

## **EMOTIONALLY FOCUSED FAMILY THERAPY: DEVELOPING THE MODEL**

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*Emotionally Focused Therapy is a model which combines attachment theory and systemic theory. This article is a transcript of a plenary given by Gail Palmer and Don Efron at a conference called the "EFT Summit" which was held in Ottawa in Spring, 2006. The authors discuss the development of Emotionally Focused Family Therapy and describe two cases from two quite diverse treatment settings.*

### **GAIL PALMER:**

In our offices, we meet families of all shapes and sizes. Scanning my own therapy archives, I remember the single mom with her only child. She was struggling to help her daughter who suffered from both juvenile diabetes and bulimia. On the other end of the spectrum was the adult son who felt lost and alone even though his family was not only large (they had 16 children) but was also powerful and influential. Emotionally Focused Family Therapy (EFFT) is a therapeutic approach that allows us to engage each and every family we meet, from the family seeking help through a private practice clinic to the parents and siblings of an emotionally disturbed child, Emotionally Focused Family Therapy can reconnect those bonds vital to health and well-being. Joan Didion (2005) wrote in her memoir, *The Year of Magical Thinking*, about her terrible loss of both her husband and her daughter. She said that her grief and connection to them gave her meaning and purpose.

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“This much I know is true. I was loved and I loved” (p. 186). Our families provide us with a framework for our existence and when the bonds are secure, meaning there is a responsiveness and accessibility, we carry this gift of love. EFFT helps ignite, repair, and restore the attachment bonds so that each family member may realize and actualize their connection to one another. Children need this connection to grow and develop as well as to leave the home. Parents need this connection to grow and develop. Family is our secure base. How do we build this base? How do we repair the foundation when it is broken? How do we rebuild when families are transformed through death or divorce? EFFT provides us with a roadmap to follow to answer these questions and guideposts along the way to help us facilitate this process with the families we meet. Following is an overview of EFFT, what it looks like, and how it has evolved with one family I have worked with in my office at the Ottawa Child and Family Institute.

With the families we meet, the EFFT therapist engages the family through an attachment perspective. Our families are not in conflict because of communication problems, parenting dysfunctions, or individual psychopathology, although all of these may be evident. They are in distress because they are struggling with attachment dilemmas. From an EFFT framework, negative interactional patterns and individual symptomatology are reflective of unmet attachment needs. Our need to seek and connect to our caretakers is primal and the ability of our caretakers to be emotionally responsive and accessible, especially when the chips are down, is critical to the quality of our family life and to our individual emotional health. Allen and Land (1999) found that families with avoidant attachments tended to have adolescents who exhibited problems such as delinquency, substance abuse, and aggression and these were those children who had the least amount of autonomy and relatedness.

Consequently, for the EFFT therapist the acting out adolescent is not seen as a conduct disorder but as an adolescent struggling with an individual need for autonomy and a continuing need for emotional connection to his or her parents.

The EFFT therapist begins with a family by framing the problem in attachment terms and normalizes the family’s distress as arising out of an attachment crisis. Attachments needs within a family vary in terms of quality and intensity depending on a number of variables. These include: times of transition and change, for example the birth of a child or the loss of a parent, which signal an increase in the need for comfort and support; the age and developmental stages of the children, for example the infant versus the adolescent; the interaction between the generations for attachment priority as when children, parents, and grandparents compete for their attachment needs to be met. This is especially true in stepfamilies where attachment needs oftentimes compete and collide but also in intact families where children and parents compete for time, attention, and support. Families become distressed when there is an inability to adjust to the changing needs of each family member. This lack of responsiveness or accessibility then creates negative interactional patterns that become entrenched and reinforcing. The nega-

tive cycle then works to further distance family members from each other and creates increased negative affect which further limits the family's ability to be responsive and accessible. The EFFT therapist frames this negative interactional cycle that has developed out of the attachment struggle as being the problem—instead of the parents or the children—and helps the family to begin viewing their problem as the cycle as opposed to blaming themselves or each other.

A family that I worked with recently at the Ottawa Child and Family Institute presented with a mother and her three children, two girls ages 18 and 16 and the son age 13. The family had recently experienced a marital breakdown and the two girls had chosen to live with their father. The mother and son were living alone and there was very little contact with the four family members as a group. An alliance between the two daughters existed as did an alliance between mother and son and there was an emotional estrangement between the mother and her daughters and also within the sibling group. In my first meeting with the family group the atmosphere in the room was one of anger and tension between mother and daughters. The son generally avoided contact with his sisters and tended to placate and please Mother. The daughters were in the positions of the withdrawers in the family as their typical stance was to be silent and distant with their mother and stonewall her around her questions and inquiries. The mother was the pursuer, feeling hurt and betrayed by her daughters' abandonment of her. Her interactions with the girls were often critical and blaming, and she would occasionally threaten to pull out of the relationship entirely. In the beginning session, the negative interactional cycle was tracked and identified as each member told their story of how they saw their family. The cycle was identified and their struggle was framed as being a response to the marital breakdown and normalized as characteristic of this transition. Each family member was struggling to find their place in this newly formed family and due to this sudden change, there had been a rupture in the bonds between these family members that needed to be healed. Providing this framework helped the family to feel hope around their future and provided a focus for the working through sessions.

The work with this family then progressed through a series of sessions with family subsystems. Dyadic sessions between mother and child were held with each child and also sibling sessions without the mother. This format allows for attachment needs of each relationship to be addressed directly and to focus on increased emotional responsiveness in each relationship. The dyadic sessions with the mother varied between the daughters and the son, as their presentation was different, although the underlying issue of attachment accessibility was the same, and each needed to be responded to uniquely and separately. The focus for these sessions was encouraging direct expression of attachment emotions so that they were more central to the family's awareness and part of the family's dialogue. By session six, all of the children were talking about connection and closeness, especially with each other, and it turned into light-hearted banter between them.

With the daughters, there was need first to reengage them with their mother which began with them expressing their anger and disappointment around being

abandoned by their mother emotionally in the past. The girls were encouraged to express their feelings directly with their mother and their secondary emotions were validated and normalized using an attachment frame. The mother needed a lot of help in being able to sit and listen to her children without responding defensively or striking back. (“You hurt me, so I will hurt you back.”) I consistently affirmed her position as mother and reinforced how important and irreplaceable she was to her girls. This helped to contain and hold the mother. She was able to arrive at a stage where she was able to tell her middle daughter that she was there and she was listening now. She recognized she did not listen well in the past but she was stronger now and she could listen. This then allowed one of the daughters to take a further step and express her more vulnerable feelings, her fear, and sadness, and how lost and invisible she had felt, particularly at this time of crisis in the family. In turn, this allowed the mother to come forward and give her comfort and provide her with support. “You know I give good hugs.” A further session with the mother and daughter then progressed with the mother telling her more about the circumstances of the separation, not the intimate details, but more of what was happening to her emotionally, for which the daughter thanked her. “This is the most honest you have been. I knew what was happening, but you were always angry and it seemed you were angry at me.”

The EFFT therapist seeds secure attachment by working through, within each dyad, the following steps:

- Accessing the underlying feelings and attachments needs
- Reframing the problem in terms of the unmet attachment needs
- Promoting the acceptance of the others’ emotional experiences
- Facilitating the expression of attachment needs and creating new interactional responses

The EFFT therapist holds the map for the family to be defined as a secure base by envisioning relationships that are supportive, comforting, nurturing, and safe and identifies and promotes emotional responses and behaviors that create this safe haven. By unlocking the negative cycle of criticize/defend and helping the daughter and the mother talk more directly about their needs in this relationship, the expression of positive affect and increased collaboration and problem solving can occur between them.

Generally, the underlying emotions accessed in this early stage of treatment are those related to feeling of failure for both parents and children and fears around loss, disconnection, and abandonment. Children can experience feelings of unlovability unworthiness and inadequacy and these vulnerable feelings can be directly soothed and comforted by a parent. Parents also may have insecure models of self that are triggered in their interactions with their children and soothing and comforting those feelings are not the responsibility of the child. Parents can however feel more competent, worthy, and lovable when they are able to estab-

lish a secure and positive connection with their children. While the parent–child relationship is not a mutual one it is reciprocal as each person affects and shapes the emotional experience of the other. Developmentally, an adolescent is more capable of a mutually supportive relationship than a child, as is a young adult more able to establish more of a friendship-like relationship with a parent.

The final stage of therapy is consolidation, where the EFFT therapist works to nurture and maintain secure bonding through intimate exchanges and family rituals. The therapist heightens and validates the family’s strengths and reinforces family rituals that promote and encourage family connection and emotional support. The entire family is often seen at this stage to consolidate the changes and reinforce the rituals. In this family, the new family grouping began to establish movie nights and rituals for connection for all family members. The girls reached out to their brother by bringing over a movie he loved and then insisted on sharing it with him. Mother’s participation was also requested and she was also able to ask for help from the kids in preparing the meals.

#### **DON EFRON:**

EFFT is a tool which we utilize in the treatment of emotionally disturbed and behaviorally challenging children in the intensive therapy programs at Vanier Children’s Services, a Children’s Mental Health Centre in London, Ontario. We provide services to the type of families which one would not automatically associate with EFFT. The children are seen as the “terrors” of their schools. The families present as poor and filled with histories of abuse, addiction, deprivation, mental illness, and loss. Despite these realities we have found that EFFT can provide an invaluable extra tool for therapists. We hope this discussion will encourage others to experiment in using EFFT in intensive programs.

We use EFFT with caution. We know it would not be advisable to provide this intensive emotionally involving therapy to all or even most of our clients. Nor do we have the resources available to provide EFFT to many families. So, we have developed guidelines which help determine which families might best be offered EFFT.

The first guideline is that the family establishes a good working relationship with one of our therapists and has found one of our programs to be helpful. This suggests that the family is “workable” and that a certain amount of trust has been established between them and Madame Vanier as an agency.

The second guideline is that at some point the therapy gets “stuck.” The family appears to the therapist to be unable to make full use of the parenting and impulse control skills which are offered. They spin their wheels. Very often this signals to the therapist that there are deeply rooted attachment injuries and interactive cycles produced by the injuries which prevent change and growth.

If these conditions are met, the therapist can make a referral to our EFFT core group (myself and three colleagues trained by Sue Johnson and Gail Palmer). We

review the case and if we believe that EFFT is indeed called for, we offer to provide co-therapy with the referring therapist or to provide consultation.

The therapy is usually for one or both parents and the child but might include other children or be multigenerational. We ask the therapist to inform the parents that the therapy will be emotionally powerful and could cause them or the children some distress. If they are willing to take this risk we proceed.

Typically EFFT therapy is offered weekly or biweekly. The average number of sessions would be about 10 to 15. This permits us to offer the therapy within the time frames of our programs.

I will present a case that illustrates the potential of the model in our setting. I have changed identifying information.

James, 10 years of age, lived with his biological father, one older sister and one younger sister. James's parents had separated when he was four years old. The children had lived with the father since the separation.

James was placed in our residential treatment cottage due to aggression toward peers, siblings and adults, school suspensions, violent outbursts resulting in restraints, nightmares, suicidal gestures, enuresis and encopresis, impulsivity, oppositional behavior, poor self-esteem, and severe learning disabilities.

We never met James's mother. She had a long history of severe depression (known to the children) and alcoholism (not known to them). She had erratic contact, promised things to them and did not follow through, and was in a new relationship with a man with children of his own.

Milieu therapy at the residential treatment facility at Madame Vanier Children's Services had been moderately successful in most areas but we received a referral from the primary therapist because of frightening episodes of James having uncontrolled rages. James would go into these rages whenever there was contact with his mother or when contact was attempted unsuccessfully. For example, after his mother called him, promised him a bike for his birthday and then did not show up or bring a bike, he exploded.

A typical cycle around these rages was as follows: James would show anxiety and request to contact his mother. He would make calls which were unanswered. He would begin to withdraw. Attempts by his father or staff to engage him only produced, "I don't know"s. He would begin to react emotionally to peers or in class. Seemingly little things triggered massive explosions in which he appeared to lose all control. During these explosions, James screamed, hit or kicked, and made threats to kill himself. The explosions could go on for hours and resulted in physical restraint by staff or the father. Afterwards, he would not remember what happened and was unable to give any explanation for his upset even if staff or father reminded him of his attempt to contact his mother. He would say he did not want to talk to her. Eventually the cycle repeated itself.

The violence of the explosions scared siblings and peers and they withdrew from him leaving him more alone. Paradoxically, this most likely led to him needing comforting and hence missing his mother all the more.

### EFFT ASPECTS

From an attachment perspective, James could be seen as “insecure-fearful/avoidant.” This suggested that he had suffered tremendous damage to his ability to form and keep secure relationships.

We decided to recommend therapy for the entire family because individual therapy with James and therapy with the father and James by themselves had not proven effective. We hoped that inclusion of the siblings might make the therapy feel safer for James.

The specific goal of therapy was to explore how the mother’s absence might be affecting James and how this might be connected to his anger outbursts. Additionally, we looked at how the mother’s behavior might cause the family members to lose closeness and connection with each other.

James would not participate at first if questions were directed toward him. However, when the focus was on the father’s and siblings’ feelings of anger, sadness, confusion, and pain and their reactions to the mother letting them down he began to participate. As time went on he was more able to talk about his feelings about his mother in a manner which his father and siblings had never heard him be able to do before.

I would like to share a few vignettes of our work with James and his family.

In one session, James’s father recounted a time when James was four years old and his mother called. James talked to her, then turned the phone over to the others saying, “She doesn’t hate us anymore.” James’s father then went on to talk with the children about how he feared they thought it was entirely their fault that she had left. They responded that they did have these thoughts at times. One of the girls remembered the first time James had been suspended at school and connected it to James’s feeling he was to blame for their mother leaving.

Another example from the sessions was when James’s father brought up an incident which occurred the night after the sixth therapy session. James woke him up in the early morning to say he was very angry at a previous counselor who had suggested he live with his mother. In the session, James was able to say how angry he was at his mother for not seeing him anymore. In turn this led to the family looking more deeply at how they coped with their anger toward their mother. The eldest girl realized she became bossy, “like a little mother.” The younger girl realized she became too talkative and impulsive. All the children agreed to deal differently in the future with their anger by talking to their father or grandmother when they felt upset about her.

Therapy was not an easy course for James. There were many ups and downs and a time when he went through an increase in the number of violent episodes in the residence (though never at home). But his ability to communicate his feelings to his father or staff continued to increase and the ability of the siblings and father to comfort each other improved and they were able as a family to make decisions about how to deal with such issues as Mother’s Day.

One final vignette illustrates the enormous change with James. Toward the end of therapy, his mother did call one day. Always in the past this had led to the rages. This time James talked to her for a few minutes and then handed the phone over to others. He did not have temper explosions afterward nor any other signs of increased anxiety.

Therapy continued in weekly, then bi-weekly, sessions for three months and ended shortly before James was discharged home.

One year later phone calls to the father and to James's teacher confirmed that he had maintained the gains he made in the therapy.

It is always a challenge to stretch models of therapy to fit settings like Vanier. It takes a strong, flexible model to be that adaptable. EFFT is strong enough and flexible enough to make the transition to our intensive treatment setting.

## CONCLUSION

Emotionally Focused *Family* Therapy is the little sibling in the Emotionally Focused Therapy world. The potential for its use has been largely untapped to date. There are many reasons for this including the historic development of Emotionally Focused Therapy with couples and the greater difficulty of scheduling and controlling what happens in family therapy sessions. Nonetheless, we feel strongly that EFFT has much to offer families and should be more practiced by therapists trained in EFT. The two presentations here show that EFFT is applicable to diverse settings and situations. We sincerely hope that readers will use this article as a springboard for their own work with children and families.

## REFERENCES

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