



INTEGRATING SEX AND ATTACHMENT IN EMOTIONALLY FOCUSED COUPLE THERAPY

Susan Johnson and Dino Zuccarini
University of Ottawa

In this article, sexual functioning is placed in the context of love as an attachment bond. Attachment theory offers the most coherent and empirically validated theory of adult love and is summarized together with the implications of this theory for the practice of couple therapy in which sexual issues are often addressed. Recent research on attachment and sexuality is outlined and a model of healthy sexuality where attachment and sexuality are integrated is offered. The principles of an attachment-oriented approach to sex issues are set out and illustrated with reference to the process of emotionally focused couple therapy. Case descriptions and brief in-session transcripts are included.

In the introduction to the fourth edition of the classic text *Principles and Practice of Sex Therapy*, Leiblum (2007) notes that there has been increasing recognition of the need for an integrated approach to the treatment of sexual disorders and complaints. The advent of oral medications has paradoxically made it apparent that "treating the genitals alone is unlikely to lead to long-term success" (p. 7). A focus on relationship context is essential. The success of psychological interventions focused on individual partners is clearly associated with relationship factors. In a British study for erectile dysfunction (Hawton, Catalan, & Fagg, 1992), the success of sensate focus and graduated sexual stimulation techniques was determined largely by the couples' ratings of communication prior to treatment. As Masters and Johnson (1970) noted, there is no such thing as an uninvolved partner in any marriage in which there is some form of sexual inadequacy.

Just as the field of sex therapy is once again recognizing the power of the relationship in which sex occurs, so couple therapists are recognizing the power of sexual responses to define the quality of love relationships. While contented partners attribute only between 15% and 20% of their happiness to a pleasing sex life, unhappy mates ascribe 50–70% of their distress to sexual problems (McCarthy & McCarthy, 2003). Sexual problems most often reflect and then actively exacerbate relationship conflict. They also exacerbate distance. Once sexual contact ceases, often sensual and affectionate touch follows. Couple therapists almost inevitably find that sexual anxieties, conflicts, and deprivation are part of relationship distress. While some therapists focus on relationship issues and trust that if partners get along better, sexual issues will resolve themselves, many couple therapists find themselves actively helping couples to specifically address sexual difficulties as part of the process of relationship repair and relapse prevention, especially when it is clear that the relationship is contributing to partners' sexual functioning difficulties, and these difficulties are not solely caused by organic or physical health problems. The line between sex and couple therapy is becoming finer and finer.

However, in the area of sexuality, couple interventions still tend to be narrow or "problem-oriented" (Heiman, 2007), perhaps because there is little clarification on what general relationship factors are important in defining sexual disorders or satisfaction. In terms of a general explanatory framework, sexual problems have often been seen as arising either from an individual partner's anxiety that is exacerbated by negative interactional patterns or from too much "emotional fusion" or "enmeshment" within a couple relationship that is then presumed to dampen eroticism and desire (Schnarch, 1997). Neither of these frameworks has placed sexual responses in the context of a systematic and well-researched theory of adult love that offers a

Susan Johnson, EdD, Professor of Psychology, University of Ottawa, and Director of the Ottawa Couple and Family Institute; Dino Zuccarini, BA (Honors), is a psychology doctoral student at the University of Ottawa.

Address correspondence to Susan Johnson, Centre for Psychological Services, University of Ottawa, Vanier Building/11 Marie Curie Ottawa, Ontario K1N 6N5, Canada; E-mail: soo@magma.ca; oefi@magma.ca

couple therapist a map to a couple's sexual and relationship problems and a clear guide to resolving these problems.

In this article, sexual functioning is placed in the context of attachment theory and the process of emotionally focused couple therapy (EFT), an empirically validated approach to repair distressed relationships that focuses on adult relationships as attachment bonds (Johnson, 2004, 2008, 2009). EFT demonstrates excellent outcomes; research shows that 70-73% of distressed couples are no longer distressed at the end of therapy and 86% report significant improvement in their relationship (Johnson, Hunsley, Greenberg, & Schindler, 1999). Results also appear to be stable at follow-up even for high-risk couples or those dealing with significant emotional impasses and injuries in their relationship (Clothier, Manion, Gordon-Walker, & Johnson, 2002; Makinen & Johnson, 2006).

THE ATTACHMENT VIEW OF LOVE

The attachment perspective (Bowlby, 1969, 1988; Mikulincer & Shaver, 2007a, 2007b) offers the couple therapist a comprehensive, normative, and empirically validated theory of adult love that is also specific enough to address individual experiences and differences. It is a systemic theory that focuses on patterns of interaction and how one partner's behavior inevitably triggers the other's in a series of feedback loops. It is also a theory of individual development and affect regulation. Attachment theory offers the couple therapist a focused and integrative perspective on relationship, a clear set of goals and model of relationship and sexual health, and a map to effective intervention (Johnson, 2003).

Original formulations of adult attachment theory (Shaver, Hazan, & Bradshaw, 1988) divided love into three separate behavioral systems: attachment that involves proximity seeking, distress on separation, and the use of the attachment figure as a safe haven in the face of stress, caregiving, and sex. Of these three separate but connected systems, the attachment system that focuses on safety and a sense of felt emotional connection with another is considered to be preeminent and provides the scaffolding for the development and enactment of the other two. At moments of threat or disconnection from an attachment figure, the attachment system is triggered and has control precedence organizing behavioral responses to gain emotional connection and restore a felt sense of security.

At various times in a relationship, caregiving or sexuality may move to the fore. For example, at the beginning "infatuation" stage of an adult relationship, sexual attraction brings partners together and sexual intercourse fosters the development of attachment bonds. Later in the relationship, emotional support and attachment seem to become generally preeminent (Hazan & Zeifman, 1994). Individual partners and couples may also vary in terms of the significance of sexuality in the maintenance of their bond. All through life, however, sexuality and caregiving are experienced, expressed, and enacted differently in those with secure versus insecure attachment (Diamond & Blatt, 2007; Mikulincer & Shaver, 2007a, 2007b). Bowlby (1969), the founder of attachment theory, also believed that as development proceeds, each behavior system and its interactions with the other two became more complex and overlapping. In a relationship, sexual experience and responses occur within the context of the attachment and caregiving systems. One of the main tasks of adulthood can be seen as the functional integration of these three systems.

Attachment theory states that seeking and maintaining a sense of emotional connection with significant others is an innate, primary motivating principle in human beings across the life span. The physical or representational presence of attachment figures provides a sense of comfort and security, while the perceived inaccessibility of such figures creates distress. Positive attachments create a *safe haven* that offers a buffer against the effects of stress and uncertainty (Mikulincer, Florian, & Weller, 1993) and an optimal context for the continuing development of a mature, flexible, and resourceful personality. Secure attachment also offers a *secure base* from which individuals can explore their universe and adaptively respond to their environment. This promotes the self-confidence (Feeney, 2007) necessary to risk, learn, and adjust to new cues and contexts. Safe connection with an attachment figure strengthens the ability to stand back and reflect on oneself and the other's state of mind (Fonagy & Target, 1997). Securely

attached individuals are better able to take emotional risks to reach out empathically to and provide support for others (Feeney & Hohaus, 2001; Simpson, Rholes, Orina, & Grich, 2002) and cope with conflict and stress. Secure attachment fosters autonomy (Feeney, 2007). The more securely connected we are, the more separate and different we can be. Health in this model is a felt sense of interdependency rather than a commitment to attaining "self-sufficiency." Secure relationships tend to be happier, more stable, and more satisfying.

Emotion is central to attachment. Across the life span, the building blocks of secure bonds are emotional accessibility and responsiveness. Emotional responsiveness has been found to be a powerful predictor of the future quality of newlyweds' relationships (Huston, Caughlin, Houts, Smith, & George, 2001). Attachment theory normalizes many of the extreme emotions that accompany distressing moments in relationships. In all primates, loss of connection with an attachment figure induces a particular kind of fear—a primal panic (Panksepp, 1998) heightening attachment needs and so proximity seeking. A sense of connection with a loved one is a primary built-in emotional regulation device.

If attachment behaviors fail to evoke comforting responsiveness from a loved one, a prototypical process of separation distress occurs. This involves angry protest at disconnection, clinging, depression, and despair, culminating eventually in grieving and emotional detachment. Bowlby viewed anger in close relationships as often being an attempt to connect with an apparently inaccessible loved one. He distinguished between the anger of hope where a viable response was expected, and the anger of despair, which became desperate and coercive. In secure relationships, protest at perceived inaccessibility is recognized and accepted (Holmes, 1996). An attachment-oriented therapist views many extreme emotional responses in distressed couples as primal attachment panic or secondary reactive responses to this panic. For example, in an attachment-oriented couple therapy, a partner who is extremely angry and demanding intercourse three times daily is guided not only to understand how these demands make it difficult for his wife to feel sexual and respond to him but also to access his deep fear that he is about to be abandoned and his sense that only in lovemaking can he feel soothed and secure.

Attachment theory also outlines patterns of individual differences that occur in dealing with attachment emotions and needs. In secure relationships, the connection to a partner establishes a sense of emotional homeostasis. Distressing moments of disconnection and emotional distress are temporary, and needs and fears can be coherently expressed and addressed. In insecure relationships, there are finite strategies for dealing with a negative response to the questions, "Are you there for me, will you respond when I need you?" and "Can I depend on you and do you value me and the connection with me?"

In the first more anxious strategy, at moments of perceived disconnection, attachment anxiety and the whole attachment system become hyperactivated. Attachment behaviors become heightened and intense as anxious clinging and even aggressive attempts to obtain a response from the loved one escalate. Even when the loved one responds, this response may not be completely trusted and a heightened emotional sensitivity to relationship cues may remain. This response can be momentary or it can become chronic and develop into a chronic pattern of anxious attachment and a habitual way of engaging one's partner. When hope for responsiveness has been lost, the second more avoidant strategy for dealing with the lack of safe emotional engagement is to deactivate and suppress attachment emotions and needs, avoiding emotional engagement. Unfortunately, the suppression of affect is hard work and ineffective, often resulting in increased physiological arousal and tension, not only in the subject but in interactional partners (Gross, 2001). If this affect regulation style becomes generalized it effectively cuts off the person from an awareness of his or her emotional responses and needs and shuts out the other partner. More men than women adopt this avoidant attachment style (Levy, Blatt, & Shaver, 1998). These two insecure strategies, the anxious heightening of emotion cues together with hypervigilant clinging and detached avoidance, tend to pull for confirming responses from a lover. These styles or strategies are "self-maintaining patterns of social interaction and emotion regulation strategies" (Shaver & Clarke, 1994, p. 119). While these habitual forms of engagement can be modified by new relationships, they can also mold current relationships and so become self-perpetuating.

Attachment styles impact many key relationship behaviors because they sculpt the nature of emotional engagement with others. They appear particularly to shape responses to conflict and the seeking and giving of support. Those with a secure style are generally happier, and more able to reach out for and provide support (Simpson, Rholes, & Nelligan, 1992; Simpson, Rholes, & Phillips, 1996). They have closer, more stable, and more trusting and satisfying relationships (Collins & Read, 1990; Simpson, 1990). They can better acknowledge and communicate their needs and are less likely to be verbally aggressive or withdraw during problem-solving (Senchak & Leonard, 1992). Research suggests that partnerships with at least one secure partner are more harmonious and have fewer conflictual interactions (Cohn, Silver, Cowan, Cowan, & Pearson, 1992).

Internal representations or working models of self and other are also a key part of attachment theory. These models are used to guide perception and predict others' behavior. Secure attachment is characterized by a working model of self that is worthy of love and care and is confident and competent and a model of others as dependable and worthy of trust. They are formed, maintained, and, most important for the couple, revised through emotional communication (Davila, Karney, & Bradbury, 1999).

Attachment theory outlines the basic human responses, particularly the needs and fears that structure long-term bonds, the primary context for the ongoing construction of sexual behaviors across the life span. It links specific emotional responses and cognitive models to key behaviors, turning toward, against, or away from a partner. It offers a comprehensive new understanding of romantic love (Johnson, 2008a, 2008b) and a map to key pivotal emotionally "hot" events that seem to define relationships and in which individual identities, including sexual identities, are shaped. This includes key recurring moments of palpable emotional disconnection where reactive emotions spark off the negative cycles most associated with relationship distress and dissolution, such as demand and withdraw (Gottman, 1994) and key positive moments of bonding that restore connection and create new positive emotions. In summary, attachment theory provides the couple therapist with a clear set of goals, a focus and compass in the process of change, and a language for the dilemmas and stuck places in love relationships (Johnson, 2007). It provides a basic framework in which sexual behaviors can be understood and the ways that these behaviors reflect and create patterns of interaction in and out of the bedroom elucidated.

Attachment and Sex

In recent years, a growing body of research linking the couple relational context to couple sexuality has emerged. Attachment is powerful in coloring and texturing sexual self-experience and relatedness. Secure attachment facilitates "relaxed and confident engagement" in sex (Mikulincer and Shaver, 2007b). The nature of security and research on the effects of attachment security suggest that a secure partner will be able to communicate more openly, assert needs more easily, be more empathic and responsive to his or her partner, and explore physical and emotional closeness in and out of the bedroom. Indeed, anxiety and avoidance are linked with fewer positive and more negative feelings during sex in many studies (e.g., Birnbaum, Reis, Mikulincer, Gillath, & Orpaz, 2006). Higher levels of anxiety are linked with lower levels of arousal, intimacy, and pleasure. Insecurity is associated with a lower rate of orgasms in women and lower sexual satisfaction in both men and women (Birnbaum, 2007). Anxious partners seem to focus on emotional factors such as the lack of romance when noting dissatisfaction, while more avoidant partners focus on the physical aspects of sex (Davis et al., 2006).

Occasions of frustration and failure and differences in individual partners' desire and arousal occur throughout the history of a couple relationship. How these frustrations and differences are dealt with and how they impact the relationship as a whole, as well as levels of desire, arousal, orgasm, and satisfaction in future sexual encounters, will be influenced by each partner's level of security in the relationship and associated attachment strategies. In general, ways of regulating and expressing emotion play a key part in sexual experience and interactions. As Heiman (2007, p. 100) notes, "Affect-regulated interactions predominate in sexual interactions because of sexuality's emphasis on desire, arousal and nonverbal communication."

Attachment Strategies and Sexual Engagement

There is now a growing body of research on the links between attachment strategies and engagement in sexuality. For example, in young adults, avoidant attachment seems to be associated with less frequency of intercourse and more solitary masturbation (Bogaert & Sadava, 2002). In couple relationships, avoidant men and women were reported to be having sex less often and trying to avoid sex with their partner (Brassard, Shaver, & Lussier, 2007). Avoidants also have more positive attitudes to casual emotionless sex and "one night stands" (Stephan & Bachman, 1999), tend to detach sex from love and commitment, and generally favor short-term mating strategies (Gillath & Schachner, 2006). Attachment anxiety and avoidance in men seem to make the adoption of physical force and coercive strategies in sexual relations more likely (Smallbone & Dadds, 2000). Insecurity results in difficulties in articulating needs for love and attention; therefore, demanding sexual behavior can be a form of "protest" behavior triggered by attachment fears and used as an attempt to deal with attachment fears through coercion and control. Generally, attachment strategies are associated with different motives for engaging in sex. More secure partners identify increased closeness as a main motive for sex, whereas anxiously attached people report having sex to gain a partner's reassurance and avoid rejection. Avoidant adults endorsed self-enhancement motives; they had sex to fit into the group or so as to be able to brag about it (Davis, Shaver, & Vernon, 2004; Schachner & Shaver, 2004).

In terms of efficacy and confidence, high scores on attachment anxiety and avoidance are associated with lower perceptions of physical attractiveness and sexual self-esteem and more perceptions that sex is controlled by the other partner or by situational factors (Bogaert & Sadava, 2002; Feeney, Peterson, Gallois, & Terry, 2000; Shafer, 2001). Insecure partners also are more likely to report problems in sexual communication (Davis et al., 2006). Insecurity is associated with stronger concerns about sexual performance and less willingness to experiment sexually within a romantic relationship (Birnbaum et al., 2006; Hazan, Zeifman, & Middleton, 1994).

More and more studies suggest that attachment security significantly impacts how we approach and engage a partner in sex. Security will also logically impact how sexual encounters feed back into the process of relationship definition. Anxiously attached partners generally weigh daily relational events more heavily when judging the quality of their relationships and they are more sensitive to any cues that imply changes in perceived rejection or support (Campbell, Simpson, Boldry, & Kashy, 2005; Fraley & Shaver, 2000). It is our clinical experience that anxiously attached partners are hypersensitive to any apparent lack of sexual desire, arousal, orgasm, or satisfaction in their partners, taking these as signs of imminent abandonment and that these partners rely heavily on sex to meet their attachment needs. Indeed, a recent study finds that having sex impacts appraisals of relationship quality among highly anxious partners but not among more secure partners. However, in anxious men, just having sex seemed to improve their view of their relationship. In women, the quality of the sexual encounter mattered. Their feelings about it had to be positive for this to occur (Birnbaum et al., 2006). These data seem to reflect the perennial dialogue between male and female distressed partners where women want to feel close and then make love to express these feelings of closeness, whereas men want to make love stating that the sex act itself will create feelings of connection and closeness.

Healthy Couple Sexuality: An Attachment Perspective

Healthy sexuality can be seen from many perspectives. In this section, we consider sexuality from an attachment perspective. In general, insecure anxious partners seem to dismiss sex per se and focus on the attachment aspects of sexual contact. Insecure avoidant partners who see others as untrustworthy and undependable tend to focus on their own pleasure and the sex act and dismiss the emotional connection aspects of sex. Avoidant partners dislike affectionate behaviors such as kissing and cuddling while anxious partners seem to focus on affection and prefer this to sexual activity (Gillath & Schachner, 2006; Hazan et al., 1994). The essence of a positive, secure romantic relationship would seem to be that in such a relationship the three systems referred to by Bowlby—attachment, caregiving, and sex—can be integrated on an intrapsychic and interpersonal level. Sexual pleasure is then multidimensional. Lust and passion can be infused or flow into affection and intimacy.

The integration of sexuality and attachment has to start with the attachment system and the creation of safe emotional connection. As Heiman (2007) states, "Since every act of sex is an exploration of one's own and the other's body and mind, if attachment needs are unassuaged, sexual arousal will be compromised." This author mentions only arousal, but his comment would seem to apply to all four components of sexual functioning: desire, arousal, orgasm, and satisfaction. The implication here is that safe attachment, characterized by attunement and responsiveness to emotional and physiological cues, is the best foundation for satisfying sex and that satisfying sex and a sense of felt security reinforce each other. When partners are emotionally accessible, responsive, and engaged, sex can then become intimate play, a safe adventure (Johnson, 2008a, 2008b). This may be especially true for female partners due to the highly contextual nature of female desire (Basson, 2007).

Arousal requires relaxation to take in stimulation and orgasm requires a tension and excitement but also an ability to let go and surrender to sensation. Neuroimaging studies show that orgasm, at least in women, involves deactivation of the hippocampal regions of the brain associated with anxiety (Bartels & Zeki, 2004). Orgasm and loving touch are also triggers for the "cuddle hormone" oxytocin (Carter, 1998) associated with bonding behaviors. This neurotransmitter induces pleasure, calm, and contentment, actively reducing the release of stress hormones such as cortisol. One of the most basic elements of sexuality, touch, integrates the language of sexuality and of attachment. Touch arouses and it also soothes and comforts.

The viewpoint stated above runs counter to the popular and constantly reiterated concept that familiarity, predictability, and availability in a relationship are antithetical to passion that requires a certain kind of danger, thrill, and novelty. Attachment security can then be seen as antithetical to optimal sexual satisfaction. This viewpoint is part of the culture of romance and is accepted by many couples as simply the way things are. The solution to seemingly inevitable sexual boredom and growing dissatisfaction in long-term attachments is then to focus on sexual technique or somehow inject distance or sexual novelty into a relationship. Unfortunately, this often simply misses the mark. It does not foster attunement to a partner or the ability to be emotionally present or responsive. Focused attention and full engagement in the moment, however, tend to heighten eroticism and can override technique issues (Kleinplatz, 2001).

Couple Distress and Sexual Problems

In many distressed relationships, partners are caught in cycles of critical demanding and defensive withdrawal, both in general and in sexual interactions. The more demanding partner, most often the female partner, is usually more anxiously attached, seeking reassurance and affection in the bedroom and out of it, while the more withdrawn partner, usually the male, may initiate sexual contact but avoid closeness and remain at an emotional distance. For each partner in this cycle of distress and attachment insecurity, sexual experiences become one dimensional. The focus for one is sensation and performance and for the other is affection and reassurance. Sexuality then becomes a place of increasing alienation and anxiety. In this situation, the solution, at least for an attachment-oriented emotionally focused therapist, is to deescalate these negative cycles and structure secure bonding interactions. New levels of emotional safety and connection then foster more positive and integrated sexual experiences. This seems to occur naturally but can also be fostered by the therapist. For example, a withdrawn husband can begin to disclose how he longs to feel desired by his partner and how he now ejaculates fast to avoid any signals of disappointment or rejection from his partner. He shares that he only asks for sex because he does not know how to initiate closeness in any other way. This disclosure changes the way he is perceived by his partner and fosters reciprocal sharing about their sexual and emotional relationship. Creating increased levels of attachment security and relationship satisfaction opens up new possibilities in a couple's sexual interaction.

Understanding love as attachment provides an image of optimal healthy relatedness and optimal healthy sexuality. In a secure relationship, emotional responsiveness, tender touch, and erotic playfulness can all come together. Stern (2004) observes that secure lovers are attuned to each other, sensing each other's inner state and intention and responding to each other's

shifting states of arousal in the same way that an empathic mother is attuned to her baby. Nonverbal cues, sighs, gaze, and touch carry exquisitely coordinated signals. The resulting sense of deep rapport creates a "synchrony" where emotional, physical, and sexual connection can be integrated. In these moments, emotional safety shapes physical synchrony and physical synchrony embodies emotional safety (Johnson, 2008, 2009). The thrill offered by attachment security is the openness to moment-to-moment connection and exploration with an engaged partner and the ability to surrender to sensation without reserve or caution.

The implication of this for the couple therapist is that whether the couple's sex life is an oasis of pleasure in an otherwise distressing relationship, a side issue that partners hope will improve as they feel happier together, a key part of their relationship distress, or a huge relationship issue and a long-standing functional sexual problem that mutually exacerbate each other, the first level of intervention is to increase emotional safety and secure connection.

Treatment Implications: The Emotionally Focused Model of Couple Therapy (EFT)

Before a discussion of couple therapy with couples where sexual issues are a key part of their relationship distress, a brief summary of the EFT model is necessary. EFT combines an experiential focus on the moment-to-moment construction of experience, especially emotionally laden experience, with a systemic focus on the construction of key patterns of interaction. The EFT therapist is a process consultant who creates a collaborative alliance where he or she can empathically follow or lead the client toward new corrective emotional experiences and meanings and new kinds of positive interactions.

More specifically, the goals of EFT are to expand constricted emotional responses that prime negative interaction patterns, restructure interactions so that partners become more accessible and responsive to each other, and foster positive cycles of comfort and caring. For example, the therapist will help habitually angry, demanding partners talk about their fear and sadness in a way that pulls their partner toward them and help habitually withdrawn partners move out of a silent, passive position into talking about their hurt, longings, and needs. The therapist particularly focuses upon emotion because it so potently organizes key responses to intimate others, acts as an internal compass focusing people on their primary needs and goals, and primes key schemas about the nature of self and other. Negative emotional responses, such as frustration, if not attended to and restructured, undermine the repair of a couple's relationship, while other "softer" emotions such as expressions of vulnerability can be used to create new patterns of interaction.

According to EFT theory, although other factors such as the socialization of gender roles may play a role in the development of relationship distress, the most important factor is attachment insecurity and how the couple deals with specific moments of disconnection and with general fears and insecurities (Johnson, 1999). Attachment insecurity complicates the process of emotional engagement and responsiveness and so creates a pathway to the absorbing states of negative affect and constricted interactions, such as criticism followed by defend and withdraw, identified in research on divorce prediction.

In EFT, the process of change has been delineated into nine steps that are designed to be implemented in approximately 10 to 20 sessions. The first four steps involve assessment and the delineation of problematic cycles and the absorbing states of emotion that are associated with them. At the end of this first stage of therapy, the couple is able to unlatch from their negative cycle, see the cycle and the distance and insecurity it fosters as the problem, and stabilize their relationship.

In the second stage of therapy, steps five to seven, partners, no longer overwhelmed by their emotions, are able to use their emotional experience as a guide to their needs and communicate these needs in a way that maximizes the other's responsiveness. Withdrawn partners are able to explore the emotional experiences that evoke their withdrawal and become more emotionally engaged. More hostile partners become able to express their hurts and fears and take new risks with the other partner. It is at this point that partners are invited into a new dance where both are emotionally open and engaged and that both are able to ask for attachment needs to be met. These moments constitute key change events associated with success in EFT, namely, a softening (Johnson & Greenberg, 1988). The couple is then able to complete a positive bonding

interaction where each can risk, share, and find a safe haven in the other. This is a powerful antidote to the negative cycle and defines the relationship as a more secure attachment. The couple can then go on to the consolidation phase of therapy where they construct clear models and narratives of their relationship, its distress and its recovery. They are now able to communicate clearly about crucial issues and solve pragmatic, ongoing problems in the relationship.

Recurring interventions in EFT include empathic reflection, validation of emotional realities, the use of evocative questions, and heightening and interpretative statements. The therapist also tracks and reflects sequences of interaction, for example, the moves in a couple's sexual interaction or in their more general interactions, reframes responses in terms of attachment or in terms of the negative cycles that have taken over the relationship, and creates enactments where partners talk to each other in more coherent and emotionally responsive ways.

In terms of sexual issues, the therapist will first explore the quality of the couple's physical relationship and place this within the context of their general cycle in Stage 1 of EFT. The therapist might comment, "I understand, Jim, that you have felt 'attacked' in this relationship and have gradually shut down more and more, so that even your sexual needs became shut down. You feel 'frozen' and no longer ask Mary for lovemaking. And you, Mary, have felt more and more shut out and rejected and so have turned to demanding more attention and more lovemaking." The therapist will also place sexual responses in an attachment frame, for example, linking lack of desire and arousal to lack of safety and a preoccupation with self-protection. If a couple does not have specific sexual issues (such as long-standing premature ejaculation in the male partner), and sex has simply suffered as a result of relationship alienation and distress, a couple's sex life begins to improve at the end of Stage 1 when partners feel more hope for their relationship and can come together as a team against the incursions of their negative cycle in the bedroom and outside of it.

In Stage 2 of EFT where the focus is on creating positive cycles of emotional responsiveness, as partners are able to risk, confide attachment needs and fears, and reach for and respond to each other, the therapist also encourages the couple to confide and risk in the area of physical closeness and sexuality. For some couples, especially for those who have experienced trauma, this may involve new limits on sexuality (Johnson, 2002). Maria is able to tell her partner, "Some of the ways you have of coming on to me are alarming for me. They remind me of the rape somehow. I need you to start slow and talk to me. Use my name and not come up behind me and grab me." Her partner is then able to be empathic and reassure her. When it becomes apparent that sexuality is experienced as dangerous, the couple will be encouraged to stop intercourse and stay with pleasuring touch for a while. Other couples, once they feel more securely connected, are able to turn to blocks that occur in their sexual dance and openly address them. Sarah is able to talk about how she uses her lover Gil's "horniness" as a test to whether he really loves her. So when he is tired or less interested, she goes into attachment panic and flips into anger. Gil, who can now listen and confide about his sense of "pressure" around sex, states that he needs to be able to say no and talk about how, in these instances, he can reassure Sarah so that they can stay connected. Stan can tell his wife, "Most of the time our sex is great but then I suddenly get afraid. Maybe I suddenly have this voice in my head that says that I am bound to disappoint you and I start to lose my erection: I need you to just let me tell you about that voice and to be patient with me, reassure me a little. When we do that, the erection comes back." At times, the therapist does need to offer information to normalize responses and support the transfer of safe emotional engagement and exploration into the sexual sphere. Stan is reassured to find out that in a 40-min lovemaking session many men will lose their erection for a few moments. Sarah is now safe enough to confide that she seldom orgasms and has decided that she is inadequate sexually and so "knows" that she will eventually lose Gil's love. She needs to know that the majority of women do not consistently reach orgasm from penetration alone. Once a couple can reach mutual accessibility and responsiveness, a new kind of more synchronous sex is possible. In Stage 3 of EFT, partners can solve pragmatic problems such as a lifestyle that almost precludes the time for lovemaking and create a joint story of their relationship problems and recovery that includes the sexual aspect of their bond and acts as a prototype for the future.

Satisfying sexual encounters now strengthen the couple's bond and a more secure bond continues to build more erotic and more satisfying sex. The principles for an attachment-oriented approach to sex issues in a humanistic intervention such as EFT are as follows:

1. It is necessary to place problematic sexual responses and patterns in the context of the recurring spirals of negative interaction patterns such as demand withdraw that continually confirm attachment insecurities.
2. The validation of the need for emotional safety as the essential foundation for sexual openness and responsiveness is a key part of therapy.
3. It is necessary to deescalate negative cycles and create a platform of safety, a preliminary secure base from which to explore and unpack negative cycles of sexual interaction.
4. Once negative cycles of sexual interaction have been outlined and owned, the deeper primary emotions linked to sexual responses are explored and placed in the context of attachment needs and fears. So sadness, fears about rejection and abandonment, and fears and shame about an inadequate or unacceptable self are explored and placed in the context of attachment needs. As common in the EFT model, key moments in a couple's sexual life or conversation about sex will be focused on and explored so as to deepen emotional awareness. Emotionally focused interventions are still systemic in nature in that they place emotions into the spirals of negative responses that a couple creates and is then constrained by. Emotion is seen as a leading or an organizing element in the couple's attachment and sexual system.
5. As part of the last consolidation stage of an attachment-oriented couple therapy, partners formulate a story of their relationship distress and repair. So a couple is also encouraged to create a coherent story of their sexual relationship, including how problems emerge and how they are now able to deal with them.
6. Enactments are created in Stages 2 and 3 of EFT where partners, now emotionally accessible and responsive, can directly disclose sexual fears and needs to each other.
7. During these enactments the therapist actively encourages the integration of attachment and sex. So he or she will support one partner's needs for loving touch and dialogue as part of foreplay and another partner's desire to be held after sex and elucidate the attachment meanings of such moments.
8. The therapist will guide partners to formulate and share erotic cues, blocks to surrendering to sensation and sexual longings, and also offer a model of sexuality as erotic exploration and play, as a safe adventure in which erotic excitement comes from the ever new moment-to-moment engagement with an accessible partner. This is a model that suggests that practice and emotional practice make perfect rather than the cliché view that passion and long-term attachment are antithetical.

The most common sexual problems in North America are reported to be low sexual desire in women (for qualifying comments concerning initial versus responsive desire, please see Basson, 2007) and premature ejaculation or lax erections in men (McCarthy & McCarthy, 2003; Metz & McCarthy, 2004). Let us now turn to two case examples of couples facing these problems. In the couples presented, the focus was on deescalating the negative cycles of interaction that maintain attachment insecurity, reprocessing negative emotional experiences of sex, and building positive cycles of responsiveness that heal the relationship and also heal the sexual wounds and problems that have been part of relationship distress and part of the individual partner's experience of sexuality.

Snapshots of Key Moments in Therapy

Amy and John. Amy announced within the first 10 min of session 1 that the key problem for her and John was that "We are roommates, and I am just not into it, sex I mean. So now he has started visiting porn sites." She then went on to warn the therapist that she did not want any advice about vibrators or training in erotic fantasies and she could orgasm just fine. Her doctor had given her all these and she was not interested. John announced that he had about given up on the relationship and had withdrawn more and more into his work. Amy then pointed out that lately when he was "working" on the computer he was in fact visiting porn

sites. John fell silent. This couple had been married for 6 years, had only initiated sex after marriage, and had then immediately become the parents of twins. There had been many complications as a result of a difficult birth, and as a result of these complications, Amy had extensive scarring on her abdomen. Amy had then been diagnosed with multiple sclerosis and noted that she had faced this diagnosis "alone." In the session, Amy criticized John for his "distance" and his "refusal" to help her around the house. John spoke with nostalgia about the first few months of their marriage when they were "closer and seemed to enjoy flirting and making love even." Amy commented, "How can you flirt with the Silent Man, with a wall? I have given up on it." When we tracked the negative interactions in this relationship, the couple agreed that after the twins were born they had become caught in a pattern of Amy taking the lead as "ruler" of the house and setting up schedules and tasks, while John vacillated between trying to be a good husband and father and "shutting down," feeling replaced, unsure of himself, and criticized. The one place John continued to reach for his wife was to invite her to make love. She nearly always refused. A critical moment in Stage 1 of EFT (Deescalation) occurred when this couple were able to grasp their negative pattern, see it as their common enemy, identify the primary attachment-oriented emotion in this pattern, and relate this to the negative pattern in their sexual life. A snapshot of this process in Session 7 follows:

Therapist (Th): So John, even though you had, as you put it, decided to "fly under the radar, duck the bullets, and stay low and still," you would still take the risk and invite Amy to make love?

Amy: He just gets horny is all. Right? (John looks away and stays silent.)

Th: What happens to you, John, when Amy says, "He just gets horny"? It's like you ducked and went still right here-- right now.

John: What can I say? She believes what she just said. And I do get horny. That is why I have visited those sites a few times. But it's not what I want. I don't want to talk about this.

Th: It is not what you want. And this is hard to talk about. You don't think Amy will hear you? This is part of the spiral we have been talking about, yes? You stay quiet and move away rather than face Amy's "anger." But you still find the courage to ask her for lovemaking.

John: (He looks up.) Yes. But I only ask once (He laughs.) I do move away. That is the only time I try to get close, so she probably does think it's all about sex. But then she never wants to anyway. If I am so disappointing and she doesn't even miss making love, well then . . . (He throws up his hands.)

Th: When you throw up your hands like that, that is like, this is hopeless? There is nothing I can do. Is that it?

John: Yes. Last time we talked about me being afraid all the time, waiting for Amy to criticize me and tell me my flaws. And I said it wasn't really fear. But you know, I have been thinking about it and it's not fear, it's worse than that. Don't know what to call it.

Th: It's worse than fear, waiting for that message that you don't measure up. That you can't please her, it's hopeless. What does it feel like right now to talk about this?

John: It's hot in here. (Then he laughs.) My whole body tenses up. I do feel hopeless. I get that she looks at me and just sees a blank wall. She thinks I don't care. But I am going crazy inside. I can't do anything right here.

Th: Yes, you look calm and still but inside you are hopeless, tense, crazy, and you stay still, do less, so Amy sees indifference (She nods her head) but this feeling that you can't ever do it right is . . .

John: Terrifying. I have lost her already. I've failed here. Failed miserably. So I just shut down.

Th: Yes, can you tell her, "I am terrified. I can't find a way to come close, to please you. I get feeling so helpless and hopeless. So I shut down and numb out"? (He nods.) Then you see a wall.

John: (Turns to Amy) I move away so as not to hear your indictments. I freeze up. It's very scary to feel that I can't put one foot right with you. And I did let you down when you got your MS diagnosis. I didn't know what you needed. I froze up (Amy looks confused, but she is staring at him), but I do ask, ask for lovemaking.

Th: Right. Amy feels "alone" and like you have somehow left her (She nods), and she demands your attention by pointing out what is missing or what you could have done. We talked last week about how desperate she feels when she does that. But you hear that you have blown it and move farther away. And then Amy feels even more alone. Round and round. You shut down and she feels shut out. But then, even though you are "terrified," you do move in and ask for touch and for lovemaking. But Amy doesn't feel safe enough to begin that dance.

Amy: Sex for me is still kind of unfamiliar territory. And anyway, all I feel is mad and tired. Maybe sex isn't my thing anyway. I am mad or numb. Most of the time, I don't feel wanted at all, so . . .

Th: So what happens to you, Amy, when John says, "Yes, I move away. I am terrified. It is so hard to hear that I disappoint you. Your anger tells me that I've failed. You think you have no impact on me but your anger has me freeze up"?

Amy: (Looks at him, puts her head on one side, turns to John) You really feel that? (He nods emphatically.) You get scared. I never saw you as scared. I guess we really have got caught in this spiral thing. We both end up terrified maybe. But when I feel so shut out, I just can't turn around and make love.

Th: Right. That is too risky. And you are hurting so it doesn't feel safe to open up like that. But in spite of this spiral of desperate demand and freeze up shutdown. John, you still come to Amy and ask for lovemaking. You are still longing . . .

John: Yes. The happiest times in my life was when I was first with Amy and felt so close to her. And when we made love, I knew that I really mattered to her. I know she is shy around sex. And I think since the babies and she has those scars, she is real shy. (He reaches out and takes Amy's hand.)

Th: You long for that closeness, that sense of being her special man, her mate. This is not about just orgasm. You long to feel desired and so you risk asking, even though you are "terrified" of failing and losing her. And you know that she is shy and unsure about sex, and she is maybe worried about her body, her scars. When you think of that, you reach out for her hand. You want to comfort her about that, reach for her, hold her hand so she isn't so shy? (He nods) Can you tell her please, "I have been so shut down but . . .

John: I know I have shut you out. But, like we said in the last session, we have to help each other out of this spiral thing. I am lonely too. It's terrible to hear that I disappoint you all the time. I want to be a good husband. And the one time I really felt that you loved me was when we used to make love, I would like that again. And I want to help you feel safe, like (the therapist) says, so you can relax and we can learn about lovemaking together. I know we have to come together first, feel closer.

Th: Yes. You long for that sense that Amy loves and desires you. You want to step out of this dance and be with her again. Amy, how do you feel when John says these things?

Amy: It feels good. To feel like I matter to him. It calms me down. I get so mad; it's like I will make him listen to me. Then it just gets negative. But when he talks like this, I get that he needs me. But it's new. And making love just seems like too much. I am shy. It's hard for me to relax around sex stuff. I didn't know that he understood about the scars. It's like I don't want him to see me. But I like that he knows that that is hard and that he holds my hand.

John and Amy were more and more able to step out of their negative cycle at home and to talk about their underlying emotions. Their view of the other expanded and they began to take more emotional risks with each other. As they took more emotional risks, they began to outline their sexual cycle more. John would reach but Amy was "too mad, too sad, and too scared" to respond. John would then withdraw in the bedroom and everywhere else. In Stage 2 of EFT, the couple began to disclose more of their attachment fears and needs and, with the therapist's help, to translate this into physical touch. After a period of cuddling, comforting touch, holding, and discussing the blocks to "letting the hot feelings in and going with them," they began to make love. Amy's fears about her body being unattractive had to be explored in session and John had to reassure her of his desire many times. As part of the third and last stage of therapy, they were able to plan to explore their bodies and sexual responses together, with Amy finally being able to tell John what aroused her and how she had never learned how to listen to

her body or think of sex as play. He said he would help her. As she became turned on in bed, John became more and more confident of her love and became more and more emotionally available and asserted his needs for "feedback but no attacks" and "no putdowns." As he became more available and responsive, Amy felt more safely connected and engaged, in bed and out of it.

Jason and Giselle. Jason and Giselle presented in therapy with sexual issues related to Jason's premature ejaculation, arousal difficulties, and waning sexual desire and Giselle's inhibited desire and arousal. Initially, Giselle had pursued Jason sexually, initiating sexual contact in her efforts to restore a sense of connection to Jason. Now in Stage 2 of EFT, with the deescalation of the negative cycle defining their sexual interactions, both partners were able to engage emotionally concerning the attachment anxieties underlying their sexual interactions. Both partners were now aware of how sexual contact had become a pressure-filled place. Working with Jason and Giselle's moment-by-moment sexual experience and interactions, the complex emotional experience underlying Jason's withdrawal was unpacked. Jason's anxiety about Giselle's sexual initiations and intercourse, at first glance, centered around his frustration and disappointment in his inability to perform sexually and please Giselle. Eventually, these feelings dissolved into more vulnerable attachment-related affects related to fears of failure, inadequacy, and fears of rejection. At first, Giselle had been angry, critical and attacking of Jason's sexual difficulties, prompting him to "get over it." Jason would withdraw into his obsessive thoughts about his failing masculinity, and overfocus on his failing penis, which eventuated in his withdrawal from sex, including his rolling over in bed and ceasing all subsequent physical contact. At other times, his anxiety over Giselle's anxious demands for penetration would result in his ejaculating prematurely. Giselle's angry, critical complaints, once explored, allowed more deep-rooted sadness related to Jason's lack of emotional accessibility during sex to brim to the surface. Jason's withdrawals during sex had reaffirmed a deeply held negative self-view related to her worth and attractiveness. Giselle's desire had eventually begun to wane as sex became associated with sadness at disconnection and feelings of aloneness.

In this brief excerpt, the EFT therapist explores sexual experience and interactions to support each partner's ability to risk more open expressiveness and to foster interactions that create greater emotional safety in the sexual realm.

Jason: I start thinking that "Oh! Here we go again, I'm going to lose it or I'm going to ejaculate," and that's when I begin to feel a lot of pressure, I feel frustrated, I've got to get it right this time, or else she won't want to be with me, that's intolerable.

Th: I get the sense that sometimes for you, Jason, it's like perform well or lose her, yes? That's a lot of pressure. That's the scariest part of sex for you right now, right? Each sexual move has become so filled with fear. . . . If you don't get it right, if you don't give her the pleasure she wants, then you fear you'll lose her. It's too hard to let her know how scared you are. Sometimes when these fears build, getting close and contact is really exciting for you, but scary at the same time. So when you focus on the sensations, you ejaculate quickly, other times, you go elsewhere in sex. You focus on your penis, how erect it is, am I performing well . . . you kinda leave you and her at that point. You withdraw; you focus on whether you're performing okay, because it's life or death for the relationship at that point. . . .

Jason: I'm so afraid of her reactions because in the past she got really angry when I didn't penetrate her long enough, so I've always been focused on that. I get so scared. If I don't get this sex thing right with her I'll lose her.

Th: Jason, what would it be like for you to reach for her now, to take a risk to let her know that you fear losing her?

Jason: Giselle, I'm so afraid that I'll lose you if I don't perform right, give you better sex.

Giselle: (Reaching for Jason's hand) You're not going to lose me, I'm here for you, and you're not going to lose me.

Th: What's happening for you right now, Giselle? What are the tears about, this sadness that's coming up, tell him about it?

Giselle: It's not that I got angry that you didn't penetrate me long enough. It's that when you'd ejaculate quickly or lose your erection, you'd pull away from me and get up and leave or get all flustered. I really didn't care about your penis, it's that you'd leave me there. I'd feel

so alone at those times. I'd be feeling close, and then you'd get into your frustrations about your penis. Then I'd feel so alone, after feeling so close. I wanted you to stop thinking about your penis so much, to continue to touch, or hold me. I've been so sad because sex had become like the rest of our relationship. I've felt more and more alone, and I've wanted to feel closer.

Th: It's like when he went into performance mode, or would ejaculate quickly and just leave you there without touching, caressing, or holding you, you got angry, because you wanted him to be with you, you longed for him to touch you, hold you, not to leave you alone. Can you tell him about those longings?

Giselle was able to do this, and this couple's ability to communicate openly about their sexuality and so to create in-synch responses, to deal with moments of frustration together and not allow them to derail lovemaking, and to relax into physical pleasure and a felt sense of emotional connection improved.

CONCLUDING COMMENTS

Gratifying sexual interactions contribute to relationship satisfaction and stability and heighten feelings of love, while sexual dysfunctions increase conflict and distance. Conflicts and distance most often also interfere with sexual desire and satisfaction (see Sprecher & Cate, 2004, review). As McCarthy and McCarthy point out (2003, p. 32), "Sex works best when each spouse is open and receptive." We take this to imply open and engaged with their partner, so both are accessible and responsive emotionally and physically to their lover and to their own emotions and needs. If sex, caregiving, and attachment are disconnected, they often interfere with and undermine each other. Now that we have a comprehensive theory of adult love, we can help partners integrate them into a loving bond where each of these elements can enrich the other.

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