FAMILY PROCESS

# EFT and Intimate Partner Violence: A Roadmap to De-escalating Violent Patterns

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*This article aimed to extend and refine the existing roadmap of emotionally focused therapy (EFT) in cases of situational couple violence (SCV). SCV is a common problem with couples who seek out couple therapy. Based on attachment theory, academic research, EFT, and our clinical experience, we argue that SCV can be safely treated using EFT. Through a detailed case description of stage 1 of EFT with a violent couple, we demonstrate how EFT can help to reduce violence. We also discuss safety-related matters, specific therapeutic interventions, and potential limitations of the proposed method.*

*Keywords: Emotionally focused therapy; Intimate partner violence; Situational couple violence; Couple therapy*

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## INTRODUCTION

Charlene contacts me by email (the first author works in a service specializing in intimate partner violence). She describes how the fights with her husband, George, increasingly escalate into violence and that she fears that this could lead to severe injuries. When I call her for a first appointment she is in a state of panic. They had just had a terrible fight. I explain how couple therapy could help them and notice that this calms her down. I assure her that I will search, together with them, for ways to decrease conflict and violence so that they can continue their relationship in safety.

Within the field of intimate partner violence (IPV), there has been a long-standing debate whether or not couple therapy is a suitable or even ethically appropriate form of treatment (for an overview of this discussion, see Stith, Rosen, & McCollum, 2003; Stith, McCollum, Amanor-Boadu, & Smith, 2012). In light of positive clinical experience and new scientific knowledge about IPV (Hamel & Nicholls, 2007), there are now more proponents of conjoint treatment. They argue that violence can be understood as the result of interactional patterns born out of frustration, anxiety, and unmet attachment needs (Henderson, Bartholomew, Trinke, & Kwong, 2005; Slootmaeckers & Migerode, 2018). O'Leary & Cohen argue that when conjoint couple therapy "reduces arguments in a relationship, it makes logical sense that physical aggression could thereby be reduced" (2007, p. 367). Recent research by Rody, Georgia, and Doss (2018) substantiates this point of view and also concludes that the presence of low-impact IPV does not affect the outcome of couple treatment. Stith et al. (2012) argue that there is still a large gap between the recent academic knowledge related to intimate partner violence and the development of effective clinical systemic interventions for treating it. By providing a clinical case description of

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EFT with a violent couple we hope (a) to somehow reduce this gap and (b) to provide couples therapists with a roadmap describing how to de-escalate violent partners and patterns. Knowing that 50–65% of couples entering therapy report some interpersonal violence (O'Leary, Vivian, & Malone, 1992), this roadmap may be useful to many couple therapists and the violent couples who seek out conjoint therapy. Because the violence is often hidden from the therapist as these couples do not necessarily reveal the violence, nor consider it a primary problem, Heyman and Neidig (1997) assert that, notwithstanding the contraindication of violence for couple therapy at that time, many couple therapists must be treating affected couples without awareness of any violence.

## THE MODALITY OF TREATMENT DEPENDS ON THE FORM OF VIOLENCE

Oka and Whiting (2011) reviewed how four contemporary family therapy theories view and/or treat couple violence. They conclude that, given the scope and severity of the problem of violence in intimate partnerships, it is important for MFTs of all theoretical orientations to be prepared to address this issue. All the reviewed theories are concerned with the safety of both partners. It is clear that safety matters have to be taken into consideration when couple therapists find out that they are working with violent patterns. Within the field of IPV, Holtzworth-Munroe and Stuart's (1994) subtypes of batterers (family-only, borderline, antisocial) have been used to determine the type and modality of treatment. For example, Stith, McCollum, and Rosen (2011) stated that family-only types are often good candidates for conjoint couple counseling. The Jacobson and Gottman (1998) categorization of male dominant violence into Pitbulls and Cobras is also well known among IPV specialists. An important difference between Pitbulls and Cobras is that the Pitbulls become physiologically aroused when battering, whereas Cobras tend to calm down (Jacobson et al., 1994). These typologies have been criticized because they are only based on research with male perpetrators, whereas partner violence is often bidirectional and gender-neutral (Hamel, 2014; O'Leary, 2000). Today, the decisive criterion whether or not to treat a violent couple in the context of conjoint treatment is the type of violence. Johnson (1995) was the first to distinguish two types of intimate partner violence: "Situational Couple Violence" (SCV), which is the result of escalating interactions (Johnson & Leone, 2005; Kelly & Johnson, 2008); and "Intimate Terrorism" (IT), a form of intimate partner violence that originates from power, control, and gender differences. IT differs from SCV because it is not based upon a bidirectional process of negative interaction between spouses but on a unidirectional use of power and violent control over the other partner. Scholars agree that couple therapy is not appropriate for intimate terrorism. In cases of IT, couple therapy could actually lead to unethical consequences. Conjoint treatment with this unidirectional form of couple violence would make both partners coresponsible for the violence because both partners are asked to create positive change in the relationship (Schecter, 1987; Stith et al., 2003). SCV, on the other hand, is considered to be bidirectional in nature and emanates from escalating interactions (Johnson & Leone, 2005; Kelly & Johnson, 2008). Slootmaeckers and Migerode (2018) connect this form of violence to hidden fears about the security of the relationship and unmet attachment needs. According to both clinical and research literature (Bookwala, Frieze, Smith, & Ryan, 1992; Gray & Foshee, 1997; Magdol et al., 1997; Stith et al., 2012; Straus, 2008), SCV is the most common form of IPV, especially in couples seen in the therapy room (Simpson, Doss, Wheeler, & Christensen, 2007). Hamel and Nicholls (2007), two influential authors in violence literature, also recommend couple therapy as the adequate treatment in cases of SCV, especially with those couples that seek to continue their relationship. As the decision whether or not couple therapy is appropriate for violent couples depends on the type of violence, it is necessary to address the way couple therapists can differentiate IT and SCV.

Greene and Bogo (2002) describe guidelines for the differentiation of SCV from IT: the amount of controlling behavior, the motivation for violence, the impact of the violence, and the partner's subjective experience. Slootmaeckers and Migerode (2018) add three additional factors: (a) the therapist's subjective experience and level of trust in working with violent couples, (b) the partners' joint desire to enter couple therapy and their wish to find ways to repair the relationship, and (c) the therapist's ability to create safety in the sessions, together with the couple, to ensure that interaction and deeper emotions can be handled in therapy.

Slootmaeckers and Migerode (2018) argue that, within a therapeutic context, and safeguarding the therapeutic alliance, the assessment can best be considered as an ongoing process. They point out that the best way of differentiating IT and SCV is to observe the couples we therapists work with and to explore whether or not the violence is embedded in a unidirectional dynamic of control, and/or whether or not it arises when bidirectional attachment needs are expressed in a dysfunctional manner. How this can be done will be discussed later in this article.

## EFT AS A LOGICAL CHOICE TO TREAT SCV

Emotionally focused therapy is an evidence-based couple therapy that has been proven to be very effective in resolving relationship conflicts (Wiebe & Johnson, 2016). EFT is based on an empirically validated theory of adult love (attachment theory) and integrates an experiential humanistic perspective and a systemic view of reciprocally reinforcing patterns of interaction. Through EFT, couples seem to be capable of altering relationship-specific or situational attachment (Burgess-Moser et al., 2015) and to create secure attachment bonds (Wiebe et al., 2016). The process of EFT can be understood as helping partners to expand emotional realities and interactional responses, thus shifting rigid interactions to responses that lead to a secure connection between the partners (Lebow, Chambers, Christensen, & Johnson, 2012). EFT is defined as a relatively brief therapy that is organized in three stages. The first stage focuses on de-escalation of negative interaction patterns. This first stage helps partners recognize and experience their automatic and interlocking pattern of self-protection. An EFT therapist helps partners to access and own their unexpressed attachment fears, and the effect of their protective behavior on the other partner's fears. In stage 2, EFT structures new interactions that shape attachment security within the relationship. The EFT therapist works toward "blamer softening" and "withdrawer reengagement" to deepen the contact and the security felt between the partners. The goal of stage 3 is to integrate and consolidate the new responses and cycles of interaction.

While IPV has originally been described as a contraindication for IFT (see Johnson, 2004), more recent scholarship has provided a more nuanced view (see Johnson & Brubacher, 2016; Johnson et al., 2005; Schneider & Brimhall, 2014; Slootmaeckers & Migerode, 2018). EFT shares with other models of couple therapy the concern that safety is an essential criterion to consider when starting conjoint treatment with violent couples. In "abusive" relationships (Johnson, 2009), the vulnerability that EFT encourages might put the abused partner at risk. Stated differently: The occurrence of violence in itself is not a clear contraindication as such. Whether or not one partner fears the other (Johnson et al., 2005) helps the EFT therapist to distinguish between violence and abuse (Johnson, 2009). Abuse occurs in relationships where one partner has no voice or one partner is scared of, or dominated by, the other partner. In the absence of abuse, violence can be treated in the context of EFT like other relational problems. This mirrors Johnson's typology and supports the notion that conjoint therapy should not be done with intimate terrorist couples but may be applicable with situationally violent ones (Oka & Whiting, 2011).

Although individual behavior and couple relationships are complex and always hard to categorize, we believe that the EFT therapist can lean on M. Johnson's typology of IT and SCV to decide whether or not it is safe enough to work with violent couples. We consider the seven guidelines to differentiate SCV and IT provided by Greene and Bogo (2002) and Slootmaeckers and Migerode (2018) useful for the EFT therapist.

For EFT therapists, SCV interactions are connected to hidden relational fears and unanswered attachment needs. Violence is understood as an emotional hyperactivation when partners, often unwittingly, trigger each other's underlying attachment fears through their actions during conflicts. Inspired by the work of Bowlby (1969, 1973, 1984), and by the research on the role of attachment in adult romantic relationships (Shaver & Mikulincer, 2007), numerous studies have demonstrated that IPV is linked to insecure attachment (Allison, Bartholomew, Mayseless, & Dutton, 2008; Babcock, Jacobson, Gottman, & Yerington, 2000; Bond & Bond, 2004; Bookwala, 2002; Doumas, Pearson, Elgin, & McKinley, 2008; Dutton, Saunders, Starzomski, & Bartholomew, 1994; Pearson, 2006; Roberts & Noller, 1998). Anger and the ensuing aggression are natural emotional reactions to perceived attachment loss, which can be understood from different positions in the couple's cycle of interaction. Both aggression and anger carry meaning in emotional distance regulation. Feeling disconnected can have a disrupting effect. As Bowlby (1984) indicated, this disruptive effect can lead to "inappropriate aggression" that can be understood as contact-seeking behavior (Allison et al., 2008; Bartholomew, Kwong, & Hart, 2001; Doumas et al., 2008). On the other hand, the interaction between a couple can at times be emotionally overwhelming and threatening, so that distance is sought to downregulate emotions and to promote safety in the relationship. In that instance, aggression can be understood as distance-seeking behavior (Allison et al., 2008; Slootmaeckers & Migerode, 2018).

The argument that violence in SCV can be understood as part of an interaction cycle based on attachment, emotions, and needs strengthens the idea that EFT, which is informed by attachment theory, appears to be a suitable therapeutic strategy for SCV (Schneider & Brimhall, 2014).

## THE CASE OF CHARLENE AND GEORGE: FIGHTING FOR A SECURE BASE

In this section of the article, we will describe the different steps of EFT in stage 1 in detail, as applied to working with violent couples. Because EFT is based on attachment as a theory of affect regulation (Schore & Schore, 2008), EFT therapists developed many interventions to help partners regulate their own emotions and to coregulate the overwhelming emotions within the couple. For an overview and a more detailed description of these interventions, we refer to the work of Johnson (2002, 2004; Johnson et al., 2005).

### Step 1: Building a Safe Therapeutic Alliance

The first step of EFT aims to build a safe therapeutic relationship and assesses the couple's need for therapy. With violent couples, the start of therapy has four components: (a) building a safe haven and secure base with the violent couple so that the partners can take responsibility for their behavior; (b) empathic attunement from an accepting and genuine attitude; (c) crafting therapeutic goals that are in line with the underlying attachment needs; and (d) promoting hope for the relationship. Together, these tasks promote the cocreation of a context that allows and encourages people to take responsibility for their behavior. In this sense, rather than a *condition to start* therapy, we believe that taking responsibility should be a *therapeutic goal* in therapy, so we can help partners to do so. Therefore, we need to help them recognize and acknowledge the emotions that drive the

self-feeding negative interaction cycles ending in violence. In this context, the therapeutic alliance is of the utmost importance, because it offers the relational safety necessary to direct attention inwards. The therapist needs to connect with both partners and with the relationship to create a secure base/safe haven in therapy where the violent cycle can be slowed down, explored, and enlarged/deepened. Empathic attunement with both partners from an accepting and genuine attitude is essential in this. With acceptance, we mean that the therapist can accept that negative interaction cycles can be so overwhelming that they threaten the security of each partner's attachment needs with the consequence that partners can become violent in order to regulate themselves and their relationship. This does not include the ethical acceptance of violent acts in itself. In Bowlby's words: "While horror at their acts is inevitable, greater understanding of how they come to behave in these violent ways evokes compassion rather than blame" (1984, p. 10). Rather than labeling one person as the victim and the other as the perpetrator, EFT therapists consider both partners as "hurt" and acknowledge their individual attachment-related emotions, while also encouraging them to take responsibility for their attachment position and behaviors in the negative cycle. Violent couples that seek out therapy gain hope and courage when they feel the therapist is not polarizing and judging their relationship as mainly dangerous, but accepts their desire to be together. Indeed, the victim–perpetrator paradigm has been shown to influence the decision of couples or individuals to leave therapy. Neidig and Friedman (1984) described victim–perpetrator thinking as a "therapeutic dead end" a long time ago. They argued that this paradigm does injustice to the bidirectionality of a lot of violence, and that, paradoxically, it does not allow both partners to take responsibility for their behavior in the negative interaction cycle that leads to violent outbursts. To make things perfectly clear, we still contend that every person should take responsibility for his/her own aggression and violence. We argue that, in cases of SCV, both partners mutually participate in the interactional process that leads to violent patterns, but this does not mean that they are mutually responsible for it, or for its catastrophic outcome (Goldner, 1985).

In the following vignette, we demonstrate how the therapist's four tasks can be combined in the first encounter with a couple.

**Therapist** Did I hear you say that the yesterday's conflict got out of hand?

**Charlene** Yes, violence from both sides.

**George** From both?! You hit me, you scratched me! *(shows wounds on his upper arm) I just held you against the wall.*

**Charlene** So throwing me against the wall and bruising me, isn't violence to you?

**Therapist** Whoa… *(Therapist uses soft and slow voice, slows down and makes eye contact with both partners.) I'm quite taken aback with the intensity and explosive nature of your conflict and the strong emotions you show here. This worries me for both of you. When I try to connect with both of you, I can feel both your frustration and powerlessness. At the same time, it must be pretty frightening for you knowing that your fights can get out of hand this way (Genuine therapeutic attunement.)*

Can I just say how brave this is of both of you to show to me how your conflicts can escalate? It can't be an easy thing for either of you to share such a private aspect of your relationship with me, an outsider. My experience in working with couples that encounter violence has taught me that people don't usually intend to hurt each other when they fight, but that this nevertheless sometimes happens. Most of the time this feels terrible for both

partners. Be it for the person that gets hit, or for the one whose anger turns into violence. It appears to me, from your powerlessness and from your emotions, that this situation and talking about it here, is probably painful for both of you. Acceptance/promoting acceptance.) Do you agree?

**Charlene** Yes...

**George** Hmm... *(nods)*

Moreover, it is important to create therapeutic goals that are in line with the underlying attachment needs, which in turn will lead to diminishing or halting the violence. Finally, it is a preferred practice to help create some hope for the relationship, because most of these patients are in a state of panic that they might lose their relationship. Working from a genuine accepting position also undoubtedly demands personal work and reflection by the therapist themselves.

**Therapist** Is it OK with both of you to take the time together to examine how you come to the point of aggression, to see if we can understand what it could mean and the reasons behind it? My experience tells me that when we are able to slow down these conflicts, it helps us to look into them from the inside out. This in turn will help you to get a better sense of each other's feelings and experiences. *(Creation of hope, offering safety through a clear therapeutic frame.)*

During the first sessions or when the conflict escalates in the room, it is important that the therapist speaks a lot and in a soft and calm voice. This calms the partners and slows the conflict down, both through the soothing tone of voice but also through the interruption of their escalating interaction. The therapist's words will extensively reflect the emotions s/he sees (senses) in the couple and let the partners feel that the therapist is close, able to create a safe atmosphere, and that s/he will not be drawn into the escalation of the conflict. When we recognize that the violence predominantly reflects attempts to regulate fears of loss and abandonment, it makes sense and even is critical for the therapist to be close to create safety in the session. Also, it is important that the therapist's words emphasize the relationship and its dynamics rather than the individual. In doing so, the therapist helps the partners to feel that their underlying desire to continue their relationship without violent outbursts is recognized, and without apportioning blame or judgment on any of the partners.

In couples with intense or frequent violence and in which the relationship includes trauma, the therapeutic alliance deserves even more attention (Johnson, 2002). These couples are often struggling with shame and fear entering therapy, and they frequently are skeptical about how therapy can help them. Their fear and shame mostly make them rather defensive and on their guard than open, and they often hide their cry for help because they lack trust. These emotions are understandable given the fact that their attachment is insecure, and their internal working models about self and other(s) are negative. They have often lost the feeling of being loveable. These internal working models play their part in every (new) contact with others, including the contact with a therapist. The fear that their negative view of themselves might be confirmed by the therapist is intense. These clients often have a traumatic personal history, which helps to understand why they are in a state of unsafety, vigilance, and panic. This state continually triggers the unsafe attachment response. We often meet partners who, at first, are closed and difficult to reach. Sadly, carers then interpret these signals as resistance or a lack of responsibility. Sometimes partners who are hyperactivated react defensively to the reaching out of the therapist or the partner. When we understand this as a fear of not being worthy and loveable, the therapeutic relationship can be healing in itself. Not only at the beginning

but also throughout the whole therapy with SCV, it is best to expect anger outbursts and/or strong emotions. Because there is not enough safety yet between the partners, these outbursts or strong emotions can best be regulated within the therapeutic relationship. From an attachment point of view, this makes sense because the ability to regulate emotions "should have developed through sensitive attunement by the attachment figure as a child, it now must also be learned through the attunement of an attachment figure such as a therapist. The therapist must be that soothing voice until the client learns to find that voice within him or herself" (Dutton & Sonkin, 2002, p. 120). Of course, our aim in EFT is also to be able to find that soothing voice within the relationship.

## Step 2: Exploring the Negative Interaction Cycle

Step 2 of the EFT process consists of tracking the negative interaction cycle, as driven by the reactive emotions (Johnson, 2004). Based on attachment positions, EFT recognizes three negative interaction cycles: pursuer–distancer; pursuer–pursuer; and distancer–distancer (Johnson, 2002). The main task of the therapist in step 2 is to track, together with couples, how they are stuck in these cycles and explore the ways in which these cycles evolve into violent patterns.

**Therapist** I can see, and I also hear from your story, that you tend to get stuck in an argument about who is the most aggressive. Can I slow you down a bit, please? For me it is not important who crosses the line first or the most. I take the position that, deep inside, both of you know that you are saying and doing things that are not ok. Am I right about this?

**Charlene** Hmm.

**George** Yes. . .

**Therapist** OK. It means a lot that both of you recognize this. To me it seems useful that we try to get a picture of the ways that bring both of you to the point where you hurt each other. Only then can both of you understand together where the conflicts are coming from. George, would you please help me understand how the conflicts mostly evolve? *(Focusing the session toward the cycle.)*

**George** Most of the time I do everything I can to avoid conflict. But no matter how much I ask her to stop, she keeps poking at me, attacking me, criticizing me for what I do wrong.

Slootmaeckers and Migerode (2018) developed a model that explains how the different cycles can evolve into violent interactions. They advance that aggression manifests itself in a couple's relationship when the mutual connection is threatened, which consequently fuels interaction cycles that confirm each partner's deep attachment fears. This fear leads to emotional and physical hyperactivation or higher levels of flooding—a "state of feeling overwhelmed by one's partner's negative emotions and one's own emotions as the partner brings up issues" (Gottman, 2011, p. 131). This hyperactivation expresses itself in aggression.

From an attachment perspective, aggression can serve two goals in the cycle: It can either be proximity or distance seeking. An example of proximity seeking aggression is when the partner in the pursuing position forces, out of panic, the distancing partner to be close. Aggression then arises from the panic associated with being abandoned, so the ensuing violence is aimed mainly at precluding the other partner from disconnecting. The attachment mechanism of the pursuing partner gets hyperactivated, which expresses itself in violent behavior and bouts of anger. Distance-seeking aggression emerges when the distancing partner becomes reactively aggressive. These partners feel that their

attachment mechanism of distancing fails to protect them from relational and emotional flooding, especially when the proximity seeking partner is experienced as overwhelming. This violence has the function to stop the continuous contact seeking of the pursuing partner. The violent partner hopes to create some distance to regulate his or her own attachment fears and to diminish the emotional overload. The distancing partner, who at first regulates him- or herself by deactivating his or her attachment mechanism through distancing, gets emotionally flooded in the context of the continuous poking of the other partner. Then, they resort to aggression as a further self-regulating mechanism and, in doing so, paradoxically, use aggression to protect the relationship against further escalation of violence.

**Therapist** OK… you try to avoid escalation by telling her to stop. Do I understand correctly then that these conflicts are overwhelming to you? Yes? What do you do then when your attempts at stopping do not have any effect?

**George** I go to another room. Fighting like this makes no sense at all.

**Therapist** OK, I get that. So do I understand correctly that you say that when you feel the discussion makes no sense to you that you seek some distance from Charlene?

**George** Right.

**Therapist** OK, George, I get that. You seek to avoid the intensity of your conflicts.

Charlene, can you tell me what happens to you emotionally when you see him go away?

**Charlene** Oh yes… I get even madder at him then! Really, he is such a coward then. The whole day he has time and attention for his colleagues and for his job. And when it comes to me, when I ask him something, he goes away or he tells me to shut up. Who does he thinks he is, really!

**Therapist** Hey Charlene, *(establishes intense eye contact, uses slow and soft voice) I can see this enrages you. It seems like your anger seems to say something about how frustrating this is when you feel that he is not there for you?*

**Charlene** *(tears welling up) Yes… that is so frustrating!*

**Therapist** OK, frustrating. I get that. What do you do then, Charlene? What happens on the outside when inside you get so frustrated and angry?

**Charlene** Oh… I could start shouting and throwing things at him.

**George** That and so much more. She really is out of control…

**Therapist** Just a second. *(lightly touches George, and looks them both in the eye before speaking) So you (speaking to Charlene) become very angry and you throw things at him when you cannot get through to him and he closes himself off from you. Right?*

**Charlene** Yes. *(She takes responsibility for her behavior, because the underlying emotional meaning of her actions is validated.)*

**Therapist** What then happens to you George?

**George** Well… sometimes then we get lost. It depends. When I stop talking, sometimes she leaves me alone. Then things calm down after a while. But

when she goes on shouting. . .well then, I just want to get away. Really as far as possible. . .

**Therapist** And what happens then?

**George** Normally, she doesn't let me go. . . and then things get out of hand.

We see some important advantages in understanding violence through these patterns. Firstly, they offer the therapist a roadmap and the according language to describe how violence takes place in the context of an insecure attachment pattern in a couple. The patterns also allow the therapist not to be overwhelmed by the intense emotions and interactions accompanying escalating couples. Furthermore, working from these patterns offers some calm and safety to the couples when they start to recognize the meaning of the violence in terms of their relationship dynamics. Understanding the violence in the cycle creates a coherent and logical narrative that offers some order in the often chaotic relational reality of violent couples. All this is done without devaluating the individual responsibility each partner has for his or her behavior in the cycle. In the next excerpt of the session with George and Charlene, we illustrate the integration of the violence in the cycle.

**Therapist** Do you mean, that you too can become violent?

**George** Yes. . . but I never mean to hurt her. I just want her to stop, and that she lets me go. I want to push her aside, so that it stops and she does not go on. . .

**Therapist** OK,. . . *(eye contact with both) Charlene and George, I think that I understand it better now. Can I tell you how? Feel free to correct me if I am mistaken. OK? I hear you say, Charlene, that when you get the feeling that you cannot get through to George, and when you feel his job is more important for him than you are, that this is very frustrating for you and it makes you angry. Is that correct?*

**Charlene** Yes. . .

**Therapist** I am also hearing, George, that Charlene's anger overwhelms you and when that happens you close yourself off from her, don't you?

**George** Mmmh. . .

**Therapist** Then I hear you say, Charlene, that when George withdraws and shuts you out, this confirms even more your sense that he does not want to be with you. It is as if your body then decides to use anger and other means to get through to him. I understand that. It is as if you would do anything to feel . . . some connection. But then the anger and aggression are so overwhelming to you, George, *(looks at George) that you feel you must withdraw even further and close yourself off. When retreating helps, things calm down, but when it doesn't, the situation escalates and you too resort to violence to create the distance you need to feel safe. Is that correct?*

**George** *(lowering his head) I think so, yes.*

**Therapist** It is good that you can say this here George. Then *(to Charlene) this probably just confirms to you that he does not want to be with you. Is that correct, Charlene? Is this more or less what happens between the two of you during fights?*

As soon as therapists are alerted to violence within the relationship, they need to slow the process down in order to be able to place the aggression in the interaction cycle. In doing so,

they need to be careful not to explore primary emotions too soon. As reactivity might be too high early on, there is in most instances not enough emotional safety to immediately address primary emotions. Instead, the therapy should first focus on the extensive reflection upon, and acceptance and validation of secondary emotions and their underlying meaning. In doing so, and coupling these to the action tendencies and attachment meaning, the therapist builds trust and safety in this phase of therapy. This is a necessary prerequisite to move on to the next steps of the EFT process. These interventions—reflecting, accepting, validating, and connecting to attachment emotions—demand time and ample repetition. By placing the psychological and physical aggression incidents in a coherent narrative in which the secondary emotions reinforce each other, and in which the actions, tendencies, cognitions, and mutual influences become seen, felt, and connected, the therapist instills safety in the couple and in the session. This, in turn, lowers the threshold for both partners to take responsibility for their share in the escalations and in the violence. The therapist encourages partners to take responsibility for their behavior by validating it as a failing attempt at regulating their needs for emotional distance in the relationship. The couple then feels that the therapist understands and helps to clarify the cycle, which helps them to feel safer in the session. This facilitates a climate of hope, which in turn implicitly mutes the underlying need and fear from which the aggression emerges, that is, the fear that the safe connection in this relationship is lost. The immediate effect often is a decrease in aggression incidents, through an enhanced awareness of the behaviors linked to the negative cycle. This can only be reached when the therapist clearly takes the lead, is the director of the process, and offers a comprehensive narrative describing what may be happening between the partners in the couple. An important turning point in identifying and diminishing the aggression cycle arises when the partner in the proximity seeking position recognizes his or her role in the pattern. The violence then often decreases sharply. When the driving emotions, the underlying need, and the meaning of the violence are validated, the aggressive behavior decreases and this reduces the chance that reactive aggression will be triggered in the distance-seeking partner. When this shift happens, it is time to explore, to expand, and to deepen the underlying, not yet acknowledged, primary emotions.

### Step 3: Getting Access to the Primary Emotions Underlying the Violent Patterns

In step 3 of the EFT process, the therapist opens doorways to the unacknowledged primary emotions and integrates these into the negative violent cycle. The therapist should be aware that in working with violent couples they often encounter traumatized people with a lot of emotional injuries in the domain of love and bonding. Because of trauma and injury, these persons often lose the ability to regulate fear and anger (Van Der Kolk, 1996). The main goal of the third step can best be described using the concept of metamonitoring (Kobak & Cole, 1991). Johnson (2002) defines metamonitoring as a workable distance from emotions so that one is aware of and present to emotions but not overwhelmed by them. Put differently, metamonitoring is being able to step aside for a moment from the action tendency, to create a coherent image of the relationship, and to evaluate alternative strategies and viewpoints. To achieve this, the therapist reflects the primary emotions, enlarges and validates them while placing them systematically in the negative cycle. This brings about that the primary emotions become less overwhelming. In Johnson's words: "Emotions, when placed in context, become less overwhelming, and, in fact, act as guides to the meanings of events and the needs implicit in them" (2002, p. 72). This is often a moment in therapy where old pains related to the context of the family of origin or former romantic relationships resurge. Placing these emotions within the context of the negative cycle can create an important moment of change, allowing partners to experience that moments of reactivity often are an expression of vulnerability instead of threat.

**Therapist** Charlene. It is fantastic, isn't it, that you have been able to stop fights at an earlier stage so that they do not escalate into violence like before? Nevertheless, you are still very angry. I can see how hard you are working to keep your relationship safe. Is it OK for you if we explore which effect the anger has on the two of you?

**Charlene** Yes of course.

**Therapist** George, Charlene tells me that she sometimes gets very angry with you and that in doing so she wants to reach out to you. But I guess that might be difficult for you to grasp, right? Can you tell me something about how it feels for you when she gets angry with you?

**George** I don't know. It is so difficult. I am just hearing that she thinks I'm a layabout, and that anything I do sucks. I cannot stand that.

**Therapist** Those are precisely the moments you close yourself for her, aren't they?

**George** Yes, I want to run away then. It just is too much.

**Therapist** Too much. . . As if this causes too much pain inside?

**George** Yes, it is really painful.

In this step, partners get in touch with their unacknowledged primary emotions, which underlie the often more strongly expressed secondary emotions of anger and aggression. Because in violent couples these high-intensity emotions are combined with the relative lack of emotional regulation and coregulation of emotion, it is important that the therapist perseveres and does not become discouraged. Therefore, this step demands a lot of emotional work, closeness, and repetition on the part of the therapist. Even when violence often declines significantly once couples enter therapy, their conflicts mostly remain intense.

**Therapist** It is as if you end up in a very painful place when she criticizes you. *(looks at Charlene) I have just learned from you that you feel he is distant from you in these moments, and that you just want to get his attention so that he can hear what you have to say. But for you, (looks at George) what Charlene says hurts, and then you just want to get away. Can you help Charlene to understand that feeling of pain, George? How does it feel inside you when she criticizes you and you feel blamed?*

**George** That triggers me. I don't know. I just want to go. It is too much.

**Therapist** Too much . . . you want to go. . . which word or image comes to mind when you, George, say this, when you remember a moment like that?

**George** Crushing. That is so crushing for me.

**Therapist** How does that feel to say that just now. Crushing. What is the sense in your body when you say that?

**George** *(looks down and is visibly tense) It kind of pushes on my chest, right here. It is so painful to hear that I do everything wrong. I just try to do my best to avoid conflict and it is never OK.*

The therapist repeatedly clarifies things, links the primary emotions to the secondary emotions, to behavior, to the internal working models of both partners, and builds every element in the cycle, and thus, the couple slowly begins to recognize how their conflicts

evolve from dysregulated attachment mechanisms. In this step of therapy, we "touch" on old pains but carefully keep them connected to the present process of the couple. Timing and slowing down the process are essential to manage vulnerability in these reactive cycles. It remains important that the therapist is present and clearly leads the process, so that the therapeutic process can be slowed down to an effective pace, taking one step at the time.

**Therapist** George, *(tries to establish eye contact with George) when you have that crushing feeling. The pain you feel when you hear Charlene say you don't do anything well, that must be very painful for you, mustn't it? As if she does not realize how important safety is for you. As if her criticism and anger lead you to a place where you can't do anything right?*

**George** Yes that is it … Just like with my parents. When my dad beat my mom, we had to watch, and we were told it was entirely our fault. I cannot stand shouting. I have had enough of it. *(tears well up, looks away)*

**Therapist** Right, George … That is a lot for you to feel right now. I see helplessness and great sadness. They seem to be such strong feelings. Overwhelming. *(George cries now) Do I understand you correctly that when Charlene shouts and raises her voice, you do not see that she is looking for contact. You see and experience the pain of the past, where you felt crushed by tensions and reproach. Don't you? That then is a trigger for you. You do not want to be in that position again. You want to get away from it. You shut yourself off.*

**George** Exactly!

The therapist leads the session, which also includes a continuous framing of the work that the therapist and couple are doing together. More than with other couples the therapist explicitly describes and clarifies his or her actions to enhance clarity, predictability, and safety for the couple in the session. Such leading also includes that the therapist frequently asks explicit permission for every step taken. This (re)instills a sense of ownership or "sense of agency" (Herman, 1997) for the couple. The sense of agency often gets lost in overwhelming conflicts, and the conflict itself takes over. Articulating and explaining the how and why of the therapist's actions counter this feeling of loss through enhancing predictability in the process. Furthermore, it is striking that violent couples often lack words to describe primary emotions. Therefore, it is important that the therapist verbalizes extensively, offering words for what he/she sees and feels is happening. This then allows the partners to further incorporate their emotions in dialogue with the therapist. Through the experiencing of underlying emotions and meaning attribution to the escalating conflicts in the session, their internal working models of self and the other start changing. The primary emotions strongly connect to negative models of the self or unsafe models of the other (Johnson, 2002). Partners caught in patterns of violence no longer see themselves as loveable. They often see their partner as hostile and as someone who no longer loves them. The therapist's acceptance, empathic validation, and wording of the underlying emotions transform the internal working models.

**Therapist** It must be really scary that it is your partner who brings you back to that painful place. Would it be correct if you were to say to Charlene: when I close myself off then that is only because I feel tension and blame and that feels crushing to me. I have experienced this so many times before. I close myself off so I don't have to go through these feelings again. If you keep coming closer, I only feel more pressure. I would do anything to get away from that awful feeling. Close myself off and push you away. Even with violence.

**George** Yes, that is right. That is what happens then. I do not see her. I only feel crushed.

**Therapist** How important could it be for your relationship if you could tell her that yourself, George?

Throughout EFT, setting up enactments is essential in the change process (Tilley & Palmer, 2012). The goal here is to promote the empathic response of the partner, which deepens the change process (Johnson, 2002). By running through these steps again and again, the emotional realities of each partner unfold and become more explicit, thus allowing them to move toward metamonitoring and de-escalation. In the EFT model, the enactments appropriate for this stage of therapy are mostly position enactments possibly followed by enactments about primary emotions.

### Step 4: Externalizing the Violent Patterns and Attending to the Attachment Needs

EFT therapists place the difficulties, the need for distance and proximity, and the violent acts into the cycle from the very start of couple therapy. When therapy progresses, an emotionally rich and coherent story emerges which helps partners to experience and understand their violent pattern at an emotional level. Slowly they learn to recognize primary emotions and they start to regulate each other and themselves better. In step 4, the therapist draws more attention to the underlying attachment needs and continues to reframe the cycle as the common threat, so that slowing the cycle down becomes a common endeavor (Johnson, 2004).

**Charlene** My mother was never there for me. She was too busy with her "men" and with being "ill." In fact, I was alone my whole life. I cannot stand that feeling of being alone anymore. When I feel George abandons me, I explode, but in fact I feel the old pain again.

**Therapist** That is incredibly painful, Charlene. Possibly it hurts even more that you experience this pain again in your relationship with George.

**Charlene** Yes, it is horrible. Somehow I have learned to live with that feeling of being alone, the feeling of not being recognized by others. But with him it can hurt so much I can hardly stand it. When that happens, I would do anything to make myself heard.

**Therapist** Yes, then you start shouting and throwing things. It is really brave of you to share this here. Do you think you could go deeper into that feeling to find out what you could learn from it? You say it is almost unbearable not to get a response from George. You then feel this pain of being alone. When you feel this pain, you get triggered, and you would do anything to get his attention. I understand. Can you feel inside what this pain tells you about what you need from him?

**Charlene** *(starts weeping) … Just … Just that he is there. That he lets me feel I am important to him.*

**Therapist** So that you can feel that George is definitely there for you and that you are important to him. Ok. I get that! This feeling of being alone with George, the most important person in your life, must be very painful … Of course, you hope that he, of all people, is always there for you when you need him. The way you explain this helps me understand that you can get flooded by pain and panic and then react fiercely. Even more so because you told me that George is the first person in your life you have found this safe, connected

feeling with. The anguish that goes with losing this again must be terrifying. How would it be to look him in the eye and show him your sorrow and pain? To show him you need him?

Partners in violent couples tend to have experienced an unsafe attachment in childhood (Allison et al., 2008; Babcock et al., 2000; Bond & Bond, 2004; Bookwala, 2002). This leaves them less well equipped to engage in a safe romantic relationship. Often, such individuals lack a model of what a safe romantic relationship would look like. Due to an unsafe dispositional attachment style (Sprecher & Fehr, 2010), these partners tend to hide their need for safety, closeness, and love, while maintaining hope and longing for a relationship.

When the partners, because of interlocking attachment positions, get entangled in a violent pattern, their feelings of situational unsafe attachment are confirmed (Sprecher & Fehr, 2010). This creates a new relational drama: They get caught in a paradoxical relationship. The partner who seemed to help them find the solution for their hurts and needs now becomes the source of unsafety. This explains the deep emotional flooding. Sometimes this is explicit in their history of meeting: They recognized the lost child in each other's history and, in the beginning, felt, for once, understood.

When the therapist is able to repeatedly summarize the whole cycle of violence in a coherent story, s/he helps the couple reframe their problem cycle as the enemy. This attachment story (cycle), which explains how the couple got so entangled and lost in the cycle, far from each other, helps to further de-escalate and to create more safety. Both partners now feel they need each other to "fight" this cycle. When this stage is reached, the relationship and the therapy are safe enough to work toward repair, and toward more connection. Then, the therapist can work toward helping them to ask for support through the enactments in stage 2 of EFT.

When therapy is successful, couples de-escalate their violent pattern, which procures a safer context to explore and deepen the emotions and attachment needs of both partners, and which allows work toward bonding events between the couple. Typically, in EFT we work toward "blamer softening" and "withdrawer re-engagement" as key change events in the relationship to restore or create safe connection. In our clinical work, we experience that this transition between stages 1 and 2 is seldom clear-cut. Indeed, we often notice relapses of the negative pattern at moments of vulnerability. Therapists should be prepared for this so that in the event of a relapse they slow down the process and go back to stage 1 work. It is also remarkable that at the end of stage 1, some couples experience the possibility to end the relationship in a nonviolent way. What stage 2 might look like with violent couples merits full discussion in a future article.

## DISCUSSION

This article argues for the appropriateness of EFT with SCV. It builds on and contributes to the recent moving away from the view on couple therapy as contraindicated in cases of couple violence. The notion that violent couples can enter conjoint therapy is also explored by other models (Antunes-Alves & De Stefano, 2014; Oka & Whiting, 2011) and is no longer considered to be dangerous or unethical (Stith et al, 2012) per se. Because it sees adult romantic love as a relationship of attachment, the humanistic/systemic approach of EFT (Johnson, 2004) fits with the (violent) couples' desire to enter couple therapy to safeguard their love connection, but also with the interactional nature of large parts of violence as well as with the emotional underpinnings of SCV. Indeed, for many couples, violence is not a means of control but rather a way to solve personal and interpersonal matters (Johnson, 1995). When situating SCV in the framework of attachment, it becomes clear how violence and love can be two sides of the same coin. Taking this into account,

this article aims to extend the existing roadmap of EFT to provide support and guidance to therapists dealing with SCV, so that violent couples can feel welcome and understood when they risk seeking help for their overwhelming conflicts. Through a detailed case description of stage 1 of EFT with a violent couple, this article showed specific steps and useful interventions to help couples overcome their violent patterns so that they can restore physical and emotional safety in their relationship.

It should be noted that while this article is based upon new scientific knowledge about IPV, EFT, and years of clinical experience with violent couples, more research is needed to formally test the suggested approach. Furthermore, this article is limited to the description of stage 1 of EFT with SCV. A more detailed description of stage 2 of EFT, and the specific steps needed to be taken into account, merits further discussion in a follow-up article.

Although the proposed approach offers EFT therapists a roadmap for treating IPV, it still demands a selection of couples. In general, we argue that couples engaged in SCV are appropriate for couple therapy. Additionally, it is important that the assessment of the appropriateness for couple therapy is considered to be an ongoing process. Continuous assessment of safety allows for integration of care in the therapeutic relationship while also keeping an eye on safety issues. This continuous, process-focused approach moves away from the more "objective" practices of a formal assessment before entering therapy and toward a collaborative stance in therapy where client and therapist together work for a better future. The move away from assessment prior to therapy is key to promote the therapeutic relationship as central, for the central role of the acceptance of the humanity of the partners, which, in turn, is essential for a process that allows and helps partners to take responsibility for their own actions. The more linear "objective" approach to assessment can be a hindrance to such goals as it demands some form of taking of responsibility prior to entering therapy and could promote a more objectified relational stance hindering collaboration. Of course, this collaborative, ongoing assessment is more subjective and will never erase the gray zone between more "objective" distinctions of violence. This can be considered a limitation of the proposed method.

The reader might have noted our use of nongendered language. In this, we follow the gender inclusive approach of Hamel and Nicholls (2007), who have argued that both genders can be violent. In their view, a lot of violence is bidirectional and patterns of violence are similar over gender, as both men and women can suffer from partner violence, albeit the physical impact on women is generally more devastating. Hamel and Nicholls' (2007) gender inclusive approach is feminist in nature and is in line with the more recent work of George and Stith (2014), who have argued that feminist perspectives on couple violence should be placed in a third feminist wave that is an antioppressive, nonviolent, socially just feminist one rather than in a second-wave gender-essential feminist stance. Moreover, our turn to a gender inclusive approach to couple violence is further guided by the LGBT literature and the existence of violence within same-sex couples (see Baker, Buick, Kim, Moniz, & Nava, 2013).

Finally, we want to emphasize that all therapy needs to be culturally sensitive, because the perception of violence changes through groups, countries, and times. We agree with Baker (2013, p. 185) that the first major lesson is that time is an important dimension when studying social phenomena. As such, it needs to be emphasized that this article is written in a context where violence is widely condemned.

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