviors such as angry outbursts or potentially abusive responses must be contained as noted before.
- Before beginning Stage 2 of EFT, the therapist needs to make sure that the addiction is being contained. An experienced therapist noted that working with addicted couples is like being in a canoe. There is a need to balance the risks involved in working through issues and reaching for the other with the risks of emotional flooding and subsequent relapse into the addictive behavior. In Stage 2, deeper emotions are explored, distilled, and shared in ways that create more open, responsive interactions. When working with addictions, once negative cycles of interaction have been outlined and owned, the deeper primary emotions linked to addictive responses are explored and placed in the context of attachment needs and fears and expectations for or models of self and other. Thus, sadness, deep fears about rejection and abandonment, and fears and shame about the self as inadequate or flawed are explored and placed in the context of the fall into addiction and attachment needs. Key moments in a partner's exploration of experience that focus on addictive responses as apparent "solutions" to emotional starvation and despair will be focused on and explored so as to deepen emotional awareness. Emotion and attempts at the regulation of emotion are seen as a leading or organizing element in the addiction and in the couple's attachment system.
- As part of Stage 2, positive interactions are created in enactments and these enactments, where one person risks and reaches for the other, are framed as direct

alternatives to the addictive behaviors and associated demand or withdrawal responses. Thus, at this point, Doug is able to tell his wife, "When this empty feeling comes for me, I just want to run. I run to booze or I badger you for sex. Anything not to feel this emptiness. I haven't known how to ask for your caring. But I think this...this reassurance and closeness is what I need. Can I ask you...?" The therapist helps Doug and his wife make this response into a coherent acknowledgment that he is now choosing to turn to her rather than numbing out with a bottle. Loving connection is structured and framed as the antidote to addictive regulation strategies.

- As part of the consolidation stage of EFT, partners formulate a story of their relationship distress and repair. Couples are encouraged to create a coherent story of the addiction and how it impacted their relationship, including how problems related to the addiction still emerge and how they are now able to deal with them.
- The therapist will guide partners to formulate a plan to guard against relapse into the addiction and to note triggers into the emotional states that set up these relapses.

It may be useful also to note that while some commentators see alcoholics and addicts as "notoriously counterdependent" (Flores, 2004, p. 43) or extreme avoidant, we and other attachment theorists (P. Shaver, personal communication, Feb. 2010) view them most often as using fearful-avoidant or disorganized attachment strategies. This means that these partners tend to flip in a haphazard manner between anxious hyperactivating and avoidant deactivating attachment strategies. They distance others and are uncomfortable with closeness but they also continue to experience a longing for connection. They cannot simply dismiss attachment and deny their need for support. They are high on attachment anxiety and avoidance.

This strategy arises from growing up in an abusive or highly neglectful family (Shaver & Clark, 1994) and is often seen in trauma survivors who have been violated in their families. It then results in extremely intense but ambivalent, ambiguous messages being sent to the partner, such as "Come here. Why aren't you supporting me?" followed by "Go away—I don't need you." Others are, at one and the same time, the source of and

solution to fear. An addictive substance allows for the regulation of anxiety without the risk of interpersonal connection.

There is extensive evidence that those responding with a fearful avoidant strategy tend to experience the least security and trust in adolescence and adulthood (Shaver & Clark, 1994). They have especially negative representations of their romantic partners, show less empathy for distressed others, are more cognitively closed and rigid, and generally show the poorest mental health (Mikulincer & Shaver, 2007). As with traumatized clients (Johnson, 2002), the therapist may have to slow the pace of therapy and slice risks thinner as well as offer more support and structure to help these partners take risks and order their chaotic inner experience. For all of these reasons, couple therapy with addictive partners may take longer than the usual 12–20 sessions of EFT. It is also worth noting that while there are positive outcome studies (listed on www.iceeft.com) assessing the use of EFT with trauma populations, there are as yet no outcome studies completed specifically with couples facing addiction. This is obviously a project for future research.

CASE 1: “BUT I WIN AT POKER”

As described earlier, Louis and his wife, Anne, exhibited a typical withdraw–demand pattern in their extremely distressed relationship. Louis had just recently engaged in individual therapy for his addiction, although he was still denying the seriousness of his problem in initial couple sessions. However, after 6 weeks alone in his house, he was very clear that he did not want to lose his family. In terms of Prochaska, DiClemente, and Norcross’s (1992) stages of change, Louis had gone through precontemplation and contemplation into preparation and was moving into the action phase of addressing his addiction; this is a particularly stressful phase where individuals rely on increased support from helping relationships.

This professional couple was seen by the second author 15 times over a 6-month period. In the interest of brevity, in this first case example, the pivotal events and turning points together with challenges and key interventions will be summarized. At first, Louis admitted that his “obsession with” poker had destroyed his wife’s trust in him. They both agreed that they had become caught in a cycle where she would try to accommodate to his poker habit but then explode and accuse him. He would defend himself, “shut down,” and then play

even more poker. He saw his habit as “an escape” from the stress of his job. Anne called poker his “mistress.” By the first session of couple therapy, Louis had been able to limit his poker to 2 hours, one night a week, with his wife’s agreement. Anne would repeatedly angrily remind him of events such as, “On our 12th anniversary you played cards for 20 hours straight; I was never in your mind! And you lie to me all the time—to protect your card games!”

Louis would begin by trying to defend himself, “No. It was only 10 hours that time” and then would be able to admit, “You and the kids were together and I was on the outside. I got so I was oblivious. I was lost. I was absent. I guess the word ‘addiction’ is the right one after all.” Anne was now triggered into “panic and rage” if Louis even suggested playing. He had a very hard time articulating any emotion, but his face was a constant picture of sadness, shame, and bewilderment. He and his individual therapist were also working on his “depression” and he commented, “I think, really, I have been depressed forever. The first few years with Anne are the only bright spot in my life.”

Anne would then hiss, “You were the one who ended that. You left me for the high of winning.” He agreed that the anticipation of winning was the drug that intoxicated him and told her, “I can control my playing.” She would accuse, “You can’t control anything. You were consumed by that habit. And you deceived me, like I didn’t matter. I was robbed.” He would reply, “I deceived me too.”

A key challenge in Stage 1 was to create an alliance with Louis and help him articulate his experience of the relationship. He was very “logical” and spoke very fast, but was able to allow the therapist to guide him in slowing down, exploring, and pinpointing his experience. He tells Anne:

I have been alone forever. I am trying so hard. But poker was always there. I went back to counting on it when we lost each other. You were always with the kids and I would get hopeless somehow. At the poker table, I was a winner and everyone told me I was such a genius.

The therapist would have to validate his turning to cards while still noting the damage this had done and Anne’s feelings. It was also necessary to “catch the bullet” when Anne would attack him as he attempted to share. Empathic reflection, validation, and process reflection were the main ways here. Both partners were able to grasp their pattern: She would

demand, "You are playing poker too much. Do you want to be my husband? Where are you?" He would "hide," reason, defend, and play even more poker. Louis was able to admit that he had gotten to the place where he realized that he "had no idea how to be married and just got sad and overwhelmed." He was able to tell her, "I hated my work. I felt like I had lost you. I was failing, failing, so I just got more and more caught in getting high at the table. It was my lifeline."

The underlying emotional music here was the same as that which we find in nonaddicted couples. The withdrawn partner struggles with a sense of inadequacy and worthlessness and shuts down (but in this case finds a substitute safe haven in his addiction), while the other becomes more "panicked, angry, and abandoned." It was a real struggle for Louis to grasp the impact of his addiction and his "absence" on his wife. The therapist constantly framed his actions in attachment language, helped her to confide the panic and abandonment she had felt for many years, and helped him tune in to and process it. The interlinked nature of addictive behaviors and the necessity for helping couples exit negative cycles is supported by the finding that perceived criticism from a partner can undermine self-efficacy and lead to relapse (Fals-Stewart, O'Farrell, & Hooley, 2001)

Key moments in Stage 2 of EFT were when Louis was able to reengage emotionally with his wife. The therapist had to work very hard here to keep him focused, specific, and concrete. He is able to weep for the aloneness that he has "always" felt and the huge sense that he is alone because of his deficits as a person. He tells her:

I needed this catastrophe to wake me up. I don't want to lose you and I want to be a dad. But all I know is distance. I am terrified that I cannot win here. I don't know how to be a husband. But I want to learn—for you to risk and let me learn.

It is one of the routine miracles of EFT that his wife allows herself to be moved by his vulnerability and presence and thus reaches for him, even as he admits his "ineptitude." He does not need to "know"; he just needs to be there. This being said, his poker habit was an ongoing toxic irritant in the relationship as he pushed the boundaries of their agreement as to how often he could play. As he became more engaged with Anne, he was able to state limits that fit for him and to hold to them and was also able to tell her, "If I need never to touch

another card again to hold onto you, I will do it." His involvement with his job also changed and he was able, with encouragement, to list "highs" in his everyday life with his job and family, as well as "wins" that carried him through his self-doubts and "nudges" toward poker.

Louis integrates his view of his addiction with his emotional life as a whole. He tells Anne:

I compartmentalized and got lost between the rooms in my head. I hungered for that sense of invincibility cards gave me. I was numb. Hooked. Blind. I felt trapped in my job and as a husband. When you talked about my playing, I would just feel criticized. And now I am ashamed of how I let you down. I know you are watchful, vigilant, now and I accept that. I need to show you that I am safe to rely on. I never knew that I could tell my hurt to someone, that that was even possible.

Helping Anne soften and take small steps toward trust played out as classic EFT with the unpacking of secondary emotions such as rage, thus heightening core emotions such as her grief at years of "not feeling wanted or needed" and her confusion about whether she was entitled to her emotions and needs. (She came from a culture where the man defined the agenda in the home and was not questioned.) She realized that she usually "swallowed" her emotions and then exploded. However, her fear of being "duped again" and "hurt even more" was significant.

Anne (to Louis): It will grab you again and you will glaze over and become someone else. Then I don't matter. I dare not count on you. I keep remembering the night when Adam [her son] hit his head and you did not come. You did not come.

Therapist: This is a deep wound, an injury for you. That moment kind of gathered all the pain and fear of how he was lost to you and you were alone, abandoned, into a ball. You go back to it when part of you thinks about risking—putting yourself in his hands again?

Anne: We didn't matter. I was so, so terrified. My son's breathing was strange. You didn't come. How could you—choose "winning" over us? (She weeps.) It was like we didn't exist.

Therapist: You called to him, desperate, needing him and he was caught in winning and numbing. He didn't hear

you. You are telling him: "I am so hurt that you did not come and so terrified to put myself into your hands again"—yes? Tell him.

Anne: That moment, I did not have a husband; our love had never happened. You were a stranger. The cards had won. (She starts to shiver.) I am cold. Fragile. I can never feel that way again. I have to matter more than that. Can you hear me, Louis?

Louis (weeping, turns toward her): I do. I do. I let you down. I wasn't there. I have no right to ask you to begin to trust me again. I got so mesmerized, so lost. I want to warm you, to hold you warm against me. I am so sad and ashamed. Can you forgive me? I want you. I want our family. I did not understand that you were scared all those years. I saw you as so strong and in charge. I will do whatever you need to begin to feel close again. I saw you as trying to control me. I didn't understand. I am ashamed of how I hurt you and our son.

Anne (sits up in her chair and looks out the window): I just want to slug you.

Therapist: What happened just then, Anne? Can you hear him? He is telling you that he feels your hurt now—he hears your call and he is grieving that he so let you down. He wants to earn your trust. Can you hear him?

Anne: It's too scary. (She weeps and turns back to him.) You might crush me again. How could you turn to that game and leave us? You turned into someone else. I was shattered. (He weeps.)

Therapist: Can you help her, Louis? She is hurting—in pieces.

Louis (leans forward and reaches for her): I want to take care of you. To help you feel safe. I do not want to lose you. I want to reach for you for comfort and have you do the same. I will show you I am here now. (She cries and he gets up and holds her.)

This excerpt is part of the process of addressing the attachment injury that Louis's dedication to poker had created in this relationship. Anne cannot soften and become accessible and engaged with Louis until this traumatic injury (Johnson, Makinen, & Millikin, 2001) is addressed. He has to offer an antidote for her pain and fear in the form of explicit responsiveness and caring. At the end of therapy, both partners see

the negative patterns they created as the enemy and his addiction as a trap that has almost defeated them.

Louis could recognize the addictive sequence of “isolation, helplessness, tension, craving to play, release, soothing, high, numbing, and then repeat” that trapped him in the past. He noted that this “compulsion” for poker seemed to have gone and that he felt much closer to his wife. Anne described herself as gradually feeling safer and more trusting in spite of having periods of vigilance, anxiety, and sadness. He was able to tell his wife when he experienced her as in “distant administration mode” and turn to her when he felt the “warning signs” of poker craving as well as when he just wanted to be close. This couple saw the poker obsession as something they could deal with together and Anne was able to tell him, “It’s still so hard sometimes to ask for your comfort and attention, but I see you turning away from gambling and we are so much closer. I think we can do this, you and I.”

CASE TWO: “IT TAKES AWAY THE PAIN”

An only child, Paula is a 25-year-old accounting graduate. She and Peter, a 29-year-old attorney, met at a speed-dating evening at a local hotel and were married after a 5-month courtship. They had been married just over 2 years when Paula’s physician referred her for couple therapy after she had shown signs of depression due to her husband’s insistence on using pornographic movies as a key part of their sexual life. Peter suggested that she try to be more like the women in the DVDs because she was his wife and should want to please him and that, if she would not do this, then she had broken her marriage contract and did not really love him. She asked that he talk more to her and cuddle her more. He stated that he could only really talk after sex.

As Peter saw the relationship, he gave Paula “everything she wanted, flowers, dogs, everything,” so was a good partner. Peter also constantly complained of bad back pain and often requested to be taken to emergency care at the hospital. As therapy unfolded, it became clear that Peter had been addicted to Vicodin, a narcotic analgesic, since he was 15 years old. His physician father had originally prescribed them for him after he had broken his leg, and he quickly became addicted. After many years, the local physician who had been prescribing this drug for him finally cut him off. Presenting himself at urgent care with excruciating back pain, he had found a loophole in

the system. Often he would be kept overnight and discharged with a prescription for as many as 90 Vicodin tablets.

Both partners agreed that Peter had become more and more disengaged from their relationship. Paula also disparaged his propensity to cry at the slightest upset. She said his tears had become a manipulative tool and saw him as lacking in judgment, citing his erratic driving as an example. She would throw him out of the house after arguments about his addiction, his driving, and his need for porn.

The first author, who has expertise in addictions, conducted 10 sessions with Peter focusing on his addiction and getting him into an addiction program before returning to couple sessions with both partners. These sessions offered an emotional way station to gauge properly the severity, etiology, and impact of Peter's addiction on the couple. Peter's history was one colored by neglect and attachment deprivation. His mother had suffered a stroke at his birth and become blind. Peter was given to his maternal grandparents for 2 years. When his grandmother died, he then went to live with his mother, who had returned home from rehabilitation.

He described his father as "busy all the time" and his mother as "remote and scary." He could never remember her holding him and she openly blamed her blindness on his birth. He could not remember his mother ever touching him, although he did admit that she might have tried when he was older, but that he had "recoiled." His father, a busy surgeon, would only relate to him if he mentioned that he had some sort of medical problem. Peter would invent aches and pains to get his father's attention; as a child, he was given sleeping pills almost every night. His father's offer of chemical soothing seemed to be his only experience of caring and he would "invent" physical hurts to get this soothing. He referred to his parents as "strangers" and was essentially raised by housekeepers.

Peter now described himself as an addict who was also an insomniac, distrustful and angry. He had tried to get his father to ask his colleagues to prescribe Vicodin in many manipulative ways and saw this as a test of his father's love because it "took away the pain." He called his relationship with his dad, "the prescription dance." Peter stated that for many years it was the anticipation of the high that gave him the most pleasure and that the actual taking of the drug became less of a euphoric experience. He stated that he distanced from his father and his wife to punish them (as his mother had punished him) and so that they would suffer rather than him. Peter

had been to rehab in his late teens and had been so engulfed by anxiety that he had only “survived” by turning to porn sites and finding a way to soothe himself there—although, again, as suggested by the “positive incentive model” of addiction, it was now the anticipation of relief that was most potent for him and controlled his anxiety. He now repeatedly expressed the desire that his wife should lose weight to prove her love and look more like the women he saw in pornographic materials.

In their relationship, Peter realized that his anticipatory arousal and obsession with painkillers and porn was experienced as withdrawal by Paula, who would then attack or finally withdraw herself. The couple seemed to be stuck in a blame and withdraw cycle that later evolved into a mutual withdrawal. As when working with trauma couples (Johnson, 2002), the negative cycle in couples facing addiction tends to have more steps—that is, to be more complex and more extreme. As Peter was more and more able to control his addiction, this couple was able to see their negative cycle and the role of Peter’s habits of emotional regulation in this cycle. Paula was also able to acknowledge that her rage and threats to leave were part of this cycle. As he struggled with relapse, Paula’s threats and refusal to be near him when he had “relapsed” merely drove him into his faux attachments, into the soothing smoke and mirrors of Vicodin and pornography.

The challenge with Peter was to facilitate reengagement that then would allow his wife to soften toward him. Peter was able to talk about his urge to punish his wife for not loving him by shutting her out. Periods of anticipatory soothing, offered by images of Vicodin or pornography, had allowed him to distance from Paula without becoming massively anxious. In Stage 1 of EFT, Peter was able to weep at his wife’s “rejection” of him and to acknowledge that his experience of her was colored by his inability to trust and his hurt and rage at his parents. His crying, however, did not “touch her heart” because she was unsure of his sincerity. The therapist was able to help him tolerate her ambivalence. Key snapshots of Peter’s reengagement in Sessions 15 and 16 of EFT are seen in his following words:

I know I kind of flip between pleading and demanding, crying and asking for a certain kind of sex to prove you love me and then turning away and shutting you out. I get that this drives you crazy. And I have deceived you—the pills were easier to rely on. Then I would feel kind of powerful when I turned away

and you couldn't hurt me anymore. I don't know how to do this connection thing. I never had it.

I am so, so scared of you leaving me. Of your anger. I get anxious when we make love that I won't be sexy enough, aroused enough, so I push for the porno. When you do cuddle me, I hold my breath just waiting for it to stop. Then when you threaten to leave, I just go into meltdown. And my brain tells me, "Only the drug is really there when you need. It takes away the pain and the fear." I have been scared and alone my whole life. [Paula is able to respond with compassion here.]

I can't believe that you want to be with me. I am such a desperate screwup. It's hopeless. Even my mother didn't want me. All I have learned to do is try to get my dose of comfort from you, from my dad. I see now how I have hurt you. I am so afraid that I am just defective. How can I ask you to love me? I can't even look in your face here. I will see disgust—contempt—so I crawl off into my hole. I can't ask you to love me.

I don't want to spend my life running like this—looking for a high to pick me out of the mud that is sucking me under. I want to learn to love you. It's so hard for me to trust—I want to come into your arms—I need your comfort. I want you to forgive me. I want to turn to you when my demons and fears and sadness come for me.

Paula was able then to move into her own softening and the couple came together against the addiction—their mutual enemy. This process involved the healing of several attachment injuries involving Paula's sense of abandonment resulting from Peter's deception and his "choosing" of porn over his wife.

The further this couple got from addictive objects, the closer they got to each other, opening the door to a more secure and respectful relationship. Although both remain vigilant and return for tune-up therapy, that certainly has been the case for Peter and Paula.

Walant (1995) suggests that our society has contributed to the rise of addictions by creating cultural norms that pathologize dependency and make expressing needs shameful. She emphasizes the need for therapy to provide "immersion" moments of deep understanding between therapist and client as a means of countering the alienation from self and others that typifies addictive individuals. The EFT therapist might concur, but add that in successful couple therapy, partners change each other and the moments of deep connection between partners seem to us to offer the best healing arena for and natural antidote to the compulsive behaviors of addiction.

REFERENCES

- Acevedo, B. P., & Aron, A. (2009). Does a long-term relationship kill romantic love? *Review of General Psychology, 13*, 59–65.
- Bartels, A., & Zeki, S. (2000). The neural basis for romantic love. *NeuroReport, 11*, 3829–3834.
- Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. New York, NY: Basic Books.
- Brennan, K. A., Shaver, P. R., & Tobey, A. E. (1991). Attachment styles, gender and parental problem drinking. *Journal of Social and Personal Relationships, 8*, 451–466.
- Brennan, K. A., & Shaver, P. (1995). Dimensions of adult attachment, affect regulation, and romantic functioning. *Personality and Social Psychology Bulletin, 21*, 267–284.
- Cardinal, R. N., & Everitt, B. J. (2004). Neural and psychological mechanisms underlying appetitive learning: Links to drug addiction. *Current Opinion in Neurobiology, 14*, 156–162.
- Carter, S. (1998). Neuroendocrine perspectives on social attachment and love. *Psychoneuroendocrinology, 23*, 779–818.
- Coan, J., Schaefer, H., & Davidson R. (2006). Lending a hand. *Psychological Science, 17*, 1–8.
- Cooper, M., Agocha, V., & Sheldon, M. S. (2000). A motivational perspective on risky behaviors: The role of personality and affect regulatory processes. *Journal of Personality, 68*, 1058–1088.
- Cooper, M. L., Flanagan, M. E., Talley, A. E., & Micheas, L. (2006). Individual differences in emotion regulation and their relation to risk taking in adolescence. In D. Snyder, J. Simpson, & J. Hughes (Eds.), *Emotion regulation in couples and families: Pathways to dysfunction and health*. Washington, DC: APA Press.
- Cooper, M. L., Shaver, P. R., & Collins, N. L. (1998). Attachment styles, emotion regulation and adjustment in adolescence. *Journal of Personality and Social Psychology, 74*, 1380–1397.
- Doumas, D., Blasey, C. M., & Mitchell, S. (2006). Adult attachment, emotional distress and interpersonal problems in alcohol and drug dependency treatment. *Alcoholism Treatment Quarterly, 24*, 41–54.
- Everitt, B. J., Dickenson, A., & Robbins, T. (2001). The neuro-psychological basis of addictive behavior. *Brain Research Reviews, 36*, 129–138.

- Fals-Stewart, W., Birchler, G. R., & O'Farrell, T. J. (1999). Drug abusing patients and their partners: Dyadic adjustment, relationship stability and substance use. *Journal of Abnormal Psychology, 108*, 11–23.
- Fals-Stewart, W., Birchler, G. R., & O'Farrell, T. (2003). Alcohol and other substance abuse. In D. K. Snyder & M. A. Whisman (Eds.), *Treating difficult couples* (pp. 159–180). New York, NY: Guilford Press.
- Fals-Stewart, W., O'Farrell, T. J., & Birchler, G. R. (2001). Behavioral couples therapy for male methadone maintenance patients: Effects on drug using behavior and relationship adjustment. *Behavior Therapy, 32*, 391–411.
- Fals-Stewart, W., O'Farrell, T. J., & Hooley, J. M. (2001). Relapse among married or cohabitating substance abusing patients. The role of perceived criticism. *Behavior Therapy, 32*, 787–801.
- Fisher, H. (2004). *Why we love. The nature and chemistry of romantic love*. New York, NY: Henry Holt.
- Flores, P. J. (2001). Addiction as an attachment disorder. *International Journal of Group Psychotherapy, 5*, 63–81.
- Flores, P. J. (2004). *Addiction as an attachment disorder*. New York, NY: Jason Aronson.
- Gillath, O., & Schachner, D. A. (2006). How do sexuality and attachment interact? Goals motives and strategies. In M. Mikulincer & G. S. Goodman (Eds.), *Dynamics of love: Attachment, caregiving and sex* (pp. 337–355). New York, NY: Guilford Press.
- Insel, T. R. (2003). Is social attachment an addictive disorder? *Physiology & Behavior, 79*, 351–357.
- Johnson, S. M. (2002). *Emotionally focused couple therapy with trauma survivors: Strengthening attachment bonds*. New York, NY: Guilford Press.
- Johnson, S. M. (2004). *The practice of emotionally focused couple therapy: Creating connections*. New York, NY: Brunner/Routledge.
- Johnson, S. M., Makinen, J. A., & Millikin, J. W. (2001). Attachment injuries in couple relationships: A new perspective in impasses in couples therapy. *Journal of Marital and Family Therapy, 27*, 145–155.
- Kassel, J. D., Wardle, M., & Roberts, J. E. (2007). Adult attachment security and college student substance abuse. *Addictive Behaviors, 32*, 1164–1176.

- Kelley, M., Nair, V., Rawlings, T., Cash, T., Steer, K., & Fals-Stewart, W. (2005). Retrospective reports of parenting received in their families of origin: Relationships to adult attachment in adult children of alcoholics. *Addictive Behaviors, 30*, 1479–1495.
- Leshner, A. I. (2001). Addiction—A brain disease with biological underpinnings. *Voice, 6*, 1–3.
- Lewis, T., Amini, F., & Lannon, R. (2000). *A general theory of love*. New York, NY: Random House.
- Marlatt, G. A. (1998). *Harm reduction: Pragmatic strategies for managing high-risk behaviors*. New York, NY: Jason Aronson.
- McNally, A. M., Palfai, T. P., Levine, R. B., & Moore, B. M. (2003). Attachment dimensions and drinking related problems among young adults: The mediational role of coping motives. *Addictive Behaviors, 28*, 1115–1127.
- Mikulincer, M. (1998). Attachment working models and the sense of trust. An exploration of interactional goals and affect regulation. *Journal of Personality and Social Psychology, 74*, 1209–1224.
- Mikulincer, M., & Shaver, P. R. (2007). *Attachment in adulthood: Structure, dynamics and change*. New York, NY: Guilford Press.
- Miller, W., & Wilbourne, P. (2002). Mesa Grande: A methodological analysis of clinical trials of treatments for alcohol use disorders. *Addiction, 97*, 265–277.
- Molnar, D. S., Sadava, S. W., DeCourville, N. H., & Perrier, C. P. (2010). Attachment, motivations and alcohol: Testing a dual path model of high-risk drinking and adverse consequences in transitional clinical and student samples. *Canadian Journal of Behavioral Science, 42*, 1–13.
- Pinel, J. P. J. (2006). *Biopsychology*. Boston, MA: Pearson Educational.
- Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist, 47*, 1102–1114.
- Robinson, T. E., & Berridge, K. C. (1993). The neural basis of drug craving: An incentive-sensitization theory of addiction. *Brain Research Reviews, 18*, 247–291.
- Rogers, C. (1951). *Client centered therapy*. Boston, MA: Houghton Mifflin.

- Shaver, P. R., & Clark, C. L. (1994). The psychodynamics of adult attachment, In J. Masling & R. F. Bornstein (Eds.), *Empirical perspectives on object relations theories* (pp. 105–156). Washington, DC: APA Press.
- Simpson, L. E., Atkins, D. C., Gattis, K. S., & Christensen, A. (2008). Low-level relationship aggression and couple therapy outcomes. *Journal of Family Psychology, 22*, 102–111.
- Stephan, C. W., & Bachman, G. F. (1999). What's sex got to do with it? Attachment, Love schemas and sexuality. *Personal Relationships, 6*, 111–123.
- Thorberg, F. A., & Lyvers, M. (2006). Attachment, fear of intimacy and differentiation of self among clients in substance disorder treatment facilities. *Addictive Behaviors, 31*, 732–737.
- Walant, K. B. (1995). *Creating the capacity for attachment: Treating addictions and the alienated self*. Northvale, NJ: Jason Aronson.