



Attachment Versus Differentiation: The Contemporary Couple Therapy Debate

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This paper reviews the current debate between differentiation and attachment in treating couples through exploring the tenets of crucible therapy (Schnarch, 1991) and emotionally focused couple therapy (Johnson, 2004). We provide a review of the two theories—as well as the two “pure form” example models—and explore the debate in light of the integrative movement in couple and family therapy (Lebow, 2014). We also examine points of convergence of the two theories and models, and provide clinicians and researchers with an enhanced understanding of their divergent positions. Both differentiation and attachment are developmental theories that highlight the human experience of balancing individuality and connection in adulthood. The two models converge in terms of metaconcepts that pervade their respective theories and approach. Both models capitalize on the depth and importance of the therapeutic relationship, and provide rich case conceptualization and processes of therapy. However, they substantially differ in terms of how they view the fundamental aspects of adult development, have vastly divergent approaches to how a therapist intervenes in the room, and different ideas of how a healthy couple should function. In light of the deep polarization of the two models, points of integration—particularly between the broader theories of attachment and differentiation—are offered for therapists to consider.

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Imagine a clear container of oil and vinegar. When shaken up, no difference between the oil and vinegar is readily noticeable, but when left to sit, their differences become quite apparent. There has been rapid movement toward model integration in couple and family therapy (Lebow, 2014); yet, amidst this movement, debates about model-specific differences abound. Integrating (or shaking up) models seeks to blend similar and unique theories and strategies in a cogent manner. To be clear, sometimes integration means bringing very different models together in a unique way (like oil and vinegar). Integration can also include blending very similar if not identical ideas that have simply been given different language (“Tower of Babel” phenomenon; Lebow, 1984), or using aspects of various models depending on the circumstance. The current trend in psychotherapy is overwhelmingly toward integration; “integrative/eclectic” is the most common orientation (Norcross, Karpiak, & Santoro, 2005), even if it is not a majority. Gurman (2011) noted that although

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most couple therapists probably identify with a particular theoretical orientation, many practice “assimilative integration” (Messer, 2001) in which one’s “home theory” is the over-all guide and outside techniques are adopted as needed.

Pinsof et al. (2018) introduced an integrative metamodel¹ that allows for a great deal of flexibility in blending a wide array of theories and strategies, but contains its own set of principles and a guided way of practicing such integration. At the same time, there is a strong resistance and concern—particularly by model developers—to losing the conceptual distinctiveness of each model. This includes a closer look at specific ways in which certain models diverge and perhaps should not—or cannot—be soundly integrated. For instance, Lebow (2014) identifies several theoretical controversies (e.g., attachment vs. differentiation) regarding integration in couple and family therapy that are possibly unresolvable at this time. Dickerson (2010) posited that although some integration of practices and concepts from different approaches is possible, theories cannot be integrated across epistemologies (i.e., one cannot be structural and poststructural at the same time). These controversies can create complications for therapists seeking to work from an integrative approach.

Although a move toward integration cannot resolve every debate, it does offer us an opportunity to assess how certain models converge and diverge in both theory and practice. This comparative investigation of models offers therapists the capacity to integrate where appropriate and thoughtfully choose between different approaches. A clear example of this challenge—and central focus of this paper—is the debate between the merits of attachment- and differentiation-based couple therapies. Two leaders at the heart of this debate—Sue Johnson, a proponent of attachment theory (Bowlby, 1969), and David Schnarch, a proponent of differentiation theory (Bowen, 1978)—have developed models (emotionally focused couple therapy, Johnson, 2004; crucible[®] therapy, Schnarch & Regas, 2012) they purport as being diametrically opposed to one another (Siegel, Schnarch, Johnson, Sroufe, & Kagan, 2013).

In light of this example of polarization and the general trend toward integration, it can be difficult for therapists to: (i) understand the debate itself; (ii) see how the two theories converge and diverge in practice; and (iii) determine how or whether these two core models which represent the theories can or should be integrated. This is made particularly difficult as clinicians do not have ready access to clear demonstrations of each model without first buying the product, so to speak. Intentionally or not, model developers also create loyal followers; in attempts to learn one model, therapists may naturally downplay possibilities encouraged by alternative approaches. Although this paper reviews crucible therapy and emotionally focused couple therapy as “pure-form” models based on differentiation and attachment, respectively, the issue for many practitioners is not about the models per se but *how* differentiation and attachment may work together. Therefore, this paper deals with the clash of two major ideas central to couple therapy that are often used without probing their complex meanings. We will help clarify the debate, offer points of integration, and highlight challenges for clinicians to consider.

ATTACHMENT THEORY

Attachment theory posits a biologically based emotional bond of a child to caregiver (Wallin, 2007). This bond is regulated by the attachment behavioral system (Bowlby, 1969), which consists of three kinds of behavior that increase chances for survival and reproductive success: (i) maintenance of proximity to protective figures, usually in a

¹Recently renamed *Integrative Systemic Therapy*.

hierarchical order with one primary figure; (ii) use of the primary figure as a “secure base” from which to explore one’s environment; and (iii) seeking of a “safe haven” provided by the primary figure in moments of danger, stress, or alarm to achieve protection and reassurance (Wallin, 2007). The safe haven includes both physical closeness and emotional “felt security” (Sroufe & Waters, 1977; p. 3). The secure base and safe haven provide children the context for developing “autonomy-within-relatedness and relatedness-within-autonomy”; each are key to emotional health (Powell, Cooper, Hoffman, & Marvin, 2014; p. 90). Caregiver behaviors that promote security include delighting in and watching over the child as she or he explores, providing “just enough help” when needed, and comforting by matching the child’s emotion (Powell et al., 2014, p. 53).

Attachment behaviors are displayed in predictable patterns which have lasting effects throughout life; proponents describe attachment as a motivating force that is never outgrown (Bowlby, 1979; Johnson, 2004). Adult romantic relationships were studied and conceptualized as attachment processes in the late 1980s by Hazan and Shaver (Hazan & Shaver, 1987), who found that patterns of attachment among adults are similar to infants. Adults—like infants—were found to differ in predictable ways in terms of how they experience close relationships; one’s attachment “style” is related to how one views the self, other, and relationship experiences with caregivers (Hazan & Shaver, 1987). Due to their evolutionary origin in survival, attachment-related emotions can be intense (Powell et al., 2014), and isolation—either physical or emotional—can be traumatizing, to which coregulation of emotion is the antidote (Johnson, 2011). When emotional disconnection is significant, partners are limited to three options: protest the disconnection and demand emotional engagement, turn away or disown attachment needs, or securely reach out for one’s partner—which is more likely to result in safe connection (Johnson, 2017). This connection is established and maintained through emotional engagement (Johnson, 2008). One key difference for adult attachment is that adults have greater abilities for problem-solving, self-regulation, and symbolic thought, which allow for self-soothing and postponement of coregulation until support is available (Mikulincer & Shaver, 2007). Adult attachment relationships also involve additional behavioral systems of caregiving and sex (Feeney, 2008).

Emotionally Focused Couple Therapy

Emotionally focused couple therapy (EFT) is an experiential and systemic approach to working with couples based on attachment theory (Johnson, 2011).² The experiential perspective focuses interventions on emotional responses—particularly in the here-and-now—in the context of safety created by the therapeutic alliance (Johnson et al., 2005). The systemic perspective provides the assumption of circular causality—a feedback loop which shapes each partner’s behaviors in context of the other (Johnson et al., 2005). The EFT therapist relies on attachment theory for direction in how to go about changing the nature of emotional bonds (Johnson & Best, 2002). Shifts in attachment-related interactions and associated emotion are facilitated by the “process consultant” therapist (Furrow & Bradley, 2011). EFT is designed to create more security in couple relationships via: (i) creation and maintenance of a therapeutic alliance with a high degree of trust and support; (ii) accessing and engaging with each partner’s emotion to facilitate expanded or new

²Johnson (2004) views adult attachment as synonymous with adult romantic love, while Greenberg and Goldman (2008)—proponents of emotion-focused therapy for couples (EFT-C)—do not. The two models share similarities in terms of the primacy of emotion, but differ in the emphasis on attachment. Due to the focus of this paper on attachment, Johnson’s EFT is utilized rather than Greenberg’s EFT-C.

emotional experience; and (iii) restructuring the couple's negative pattern of interaction (which is the primary goal of EFT; Johnson et al., 2005).

These tasks are pursued by the therapist across three stages. Stage 1—de-escalation—includes identifying the conflict issues and the negative cycle or sequence in which the issues are expressed, accessing emotions underlying each partner's positions in the cycle, and reframing the issues in terms of the cycle, underlying attachment-related emotion, and unmet attachment needs (Johnson et al., 2005). De-escalation occurs as the EFT therapist helps the couple shift their complaints to a focus on the cycle and each partner's underlying attachment emotions and needs (Furrow & Bradley, 2011). Stage 2—changing interactional patterns—consists of identification with previously disowned attachment needs and emotions, acceptance of the other's experience, and clear, nondemanding expression of needs to create bonding events in-session (Johnson et al., 2005). The EFT therapist works to deepen and expand attachment-related experience underlining each partner's position in the cycle (Furrow & Bradley, 2011). Stage 3—consolidation—consists of consolidating new positive cycles of interaction (Johnson et al., 2005) and supporting the couple in solving concrete problems and disagreements around areas such as money, parenting, and sex (Furrow & Bradley, 2011).

Learning EFT demands the therapist view couples' concerns through the lens of attachment (Furrow & Bradley, 2011). This includes an assumption of dependence—that all adults are dependent on key others for soothing and safety (Johnson, 2008). The EFT therapist learns to “tune in” to emotional music occurring between and within partners; therapists must regulate their own fear or distress during this process (Furrow & Bradley, 2011). Formal EFT training includes 4-day externships, advanced weekend trainings, and individual or group supervision by EFT-certified supervisors (Therapist Training, 2007). Live sessions and audio and video tapes are also utilized (Furrow & Bradley, 2011).

EFT has an extensive and expanding empirical base (see Greenman & Johnson, 2013, and Wiebe & Johnson, 2016, for reviews of EFT research). Past outcome studies have shown EFT to be particularly effective for mild to moderately distressed couples (see Byrne, Carr, & Clark, 2004, for a review of outcome studies). Other than behavioral couple therapy (BCT, and its three other forms: traditional behavioral marital therapy, cognitive-BCT, and integrative-BCT), EFT is the only couple therapy method with efficacy documented via multiple RCTs (Gurman, 2011). Although the significant research base is certainly one of the strengths of EFT, “head-to-head” testing among couple therapies has been rare; research has not shown whether one couple therapy approach is better than another (Gurman & Snyder, 2011).

DIFFERENTIATION THEORY

Murray Bowen (1978) introduced the concept of differentiation to explain healthy functioning in individuals, couples, families, and societies. Differentiation is a developmental process by which individuals learn to balance the human drives for both deep connection and unique identity (Kerr & Bowen, 1988). When people become differentiated they are able to live by their own beliefs and values yet work in collaboration with others to reach mutual goals (Gilbert, 2006). *Fusion* is the opposite of differentiation, connoting a tendency to be reactive to others, and/or conform to pressures inherent in family relationships without working from an internalized set of core values (Kerr & Bowen, 1988). According to Bowen, the family system is the distinctive channel through which people attain a certain *level* of differentiation. Children were thought of as “inheriting” their parent's levels of differentiation, and then grow up to marry someone of a similar level of differentiation, passing on the heritage of functioning to the next generation. As Bowen recognized the power of this intergenerational transmission of emotional functioning, he was somewhat

pessimistic about the adult's capacity to significantly change their levels of differentiation throughout adulthood (Schnarch & Regas, 2012).

David Schnarch (1997) expanded Bowen's initial ideas about differentiation to adult romantic relationships and—whereas Bowen was pessimistic about changing differentiation in adulthood—described marriage³ as a catalyst for raising one's level of differentiation. The level of differentiation partners bring to marriage determines the degree to which their *sense of self* is dependent on their partners. In other words, partners high in fusion work from a *reflected sense of self* in which they depend on their partners for acceptance and validation (Schnarch, 2009). All individuals enter marriage dependent—to some degree—on a reflected sense of self, which in part explains why romantic attachments are so alluring: New relationships offer a *positive* reflected sense of self (Schnarch, 2009). However, high levels of fusion will increase the frequency and intensity of emotional gridlock (conflict around competing needs and desires).

Although developmental in nature, differentiation focuses mostly on adult maturation rather than infant and child development, which may partially explain why it has been overshadowed in research by attachment. Nevertheless, differentiation research is gaining momentum in studies investigating emotionally and sexually committed relationships. Cross-sectional research demonstrates significantly positive associations between differentiation and mental health (Schnarch & Regas, 2012), sexual communication (Timm & Keiley, 2011), sexual desire (Ferreira, Narciso, Novo, & Pereira, 2016), sexual satisfaction (Timm & Keiley, 2011), and relationship satisfaction and adjustment (Schnarch & Regas, 2012; Skowron, 2000).

Crucible Therapy

Crucible therapy⁴ (CT; Schnarch, 1991) brings together ideas of how emotional gridlock—although difficult for all people—can ultimately open a door for greater emotional maturity (i.e., differentiation) to blossom, leading to healthier couple and family interactions and more stable marriages. CT bridges the disparate foci of two fields—sex therapy and couple therapy—with differentiation emphasized as the key to resolving *both* sexual and emotional intimacy problems. The term *crucible* is used because of its connotation of a severe test or trial, conveying the idea that adversity can propel positive development (Schnarch, 1991). CT, therefore, considers most marital difficulties to be a sign that the marriage is working—marriage takes two people still in development and pushes them to grow. Couples who come to therapy may identify their marriage as not working and potentially as a sign they have some deficit, but Schnarch proposes that couples can only achieve long-lasting resolution around gridlock by becoming more differentiated. Rather than trying to bring anxiety down, as Bowen did, CT seeks to help people through anxiety tolerance (Schnarch & Regas, 2012). For example, rather than changing how partners communicate with each other, the crucible therapist helps partners *tolerate* the messages they are hearing, and disclose uncomfortable truths (Schnarch, 2011). This comes from a view that clients who focus on their deficits (e.g., lack of communication skills) do not draw upon already present relational capacities. Therefore, when crucible therapists try to construct a client's mind toward *resiliency* (Schnarch, 1991) they offer greater hope, realistic expectations, and a clear pathway toward unilateral self-development (Schnarch, 2011). The crucible therapist emphasizes that communication problems are best resolved through emotional development rather than skills training.

³Schnarch (1997) uses the term “marriage” for “any emotionally committed relationship.”

⁴We note here that a little more space is provided to describe crucible therapy, given the relative lack of treatment literature in comparison to what is available for those seeking to learn about EFT.

Crucible therapists use “collaborative confrontation” as a means to trigger unilateral self-development in therapy. The therapist helps each person see the dilemma they are in *with their own self*, in the context of the relationship. A couple’s presenting problems are reconstructed by the therapist as *personal* dilemmas. For example, in the typical higher–lower sexual desire dynamic, a therapist may ask “self-confrontation” questions that cause partners to consider how to deal with their limited selfhood that emerges in the conflict. This may look like the following:

Therapist: “The fact that your partner doesn’t want to have sex with you as much as you want to have with him puts you in a tough position in which you feel less desirable as a person. What will it take for you to feel good about yourself if your partner’s sexual desire doesn’t change?”

Clients are faced with their limitations as they emerge in session or captured in their story. The invitation to reclaim self is an invitation to have a more authentic and genuine relationship. When clients self-confront in the presence of one another, they experience each other differently and greater respect emerges, naturally changing their interaction patterns. This does not always have to occur mutually—one person’s change in differentiation often sparks the other’s change (Schnarch, 2011). In this example above, the higher desire partner may begin to advocate for sex in mutually respecting ways as well as loosen their tight grip on their partner for sex, allowing the partner to feel desire out of personal freedom rather than constraint.

Learning CT requires more than skills and clinical strategies, although these are important. The therapist must become differentiated themselves; clients will not reach a higher level of differentiation than the therapist (Siegel et al., 2013). The process demands therapists tolerate a certain level of anxiety, maintain an ability to confront dark truths, be committed to endurance, and be willing to see the best in people. These are not skills that can be easily taught. The self of the therapist must be developed in the process of treating clients and in the therapist’s personal life. No manual or basic training texts on crucible therapy have been published to date, making the model less accessible. There is also no certification process despite the offerings of trainings and webinars. Hence, a therapist may be interested in CT ideas, but applying or integrating it into one’s approach may be difficult. Furthermore, Schnarch offers a principle-based approach within which one cannot delineate specific steps or stages in contrast to EFT.

Unfortunately—similar to many models of couple therapy—there is no research to date supporting the effectiveness of CT (incidentally, there is some support for the couple enrichment weekends based on the same principles; Berg, 2000; Whelihan, 2000). The lack of research may cause therapists to question whether research has been done but simply not disseminated due to poor results, or whether the research has been postponed until Schnarch more fully develops CT through integrating neurobiology and mind mapping (Schnarch, 2018). Even if and when RCTs may be conducted evaluating CT, it appears unlikely that comparative studies between the two models will be done. Therefore, it will be difficult to compare EFT and CT on that level.

OTHER COUPLE THERAPY APPROACHES BASED ON ATTACHMENT OR DIFFERENTIATION

Before moving on to issues of convergence, divergence, and integration of the two theories and the specific models, we acknowledge there are other approaches to couple therapy based on the theories of attachment, differentiation, or both. An example of a non-EFT couple therapy model grounded in attachment theory is mentalization-based treatment for couples (MBT-CT; Nyberg & Hertzmann, 2014). MBT-CT is an emerging approach

based on the work of Bateman and Fonagy (2013), who initially developed mentalization-based treatment (MBT) for individual and group therapy for borderline personality disorder. Building mentalization—an ability central to attachment relationships which allows people to make sense of themselves and others regarding subjective mental states—is a primary goal of MBT.

Examples of differentiation-based approaches include Titelman's (2010) utilization of Bowen family systems theory in working with highly reactive couples, and Real's (2012) relational life therapy (RLT). Titelman primarily utilizes alternating individual sessions with each partner after initial conjoint sessions, promoting differentiation as a spouse's "own private project" because these couples often drop out of therapy due to the conflict in the room. RLT is based on the assumption that many coping strategies in relationships are "self-centered, unfeeling, and counterproductive" (p. 36). Note, RLT does not draw upon differentiation directly but, in our opinion, aligns with many of its principles. Real acknowledges that some might find RLT to be confrontational; he describes it instead as a direct and honest approach which balances emphasis on safety and challenge in therapy—an approach recognized being in contrast with the slow-paced empathy-focused style of EFT.

Two models have been developed that draw upon both attachment and differentiation with varying degrees of emphasis: Greenberg and Goldman's (2008) expanded emotion-focused therapy for couples (EFT-C) and Fishbane's (2011) relational empowerment model. These provide interesting examples of ways in which these constructs have been used side-by-side in therapy and will be discussed further in the integration section of this paper. Finally, although attachment and differentiation are not the only organizing constructs of couple relationships and therapy (e.g., social learning theory, psychodynamics, systems theory, social constructionism, etc.; Gurman, Lebow, & Snyder, 2015), our emphasis on these two models provides an ideal juxtaposition of the larger psychotherapy debates about how to deal with self- and coregulation; empathy and confrontation; and quick- and slow-paced movement.

ATTACHMENT AND DIFFERENTIATION: CONVERGENCE AND DIVERGENCE

Attachment and differentiation are both *developmental* theories in that they recognize the powerful role of an emotionally committed relationship in the process of adults growing into healthy and mature individuals. It even appears that the two associated models consider the ideal in human development to be the balance of connection and autonomy—although with some differences in what that actually looks like and how to attain it. The picture of a healthy adult has long been debated in the realm of psychology—predating Schnarch and Johnson—with opposing emphases on self-reliance (people need to stand on their own two feet) and emotional dependence (people need people; Kohut, 1971). Although there is a growing consensus toward synthesis (e.g., Guisinger & Blatt, 1994), it is hotly debated what that entails, to say nothing about cultural models that promote one ideal over another. Although CT and EFT would agree about the need for synthesis, they deviate in their focus on self- or coregulation, respectively, as the foundation of healthy *interdependence*.

The attachment perspective posits that secure attachment allows for greater harmony between the human needs for closeness and self-directed exploration. Adults can grow and develop as attachment needs are met; childhood wounds and traumas can be healed through the responsiveness and engagement of one's partner. In effect, stability lies in the healthy functioning of the couple (Johnson, 2004). Maintaining safe and secure interactions will regulate the self and help adults pursue meaningful goals both inside and outside of the relationship: *differentiation is a product of attachment security*. Partners must

learn to provide each other a safe haven and secure base, and as they do so, their interactions will reinforce safety and security, and their sense of self will become more stable. Thus, healthy *coregulation* is valued as the remedy to relationship problems and the prescription for adult development.

The differentiation perspective is, of course, different. The capacity for ongoing development similarly best takes place within a romantic relationship (Schnarch, 2009), yet the process of development does not first require safety and security, but rather, conflict (Schnarch & Regas, 2012). As adults grow and develop the self in the midst of conflict they can then connect with their partners in new, more authentic ways. Stability then lies in the healthy functioning of the individual (Schnarch, 2009). The lack of safety and security in the relationship is rather a picture of the limited development each person brings to the relationship. If both partners can take the present conflict as an opportunity to further develop themselves then they can enjoy the fruits of both healthier individual functioning and a peaceful and vibrant relationship. Differentiation is not a product of secure attachment; rather, *differentiation regulates the balance of attachment and autonomy* (Schnarch, 2009). Thus, healthy *self-regulation* promotes positive adult development and the cure to relationship problems.

CONVERGENCE AND DIVERGENCE OF EFT AND CT

The convergence of EFT and CT similarly occurs at a more metalevel. We describe what we deem to be three foundational principles inherent in both models: (i) the role of the therapist in establishing and maintaining a strong therapeutic alliance; (ii) a rich coconstructed case conceptualization; and (iii) the active directing of the therapeutic change process.

The Therapeutic Alliance

Both models privilege the importance of the alliance and its essential role in facilitating change. They encourage *some* similar alliance-forming behaviors—such as listening to and acknowledging each partner’s viewpoint with compassionate responding—but for different reasons. EFT and CT have starkly different views about the picture of an effective therapeutic alliance: EFT posits that therapists should provide a secure base and safe haven—a surrogate attachment figure—for the couple. When clients begin to trust their feelings will be heard and accepted by the therapist, they will be more likely to disclose deeper feelings, allowing the therapist to lead the couple to more soothing and connected interactions with one another. Thus, EFT encourages “relentless empathy” (Johnson, 2004) by the therapist toward each partner.

Although CT does not give the therapist the role of “attachment figure,” the therapeutic alliance is no less significant in this work. A *collaborative* alliance is about doing what needs to be done and not what would necessarily be soothing; it hinges on responsibility rather than emotion (Schnarch, 2009). Therefore, the CT therapist prudently shares with and invites clients to disclose difficult truths that are beneficial to learn even if they *feel* threatening. Clients deeply appreciate a therapist who is honest even if it is uncomfortable because they begin to see the therapist as someone who can really help. Through early collaborative confrontation, the therapist fosters quick-paced development and in turn offers hope for the relationship. In contrast, a collusive alliance allows people to avoid their responsibilities and difficult issues (Schnarch, 2009). A CT perspective would suggest that a therapist reframing selfishness as well-intended attempts to meet attachment needs creates a collusive alliance with the couple.

Coconstruction of the Case

The way we converse with our clients is a way in which we construct a reality with them about their situation. Social constructionists understand the role of shaping reality through language and dialogue in therapy (Lock & Strong, 2010). We concur that this process happens—not to deny a reality (e.g., it actually could be differentiation or attachment)—but to say that therapy is a process of *shaping* a reality with our clients. EFT and CT therapists *coconstruct* with their clients a view of their problems that directs and facilitates the therapy. Note, other models may take a more expert stance (e.g., CBT) wherein the therapist primarily constructs reality while others take a more nonexpert stance and invite clients to take the lead in constructing reality (e.g., SFBT). We contend that EFT and CT negotiate reality with clients in a way that helps them reshape their view of the problems through collaborative dialogue.

Both models help couples see their problems in the context of a systemic ecology of how love relationships work. Both increase the understanding of the two separate individuals within that system and how their behavior is related to their own internal processes. Neither spends significant time exploring family of origin but may bring that in to provide context or motivation for change in the present. Although the messages they send to clients converge on these metalevels, the messages are different. EFT focuses on the negative interactional cycle based on attachment needs (Johnson, 2004); CT focuses on the comfort and growth cycle based on levels of differentiation (Schnarch, 1997).

Emotionally focused therapists frame each partner's negative behaviors as rooted in attempts to meet attachment needs; these needs are reinforced by the couple's negative interaction cycle (Johnson, 2004). Crucible therapists, on the other hand, present clients as seeking out their own self-interest, even when it comes at the cost of hurting their partner—even sometimes intentionally inflicting emotional pain (“normal marital sadism”; Schnarch, 1997)—which comes from the limited personal growth of each partner.

The Directing of Therapeutic Change

Given the notable differences embedded in the therapeutic alliance and coconstruction aspects of therapy, it should come as no surprise that the directing of therapeutic change looks incredibly different. Fittingly, the *core processes* within each approach are captured in their names. In EFT, the process entails a deepened accessing and sharing of *primary emotion* to invite bonding and security in the relationship. Emotionally focused therapists also work *slowly* through the utilization of micro skills such as repetition, images, and a soft voice (“RISSSC”; Johnson, 2004). In CT, the process entails the construction of a *crucible* in which partners are encouraged to look deeply inside themselves and challenge themselves to change. Anxiety is sufficiently heightened and then tolerated to bring about these changes. Crucible therapists work *quickly* to promote change; Schnarch (2011) posits that a faster pace creates hope.

We believe that both models generally follow a similar trajectory in therapy that focuses on the stages articulated in EFT, even if the meaning of this process and the way of going about it are very different. EFT de-escalates conflict by helping each person access the attachment emotions beneath their position in the cycle (through reflection, probing questions, emotionally evocative responding, etc.), whereas CT does so by shifting the focus of each partner from couple conflict to self-conflict and their personal dilemmas. EFT restructures the relationship by facilitating clear expression and acceptance of attachment needs, creating more accessible, responsive, and engaging partners (Johnson, 2008) who are proficient at *coregulation*, whereas CT does so by facilitating self-confrontation and self-disclosure in the presence of one's partner, creating honest, mature, and authentic partners who are proficient at *self-regulation*. EFT consolidates gains by reinforcing new

narratives about the relationship and solidifying emotional bonding experiences; CT highlights increased emotional maturity and the positive consequences of the new growth, and facilitates ongoing “moments of meeting” (Schnarch, 2009).

IS INTEGRATION POSSIBLE? OR: THE EMOTIONALLY FOCUSED CRUCIBLE

The model developers of EFT and CT would both concur that their models cannot be integrated nor should therapists *attempt* to integrate the two models and—as has been seen from this review—they are indeed opposing in their perspectives and approach. Nevertheless, this has not stopped practicing therapists and other model developers from using and trying to bring together differentiation and attachment in a cohesive manner. Understandably, both Johnson and Schnarch seek to maintain the paradigmatic integrity of their approaches. Yet, the pragmatics of dealing with a multiplicity of complex cases and the limitations of funneling *all* clients through *one* conceptualization of the problem have led many therapists to integration.

This kind of debate is, of course, not new in psychotherapy and is in some ways similar to other debates in the field. For example, as knowledge of the roles of therapy and medication in treating human problems has grown over the last 50 years, we now know that *both* can be helpful—in some cases one is preferred over another while in other cases a combination is indicated. The trend toward integration, in this regard, has been positive. It could also be argued that disputations of the past resulted in a fragmentation of care (Preston, O’Neal, & Talaga, 2017). Of course, clinical knowledge has grown through debates, but if not handled well can lead to a fragmentation of care and spiteful division among therapists. We propose that therapists be well-informed of the competing differences inherent in the two approaches, and that we work toward finding and building upon common ground when there is some. Building bridges without watering down divergent positions *is* the true spirit of integration.

To be clear, the intent of this paper is not to promote one framework over another (note, each of us—Hardy and Fisher—have different clinical leanings toward differentiation and attachment), or 50–50 integration as the answer (only the future can tell what the most critical factors for change in couple therapy will be). Nevertheless, we do believe it is crucial for therapists to be savvy consumers of what is being promoted by attachment and differentiation and the models that have been developed to promote them. Such therapists can prudently incorporate ideas and strategies that make the most sense for their cases.

It bears underscoring that the fundamental complicating factor in attempting to integrate attachment and differentiation lies in their divergent emphases on self- and coregulation and how these emphases produce different therapeutic positions and change processes. Nevertheless, the two models reviewed here do not *completely* rule out empathy or self-confrontation—CT acknowledges that clients will not engage in collaborative confrontation with a therapist whom they do not trust has their best interest in mind, and EFT recognizes the need to help people maintain their own emotional balance while making attempts to connect with their partners. The main difference seems to lie in the *degree and type of emphasis* placed on these two fundamental constructs throughout the process of therapy. Therefore, a differentiation-based therapist need not completely rule out safety and security and an attachment-based therapist need not completely rule out self-confrontation and responsibility. In our opinion, both safety and anxiety; comfort and discomfort; empathy and confrontation; etc., are important ingredients in relationships and in the change process. The compelling question for the integrative therapist—and the field at large—is what the appropriate balancing, sequencing, and pacing of these constructs and strategies should look like in therapy, particularly with diverse client populations.

While it is beyond the scope and purpose of this paper to propose an ideal model for integration, our vision would be for greater collaborative attempts that creatively articulate an interplay between attachment and differentiation processes in therapy. Some models have already begun integrating both traditions together in unique ways. Greenberg and Goldman's (2008) emotion-focused therapy for couples (EFT-C) has preserved some of the attachment focus while adding identity and attraction to form three core foundations. EFT-C also places emphasis on self-soothing in addition to coregulation. In this model, self-regulation is promoted near the ~~EFT~~^{end of treatment}, except in cases where difficulties establishing secure attachment processes arise—then it is introduced sooner. The logic here is that people *have* to self-regulate if they cannot establish successful coregulation, and if coregulation processes deteriorate after therapy, people need good self-regulatory capacities to see those difficult moments through. Fishbane (2011) integrates the cultivation of self-regulation and having a voice (“Power To”) with a commitment to nurturing the relationship together using empathy and respect (“Power With”).

Both of these models offer unique examples that integrate attachment and differentiation and we hope to see more examples emerge in future years. In particular, it would be interesting to see self-regulation placed at the beginning of treatment as a precursor to developing healthy coregulation behaviors. This might alleviate the concerns of staunch differentiation-based beliefs (Schnarch, 2009) that emotional bonding attempts at the beginning of treatment reinforce borrowed functioning and anxiety-driven empathy (as opposed to value-driven responsive empathy that accrues through self-regulation). Ultimately, we believe most therapists find one way or another to incorporate both constructs, yet more permutations and more sophisticated articulations of them would better meet the needs of integrative therapists around the world.

We also highlight that although these ideas are central issues in our field, one of the dangers of identifying primarily with one, both, or some mixture of these constructs as the primary driver of one's therapy is the possible neglect of other extremely important experiences related to couple functioning. Pinsof et al. (2018) outlined seven metaframeworks that make up a “web of human experience” that could be considered when applying attachment and/or differentiation: organization, development, culture, mind, gender, biology, and spirituality. For instance, guiding a couple through differentiation to increase positive sexual encounters may be constrained by cultural or biological barriers.

In addition, we offer the following suggestions when/if attempting to integrate attachment and differentiation, whether drawing from each in your own framework, primarily working from one and drawing from the other, or considering specific utilization of EFT or CT:

- (1) Be wary of jumping from a focus on attachment and coregulation to a focus on differentiation and self-validation within the same case (or worse, in the same session!). By sending mixed messages, you might only confuse or frustrate your clients, or get lost in your own session planning.
- (2) If you believe you *need* to switch gears with your clients or offer a new conceptualization of the case, inform your clients about what you are doing and why. Also consider if you are “jumping ship” because of good clinical decision making, or because you simply need more practice, feedback, and supervision in the approach or model you have chosen.
- (3) Consider your case in context. What are the goals of the couple? Do they need to work on self-confrontation and taking individual responsibility? Do they believe in attachment theory as adult love and want to improve their emotional engagement with each other? Would a focus on sexual desire discrepancy, for example, be useful from the beginning (CT) or might sexual issues better be resolved near the ~~EFT~~^{end of treatment} after

sufficient emotional security has been established? Clearly each model is strong in certain points and each may have merits that can be considered in the context of the case. Consider when collaborative confrontation might make sense and when clients might simply need someone who can empathize with them and honor their defenses. When might they need to feel safe in the presence of a loved one, and when might they need to take responsibility for their own changes? When might clients need to experience emotion and when might they need to confront themselves? These are difficult questions, but asking them opens therapists to more possibilities than what is constricted by each model.

- (4) Regarding coconstruction with a specific case, consider what you and your couple believe regarding attachment and differentiation: Is differentiation a product of secure attachment (EFT), does differentiation regulate and promote security (CT), or is each process an influence on the other (integration)?
- (5) As for the specific models of EFT and CT, do not deceive yourself in thinking they are simply using different language to describe the same things. We posit they are clearly *not*: Each model has different goals, very different views of optimal and emotionally developed couple relationships, and may lead couples to function in ways quite different from the other.
- (6) If you decide to work primarily from one model and borrow a clinical strategy from the other (assimilative integration), consider whether you can or cannot actually fit it into the conceptualization—attachment or differentiation—you are working under with your clients.
- (7) If you work from an integrative model that blends approaches, consider how you will maintain sufficient paradigmatic integrity. For example, you can deepen experiencing of primary emotions so partners can give their best self to the relationship; or, you can help each partner take responsibility for not having offered emotional safety to the other. Also, remember that no model or theory accounts for all human behavior (Sexton, 2017).
- (8) Regardless of the chosen model—whether EFT, CT, or an integration of the two (or some other model entirely)—you must *do it well*. Model proponents stress fidelity; keep in mind that model fidelity is not just “sticking to it” but also “doing it well” (Sexton, 2017). Consider choosing what moves you the most; Gurman (2011) argued that the fit between you and your primary approach is crucial for effective couple therapy. Having a choice of models may be critical (Feltham, 2013) but “the best you can” must go beyond training or certifications and into deliberate practice (e.g., spending time improving skills throughout your career; Chow et al., 2015) and effective use of measurement feedback systems.

CONCLUSION

There has been a clear and ongoing movement in the field toward integration and there are many valuable aspects of the movement, but it has the potential to water down the paradigms guiding certain approaches if we are not careful in how we pool clinical strategies together. This review provides an assessment of attachment and differentiation in the practice of couple therapy, utilizing the two competing models—the attachment-based emotionally focused therapy and the differentiation-based crucible therapy—to explicitly explore their similarities and differences as applied in the consulting room. A close inspection of the two theories via these specific approaches reveals significant differences between them that, on face value, may convey integrative impossibility. Nevertheless, it *is* possible that specific strategies have relevance for some cases or circumstances and not others. The benefit of comparing these models provides therapists the ability to

conscientiously choose between them and their strategies in their work. It offers therapists a way to understand the differences and particular merits of each model. And, hopefully, it begins to help put to rest the disputations of the past that when absorbed by the field lead to fragmented care. We encourage a more sophisticated and respectful process that honors model differences as well as therapists' desires and attempts at finding the most appropriate approach for each individual case regardless of model orientation.

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