Overview of emotion-focused therapy

Chapter · January 2018

DOI: 10.4324/9781315161105

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A Trauma-Informed Approach

Edited by Mirisse Foroughe

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Emotion Focused Family Therapy with Children and Caregivers

This book introduces Emotion Focused Family Therapy (EFFT) as an evidence-based intervention for children through the integration of parent trauma and emotion-focused techniques to facilitate family-based change. A team of expert authors, including founders of EFT and EFFT, contribute to the chapters, in which recent findings from clinical trials are woven into a rich and deeply presented overview of using EFFT practically with clients. This immensely practical book also provides illustrative case studies, intervention strategies or dos and don'ts, and clinical worksheets.

Mirisse Foroughe, PhD, is a clinical psychologist and director of psychological services at Kindercare Psychology, heading the Primary Care Psychology Research Lab. She holds an adjunct faculty position with York University in Toronto and is the primary developer of the EFFT Research Program. Dr. Foroughe has received the Ontario Psychological Association Early Career Psychologist Award and the Canadian Psychological Association's 2017 PFC Innovative Service Award.


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Emotion Focused Family Therapy with Children and Caregivers

A Trauma-Informed Approach

Edited by Mirisse Foroughe

Routledge
Taylor & Francis Group
NEW YORK AND LONDON

First published 2018
by Routledge
711 Third Avenue, New York, NY 10017

and by Routledge
2 Park Square, Milton Park, Abingdon, Oxon, OX14 4RN

Routledge is an imprint of the Taylor & Francis Group, an informa business

Library of Congress Cataloging-in-Publication Data
Names: Foroughe, Mirisse, editor.
Title: Emotion focused family therapy with children and caregivers : a trauma-informed approach / edited by Mirisse Foroughe.
Description: New York, NY : Routledge, 2018. | Includes bibliographical references.
Identifiers: LCCN 2017047105 | ISBN 9781138063358 (hardcover : alk. paper) | ISBN 9781138063365 (pbk. : alk. paper) | ISBN 9781315161105 (e-book)
Subjects: | MESH: Family Therapy | Emotion-Focused Therapy | Psychological Trauma—therapy | Child | Caregivers | Adolescent
Classification: LCC RC455.4.F3 | NLM WM 430.5.F2 | DDC 616.89/156—dc23
LC record available at https://lccn.loc.gov/2017047105

ISBN: 978-1-138-06335-8 (hbk)
ISBN: 978-1-138-06336-5 (pbk)
ISBN: 978-1-315-16110-5 (ebk)

Typeset in Bembo
by Apex CoVantage, LLC

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Foreword: A Caregiver-Based Intervention

"It is easier to build strong children than it is to repair broken men."
—Frederick Douglass

As a beginning therapist, this quote was my mantra. I did not set out to work with adult trauma. I decided to work with kids because they were easier to treat, closer to the root, more amenable to change, and less defended. At least, this is what I thought—and I still believe that the latter three assumptions are true, but the first most certainly is not. Kids are not easier to *treat*, if treating really means supporting someone's transformation from a distressed state to a healthy one. Truly transforming a child's state of mental health necessarily involves—or should involve—the most important people in their lives: parents. And parents are adults, often with long histories of important suffering. So, despite my best efforts, I didn't get away from working with adults at all—I was one step removed, but there they were: in the waiting room, on the answering machine, behind worried emails, wondering how long treatment was going to take, letting me know the "real deal"—all the important (and usually more negative) details that the child left out of our discussions. They were, at the very least, an important source of feedback, and an important part of their child's life. They were also the most important part of the child's larger "system."

After many years of individually based mental health services, in the mid-20th century, family systems theory suggested an alternative to individual therapy, and many child therapists realized that we needed to work with all parts of the system—including the adults in the child's life. Family systems changed things, but for most of us working in children's mental health, the child was still the "identified patient." Indeed, even if we felt that the parents were, in fact, the psychologically distressed ones in the family—sometimes seeing their child through an impaired and distorted lens that mirrored back an image of a child that was intolerable, unparentable, defiant, out-of-control, or otherwise *wrong* in some way—what could we do? We either said nothing about it, and just tried to help the child cope, or we tried to convince parents of how they *should* see, understand, and relate to their child—largely to no avail.

You couldn't start telling parents that *they* were the problem. Well, you *could*, but there would likely be a huge fallout in terms of your rapport with them. Some therapists actually did confront parents in this way, and sometimes they never saw their patient again, and maybe the parent would find another therapist. In my early training, I worked in large school boards, mental health agencies, renowned teaching hospitals, all with many highly gifted and experienced supervising clinicians. Still, not even my supervisors had a way to talk to parents about the things they were doing—or not doing—that were interfering with their child's recovery. We all wanted to be respectful of families and wait for them to come around to understanding things. Humanistic and client-centred approaches told us that people are the experts on their own experience, and the emphasis on following the client in session made it difficult to introduce any bold reflections or controversial insights that would run counter to how parents saw themselves, or wanted to see themselves. So we said nothing to parents even when (especially when) we saw that how they were responding was getting in the way of the child's healing, or somehow contributing to the maintenance of the child's problems.

Sometimes, as a child therapist, one can come to ally very strongly with the child and blame a parent for not seeing what the child needs. In times such as these, there were covert looks of sympathy from the therapist towards the child, nonverbal themes of "you're really okay, sweetie, it's just your parents—hang in there a few more years and you can get out." All of our true clinical impressions would conveniently go right over the parent's head, because they were so busy blaming the child and pointing out all their flaws, unable to see their role in the manufacturing of a diagnosis that was sometimes mere comfort for the adult with a child they simply couldn't manage. And of course, we were so busy blaming parents that we were unable to see how our attitude towards them, both the lack of corrective coaching and the lack of expressed empathy, was creating further divide between parent and child.

Of course, the children wouldn't stay "okay" for long in this environment. The more the message of "something is wrong with you" was mirrored back to the child, through the parent's strong reactions to typical, although sometimes overly sensitive, child behaviour, the more the child came to believe that it was true—something *is* wrong with me. *I am defiant. I am sick. I have problems. I am driving my parents crazy. I am crazy*. Until the child eventually became a shadow of their true potential, usually desperately needing their parent's approval, while defiantly hanging on to the notion that they were *not* crazy and their parents were the ones with the problem, and other times submitting whole-heartedly to the notion that they were sick, troubled, and broken.

Working with these children, I felt helpless and disappointed in myself many times, realizing that I was just a part of this process designed to assuage parents of their distress and shift the blame to a child. In individual sessions

with the child, I would try desperately to rebuild their self-esteem, give them a sense of "okayness," and at least one relationship in which they were seen as worthy, healthy, and able to heal. I could sense their confusion, craving the positive image of themselves that they could see in my eyes, but needing to cling to the other image—the one of the troubled child—because regardless of how strong our therapeutic alliance had grown to be, it was not what they truly needed in order to feel whole. I was never going to replace their mother or father or primary caregiver. The trouble was, *I was working on the wrong relationship. The relationship that they needed to feel healthy in was the one with their primary attachment figure(s).* The place they needed to feel whole in was their own home. And the person that they needed on their treatment team was their parent. I could only be the facilitator of this.

Around this time, I had been working on an infant and preschool treatment team at a renowned children's mental health agency in Toronto. Under the supervision of experts in infant mental health, I trained in an approach to dyadic, parent-child play therapy, known as "Watch, Wait, and Wonder" (WWW). In this approach, I was finally the instrument of healing within an existing parent-child relationship, instead of a party in the creation of a secondary relationship that could never quite come close in significance to the original relationship between the child and their primary caregiver. When a child in WWW approached me to show or tell me something, I directed her to the mother or father. The relationship that mattered was theirs—and my relationship with the *parent* was, in dyadic therapy, even more important than the one I would form with the child. Everything in WWW subtly encouraged the parent to take on the role of the healer, the one in tune with the child's needs, the one reflecting on how to meet those needs, and the one deciding which strategies to try, when, and for how long—and knowing when they had found the way that was most healing to that child. I was a witness to a remarkable thing: a parent coming into their own, realizing that they could take full ownership of the relationship between parent and child, and feeling empowered to make all the difference in their child's forming identity, overcoming of obstacles, and mental health. The parent's *belief in their ability to meet their child's needs* was the critical factor, and it was my job to believe it for them until they believed it themselves. My belief in the parent would help restore the parent's own confidence, help repair the parent-child relationship, and protect the child's mental health.

Watch, Wait, and Wonder was the first approach I had learned that envisioned parents as the agent of change and healing for a child. However, the approach also took a long time, often a year of dyadic therapy, and it relied on the parents figuring things out for themselves. Some parents seemed to have beliefs about the child and about themselves that were so firmly entrenched, watching and waiting just didn't work. In those cases, there was no clear way to move past what was getting in the way for parents—if they couldn't see the solution was within their reach, I had to wait for them to see

it, and sometimes that came at a high cost to the parent-child relationship and to the child's mental health.

As well, the dyadic, play-based approach of empowering the parent to heal their child ended abruptly at age 6. For 7-year-olds and up, we usually offered individual therapy. There was the option of family therapy, but it wasn't with the same approach: the "client" in the family therapy was the family, and we needed all family members to be willing participants in the therapy process, which was aimed at addressing communication and dynamics within a family. If a 15-year-old presented for therapy, and didn't "want" their parent(s) involved, well, who were we to trample on their right to privacy and their ability to consent to solitary treatment? They were already 15. We could work on preparing them for the transition to adulthood . . . the transition away from the hope that they could ever get what they needed emotionally from their parents. We could teach them to accept their parent's limitations, to learn to cope with life, show them they would be okay on their own. At least they had us, the therapists, for as long as the therapy lasted. And then they would have themselves, their friends, and the rest of the world. It was the best we could do, but was it best for the child?

Throughout the individual therapy process for a child, parents would typically be ever grateful that their child had "a safe place to talk," clearly feeling that they could not offer that safe place, and they were not capable of taking on their child's needs. This is the reason they needed our professional help. We were the experts. Somehow their child had lost their way (and of course every parent actually blamed themselves for that, although only a few talked about it openly), and we were going to take the child's needs out of their uncertain hands, into our capable ones, and do a better job than they could. This was the implicit message, made explicit in some models of care as a "parentectomy."

Other parents would remain sceptical of the work we were doing (which was a mystery to them, as they were excluded from it almost entirely), with some parents even doubting the utility of therapy, and convinced that we were "fuzzy, cuddly therapists taking the child's side" and not seeing what the child was really like. Sometimes, these parents would stop bringing the child mid-therapy or would have a hard time managing the initial and middle phases of therapy, when emotional distress often increases, and would end up seeking out medication for the child without allowing therapy a chance to work.

And if things did go fairly well, and we formed a strong therapeutic alliance with their child, the parent tolerated us because their child had a place to vent, so the family could function as it had been functioning and *the parent would not have to deal with the child's inability to deal*. We gave them tools, now they could deal. It was good enough. We didn't quite "fix" their child as they had hoped we would, but we bandaged them up good enough to get by, do better in school, argue less at home, and seem to be in a better mood. These were important indicators of good functioning, so there you go. Here's your

kid back, a little better than when you gave them to us. And the parent's sense of competence? Had that changed? Did they feel any of the empowerment that the parents in dyadic play therapy had felt? Not at all—how could they? The agent of change was the clinician-child therapeutic relationship: we had some secret way of connecting with their child that they could never have. And it *was* all a secret: the child had a right to privacy after all. We all colluded in this massive parentectomy. The parent gave the child to an expert healer and was, at best, appreciative that someone could reach this child, because they most certainly couldn't be the ones to do it. Right? Wrong.

There was no other condition for which this model failed more miserably than for eating disorders. And, as it turned out, there was perhaps no other condition for which a parental sense of competence was more critical than for eating disorders. With a child at the doorstep of death, refusing the very medicine she desperately needed, it was not the knowledge and technique of the expert but the power of the parent armed with this knowledge and technique that would ultimately, the evidence clearly showed, heal the child and give her a chance at life again.

When parents were engaged in family-based treatment (FBT) using the Maudsley FBT approach, the recovery rates for children would increase from the mid-30s to the mid-80s—without relapse—changing the course of a condition that had previously come to be known as a "chronic, relapsing disorder." Coach parents to become the nurses, we were surprised to discover, and the child would heal and stay healed long after leaving the hospital. This realization changed my career, and changed the very topic of my doctoral dissertation two years after I had set out to show why it was that people with restricting eating disorders could not be healed. To know that treatment success could be increased so drastically just by helping the parents take the driver's seat—it was a new paradigm. Yet it made so much sense.

But why stop at eating disorders? Clinicians were now offering family-based treatment to people with EDs, but kids with anxiety or depression or social difficulties were still being treated as solo projects, identified patients, black sheep, the "problem child" that needed to be extracted, fixed, and then sent back to function within the family. Even the most well-intentioned "family-based" approaches, such as family therapy for a child's anxiety disorder, retained the idea of the therapist as expert on healing the child rather than empowering parents to see the healing as their role to own.

But what's wrong with that? Why not get the parents on board by teaching and instructing and leave it at that? *Because it does not include the child's primary caregivers as agents of change and healing, and does not offer parents any real support in becoming a primary agent*. Without the complete shift from blaming parents, ignoring parents, or instructing parents to empowering parents, there can be no real transformation, no increase in the parent's own sense of parenting efficacy. In times of need, the child learns to wait to speak with the therapist until therapy ends, and then learns to hide in plain sight, turn to coping mechanisms, and try to need less from their parents.

With the messaging that their parents cannot meet their emotional needs, the core of the child's pain remains. And the child learns to cope with that pain for a few months, or maybe even a few years if the strategies that we teach them helped them become quite adept at containing their intense, negative emotions. Nonetheless, eventually, inevitably, the emotions rise up and drown them, or catch them off guard, and boom—sometimes at last arriving at the eating disorder diagnosis.

It was as if the earlier cries were just not loud enough to be heard, and it was going to take the ultimate psychiatric diagnosis: the disorder with the highest mortality rate, so gripping that the child loses their ability to cope on their own or to sustain life on their own. The founders of EFFT heard these helpless cries, both the child's helplessness and the parent's, and found a brilliant way to acknowledge and process the parent's painful emotions in the service of healing the child's eating disorder. EFFT provided parents with the confidence they needed in order to heal their own child . . . in the process often embarking on a journey of healing for themselves and the whole family as well.

For other kids, it would be self-harm, suicidal behaviour, or addiction that would sound the battle cry. For some others still, nothing seemed to be enough, and the family's ability to avoid facing the child's emotions was so powerful, so entrenched, and so seemingly necessary for their own sense of "okayness" that the child would self-destruct before their eyes, while the family held on to the notion that they could do nothing to save them. At those times, I felt so angry, so disappointed in the families—*I thought of them as families who had failed their child*.

But wait. Had the family failed? And if they had failed, on who's watch? What was my role in all of this? It took years to see that it was I—the therapist—who had failed. It was *my* role to believe in the family's ability to heal itself and its members until the family believed it too. If I didn't do that, could I rightly blame the family for not believing in themselves?

As a fourth year Honour's student, I had conducted research on the power of expectancy effects: the tendency for someone to live up or down to what is expected of them. But these powerful effects are not limited in influence to children. Adults can be transformed by the expectations of others as well. If I don't tell a parent what they could do to help their child, am I not assuming that they are incapable of doing it? Unreachable. Unhelpable. What kind of helping professional believes that a huge segment of the population—parents of children with mental health challenges—can't be helped along? Do parents not look to us as professionals to guide them in the process of change and healing for their child? Why do we clinicians hold back from explicitly telling parents—just as clinicians tell parents of children with eating disorders, with the utmost compassion and absence of finger-pointing—that *parents are the most powerful agent of change*? It isn't about what *caused* the child's problems, but about "*how are we going to get the child to be rid of this problem?*" How can we obliterate what is standing in their way? And

how do we empower parents to take responsibility in their child's recovery *not because they are to blame, but because they are irreplaceable?* The answer to these and all similar questions is: Bring in the parents!

The Parent's Role in Healing Their Child

In this approach, we believe that parents are the solution to the problems gripping their child, regardless of the cause. The process of helping their child through it will only strengthen their bond, as the child comes to see that their parent can catch them, hold them, and propel them back out into the world stronger and more prepared. If a child falls off their bike when you are first teaching them to ride, would you stand back and allow someone else to help them up because someone told you that there is a guy there in the park that is an expert at helping up wounded kids? No! You would run and grab your child and lift them up and tend to their wounds, and just when you knew they were almost ready, you would encourage them back onto the bike, tuning out the rest of the world and taking a chance but letting them know that you believe they can do it! You wouldn't let anyone take your place as that child begins to ride the bike again, just as when she was a baby and took her first steps. You want to be there and be part of it. Years later, your child might even say, "Thanks for always being there for me." Or they might not. The point is, they sense that they have you to turn to and count on, and this counts for a lot in the world of attachment security.

Healing a child's emotional wounds is always within a parent's scope of ability. They are the things that children are *supposed* to look to a parent for. Emotional wounds are best healed by those closest to you, with whom you have the strongest attachment. *A therapist will never be as powerful as a parent with the same skill set*. Once parents realize that they have the skills, there is no comparison between them and a secondary relationship with someone completely insignificant in the child's actual life, history, and neurobiology. It may sting a bit, particularly for those of us having derived our sense of identity from being the "savers of the lost child." But now we can be the "healers of the lost relationship," setting in motion the most protective, the most natural, and the most enduring bond: *the bond between parent and child*. It will also be a gift, this facilitating of the healing process within a primary relationship, to the children and families with whom we have the honour to work. We will be the conduit. And that uneasy feeling of taking an already lost child even further away from their own parents will be gone forever.

So how to do this? A good start is to explicitly convey to the parents that they are important—*critical, necessary, powerful*—in their child's recovery. And then to coach them in the *how* of becoming involved in the recovery process, which almost always involves finding out their weak spots and strengthening them so that they can present their strongest, most capable, confident, and

competent self to the child. In this work, another simple yet powerful idea can be a guide:

> "The best way out is always through."
> —Robert Frost

If we want to help parents out, we have to help them through. Through their insecurities, through their self-blame, and through their own pain. Parents are in pain, too. They have current pain from their child's difficulties, and older pain from their own childhoods. Often, that old pain can get in the way of dealing with the child's current needs. They need our support to get through that pain, to work through whatever the blocks might be—and this can seem like a huge task to us, the child therapists who (for whatever reason—but maybe important to think about) decided only to work with the "easier to treat" children . . . because children are so honest, so open, so wanting to heal. But what do children need most? What do they need to feel in times of distress? Of course, it's to know *that they could turn to their parents in times of need*. This is the core of attachment theory: the baby cries until the loving parent soothes the cries. This is the most powerful healing that a human can experience: to see one's own parents as the image of strength and love so that the child feels so supported that there is no doubt they can make it. Even if the child feels unbearably weak, the parent can catch them if they fall. The parent will not break. The parent will not run. The parent will not cower. In the face of the seemingly powerful "illness," "disorder," "addiction," or "problem," the parent will be an even stronger power, and the force of their love, persistence, and sheer will to save the child will be exactly the medicine that the child needs in order to heal. Now let us get out there and invite those parents in from the waiting room.

Mirisse Foroughe

1 Overview of Emotion-Focused Therapy

Genevieve Vrana and Leslie Greenberg

An Evidence-Based Treatment

Emotion-Focused Therapy (EFT) is recognized as an evidence-based treatment for depression and marital distress (Elliott, Greenberg, & Lietaer, 2004; Johnson, Greenberg, & Schlindler, 1999). It has also demonstrated positive outcomes for trauma (Paivio & Nieuwenhuis, 2001; Paivio & Pascual-Leone, 2010), eating disorders (Robinson, Dolhanty, & Greenberg, 2015; Robinson, Dolhanty, Stillar, Henderson, & Mayman, 2014; Wnuk, Greenberg, & Dolhanty, 2015), anxiety disorders (MacLeod, Elliott, & Rodgers, 2012; Shahar, Bar-Kalifa, & Alon, 2017; Watson & Greenberg, 2017), and interpersonal problems (Greenberg & Malcolm, 2002; Greenberg, Warwar, & Malcolm, 2008; Paivio & Greenberg, 1995). A manualized form of EFT for depression was found to be highly effective in treating depression in three separate clinical trials (Goldman, Greenberg, & Angus, 2006; Greenberg & Watson, 1998, 2006; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003). In these trials, EFT was as or more effective than a client-centred (CC) empathic treatment or a cognitive behavioural treatment (CBT). Both CBT and CC were highly successful in reducing depression; however, EFT was more effective in reducing interpersonal problems than either of the two other treatments, along with promoting more improvement in symptoms, compared to the CC treatment. Further, EFT was highly successful in preventing relapse over an 18-month follow-up period (77% non-relapse; Ellison, Greenberg, Goldman, & Angus, 2009).

EFT has generated a lot of research on the process of change—possibly more than any other treatment approach. Several therapy process variables have been found to contribute significantly to therapeutic outcome in EFT, namely: therapist empathy, therapeutic alliance, client depth of experiencing, emotional arousal, making sense of aroused emotion, productive emotional processing, and particular emotion sequences (e.g., Boritz, Angus, Monette, Hollis-Walker, & Warwar, 2011; Choi, Pos, & Magnusson, 2016; Elliott et al., 2004; Goldman, Greenberg, & Pos, 2005; Greenberg, Auszra, & Herrmann, 2007; Malin & Pos, 2015; Missirlian, Toukmanian, Warwar, & Greenberg,

2005; Pascual-Leone & Greenberg, 2007; Pos, Greenberg, Goldman, & Korman, 2003; Tarba, 2015; Wong & Pos, 2014).

Theoretical Underpinnings

EFT is a humanistic-integrative approach that emphasizes the importance of human emotion in psychological functioning and therapeutic change. With early roots in humanistic, Gestalt, and existential therapies (Frankl, 1959; May, 1977; Perls, Hefferline, & Goodman, 1951; Rogers, 1957; Yalom, 1980), as well as family systems theory (Bowen, 1966; Pascual-Leone, 1987), EFT later drew on advances in cognitive neuroscience and emotion research (Damasio, 1999; Frijda, 1986; Izard, 2002; Tamietto & de Gelder, 2010). In this context, EFT theory and practice were developed through several years of research into the process of therapeutic change (Greenberg, 1986, 2002; Greenberg & Johnson, 1988; Greenberg, Rice, & Elliott, 1993; Greenberg & Safran, 1987; Rice & Greenberg, 1984).

Although EFT uses an integrative framework, there is a sustained focus on a person's emotions. An emphasis on experiential engagement and felt emotions is seen as the primary vehicle of change. In EFT, a person needs to experience their painful feelings in order to change them; in other words, they have to arrive at a place before leaving it (Greenberg, 2012).

Research has shown that emotional experiences are fundamentally adaptive to human functioning. Emotions can and often do occur earlier and more quickly than cognitions, and they make an integral contribution to information processing (LeDoux, 1996; Greenberg, 2011; Forgas, 1995, 2000; Greenberg, 2002; Greenberg & Safran, 1987). Moreover, people rely on emotion as a foundation for many cognitive processes, particularly for making decisions (Bechera, Damasio, Tranel, & Damasio, 1997; Damasio, 1994).

Emotions are connected to our most essential needs, rapidly alerting us to situations that are important to our well-being and ensuring that we are prepared for action (Damasio, 2003; Frijda, 1986; Greenberg, 2004; Izard, 2002; Tomkins, 1962). For example, fear can quickly alert us to danger, making sudden escape possible; anger can signal that our boundaries have been violated, promoting an assertive response; sadness or grief can indicate a loss, encouraging us to seek comfort and support from others. More "positive" emotions, such as joy and contentment, tell us that we are safe, that threats to our survival are absent, and that we can let our guard down.

People form associations between lived experiences and the emotions evoked at the time, creating emotional memories. In other words, people react from their emotion systems, not only to biologically inherited cues of danger and safety, but also to learned associations, such as a parent's impatient voice or the tune of a soothing lullaby (Greenberg, 2011). In EFT, these emotional memories form a part of organizing networks referred to as *emotion schemes* (Oatley, 1992; Greenberg et al., 1993; Greenberg & Paivio, 1997).

Emotion schemes involve several elements: 1) *situational-perceptual* experiences, including immediate appraisals of current situations and emotionally charged memories, such as noticing that you are alone or isolated from others and remembering an experience of abandonment from childhood; 2) *bodily sensations and expressions*, such as tightness in the chest or a sinking feeling in the stomach; 3) *implicit verbal-symbolic* representations, including self-labels (e.g., "unlovable"); and 4) *motivation-behavioural* elements, including needs and action tendencies like wanting closeness with others or withdrawing from contact (Elliott & Greenberg, 2017). Exposure to any of the above elements of an emotion scheme can quickly and automatically re-activate the entire scheme. For example, a present-day situation that bears resemblance to an earlier experience of rejection can serve as a cue to re-activate old, familiar feelings of sadness and hopelessness. This means that people can re-experience an emotional memory many times long after the original event. These kinds of emotional experiences are the main targets of intervention in EFT.

Distinguishing Between Different Kinds of Emotions

While EFT acknowledges that emotions are adaptive to human survival and well-being, emotional processes can become problematic as a result of past trauma or even ongoing misattunement between a person's emotional needs and what is available in their environment (McGuinty et al., 2015). Consequently, emotion-focused therapists use a system of in-session process diagnosis to differentiate between types of emotional responses and intervene accordingly (Greenberg & Paivio, 1997; Greenberg & Watson, 2006; Elliott et al., 2004). In this system of sorting out the client's emotions, an important distinction is made between primary and secondary emotions. *Primary emotions* are a person's most fundamental, direct initial reactions to a situation, such as being sad at a loss or angry at a boundary violation. *Secondary emotions*, on the other hand, are responses to a person's own thoughts or feelings rather than to the situation. For example, feeling angry in response to feeling hurt by someone, or feeling guilty about feeling angry.

EFT's emotion diagnostic system also distinguishes between primary states that are adaptive and those that are maladaptive (Greenberg & Goldman, 2007; Greenberg & Watson, 2006). *Primary adaptive* emotion responses are a person's first, natural reactions to the current situation that would help them take appropriate action (Greenberg, 2010). For example, if a person is being violated by someone, anger is an adaptive response, because it helps them take assertive action to end the violation. Another example of an adaptive emotional response is sadness over a loss, which motivates the person to seek connection. In contrast, *primary maladaptive* emotions are less reliable guides for action. They are the old, familiar feelings that occur repeatedly and do not change over time, such as a core sense of loneliness and anxious insecurity or a feeling of worthlessness and inadequacy that plagues a person

throughout their life (Greenberg, 2010). These maladaptive feelings do not shift in response to changes in circumstance and they also do not provide adaptive directions for solving problems when they are experienced.

For therapeutic change to occur, primary adaptive emotions need to be accessed for their adaptive information and ability to organize helpful action, whereas maladaptive emotions need to be accessed, regulated, and transformed into more adaptive emotional responses (Greenberg, 2010, 2011). As well, secondary emotions need to be bypassed so that the primary emotions underlying them can be accessed and used in the healing process (Elliott et al., 2004).

A third category of emotions is *instrumental emotions*. These are strategic displays of emotion for their intended effect on others, such as feigning sadness to receive the comfort of others (Elliott & Greenberg, 2017; Greenberg & Watson, 2006). Common examples include "crocodile tears" (instrumental sadness), "crying wolf" (instrumental fear), and displays of intimidation (instrumental anger). Instrumental emotions may be expressed deliberately out of habit or automatically without full awareness. Therapists need to gently and empathically help clients become aware of the effects of and intentions behind expressing these emotions, so that clients may find more direct ways of expressing themselves and stating their needs (Elliott et al., 2004; Greenberg, 2011).

Principles of Emotional Change

EFT therapists are guided by five principles of emotional change described below: *awareness, expression, regulation, reflection,* and *transformation* (Greenberg, 2011).

1) ***Awareness***: Increasing awareness of emotions and their various components is the most fundamental goal of treatment in EFT (Elliott & Greenberg, 2017). Lieberman and colleagues (2007) note that naming a feeling in words helps reduce arousal in the emotion centre of the brain, also known as the amygdala—in other words, you have to "name it to tame it." Emotional awareness involves accepting emotions rather than avoiding them; it also involves consciously experiencing them in the moment rather than simply thinking or talking about them (Elliott & Greenberg, 2017). Becoming aware of and symbolizing core emotional experience into words provides access to both the adaptive information and the action tendency of the emotion, thereby enabling the pursuit of relevant goals.
2) ***Expression***: Emotional expression is a unique aspect of emotional processing that predicts adjustment to a range of issues, such as interpersonal emotional injuries, trauma (Foa & Jaycox, 1999; Greenberg & Malcolm, 2002), and even unforeseen illnesses like breast cancer (Stanton et al., 2000). Expressing emotion in therapy does not involve the mere venting

of secondary emotions. Instead, the focus is on overcoming the avoidance of strongly experienced emotions and expressing previously inhibited primary responses (Greenberg & Safran, 1987; Greenberg, 2002). Greenberg, Auszra, and Herrmann (2007) found that the manner in which aroused emotions were expressed in EFT distinguished good from poor outcomes. They defined productive emotional expression as occurring when a client processes the emotion in a "contactful" way—that is, without either being stuck or being a passive victim of the emotion.

3) ***Regulation***: Awareness and expression principles are useful when emotion is absent or overregulated; however, when emotional arousal is too high, emotions can no longer help with adaptive action (Pascual-Leone & Greenberg, 2007). Intense emotions that need down-regulation tend to be secondary emotions, such as panic or despair, or primary maladaptive emotions, such core shame or anxious insecurity (Elliott & Greenberg, 2017). EFT uses a range of methods for helping clients regulate these emotions. Soothing can be provided instinctually by clients themselves or from the therapist in the form of a safe and calming presence, empathic attunement, acceptance, and validation. Therapists promote clients' abilities to be compassionate to their painful emotional experiences. Emotion regulation processes may further involve identifying and avoiding triggers, identifying and labelling emotions, allowing and tolerating emotions, using physiological soothing techniques like abdominal breathing, distraction, increasing positive emotions, or enhancing resilience in the face of painful emotions (Elliott & Greenberg, 2017).
4) ***Reflection***: Over and above symbolizing emotions into words, reflection on aroused emotion helps clients make sense of their experience and encourages its incorporation into their self-narratives (Angus & Greenberg, 2011; Goldman & Greenberg, 2015). In this process, the client's feelings, needs, thoughts, and goals are clarified and organized into coherent stories, and different parts of the self and their relationships are identified (Greenberg, 2010). The result of this reflection is deep, practical self-knowledge. Situations can be understood in novel ways and experiences can be reframed, leading to new views of self, others, and the world.
5) ***Transformation***: In EFT, the most important mechanism for changing old, familiar, painful emotions is that of transforming them into another emotion, or *changing emotion with emotion* (Greenberg, 2010). Maladaptive emotions are not removed, nor are they merely lessened by the person feeling them; instead, other emotions are used to transform or undo them.

Research has demonstrated that meaningful positive experiences can undo the neurochemistry and physiology of negative experiences. Frederickson

(2001) found that positive emotions have the potential to loosen the hold of negative emotions on a person's mind by broadening the person's momentary thought-action repertoire. For instance, the experience of joy was shown to produce faster cardiovascular recovery from negative emotions than a more neutral experience. Additionally, resilient individuals have been found to cope with negative emotions by drawing on positive ones to undo them (Frederickson, Mancuso, Branigan, & Tugade, 2000).

Building on the notion that positive emotions can change negative ones, EFT theory proposes that maladaptive emotions can be transformed by dialectically opposing, adaptive emotions (Greenberg, 2002). For instance, changes in previously avoided painful emotions, such as core fear of abandonment, can be brought about by the activation of incompatible, adaptive experiences, such as empowering anger, sadness of grief, or self-compassion, which undo the old responses (Greenberg, 2010). Similarly, maladaptive shame can be transformed by accessing anger, sadness of grief, self-compassion, pride, and self-worth (Greenberg, 2010). Moreover, hopelessness and helplessness can be transformed by adaptive anger. Once the alternate emotions have been accessed, these new emotional resources begin to undo the programming that previously determined the person's mode of processing. New emotional states enable the person to challenge their perceptions of self and others that are connected to maladaptive emotions (Greenberg, 2011).

Also contributing to emotional transformation is the interpersonal context in which therapy takes place (Greenberg, 2011). Lived interactions between client and therapist provide corrective emotional experiences (Alexander & French, 1946). For example, a client's feeling of maladaptive shame can be changed when, instead of the expected disgust or rejection, the client experiences acceptance and soothing from the therapist. Introducing new experiences into currently activated memories of past events has been found to lead to memory reconsolidation, as the new material becomes incorporated into past memories (Nadel & Bohbot, 2001). This in turn facilitates the experience of new adult understanding and promotes more adaptive socio-emotional responses.

Three Phases of Therapy

Emotion-Focused Therapy can be broken down into *three major phases* (Greenberg, 2002, 2011; Greenberg & Watson, 2006). The first phase of *bonding and awareness* is followed by the middle phase of *evoking and exploring*, before the final phase of *emotional transformation*. The focus of the first phase is to establish a positive therapeutic bond between client and therapist while increasing the client's emotional awareness. The therapist communicates the Rogerian core conditions of empathy, congruence, and unconditional positive regard (Rogers, 1957). In addition, the therapist is fully present and highly attuned to the client's moment-by-moment emotional experience (Greenberg, 2011). The therapist's reflections of the client's experience

encourage an inward focus on the client's lived emotions, including physical sensations and feeling states. A rationale for working with emotions is established.

In the second phase of evoking and exploring, the therapist facilitates the experiencing and exploration of underlying painful emotions (Greenberg, 2011). The process of arriving at an emotional response can be best enabled experientially, such as by having the client enact the part of the self that evokes the emotional response. Blocks to emotional experiencing are also identified and worked through.

Once the client's core maladaptive emotion schemes are activated, a window of opportunity is created for the transformation that characterizes the third and final stage of EFT (McGuinty et al., 2015). With the lived emotional experience now "open," the client can generate an alternative adaptive emotional response (e.g., self-soothing, empowered anger, sadness of grief, etc.), which can be used as a self-healing resource (Greenberg, 2011). The therapist's role is to validate the client's new feelings and corresponding needs. As this new emotional experience is strengthened over time, a natural action tendency associated with the emotion becomes activated (e.g., assertive limit-setting, or self-care and self-compassion) and eventually becomes incorporated into the client's narrative (Greenberg & Angus, 2004; Frederickson, Mancuso, Branigan, & Tugade, 2000; Tugade & Fredrickson, 2004, 2007).

Markers and Interventions

A defining feature of EFT is that interventions are *marker guided and process directive*. Certain in-session client states are viewed as *markers* of underlying affective-cognitive processing problems. These markers inform the therapist's choice of intervention, or *task*, along with the client's readiness to work on a given problem (Greenberg, 2010; Greenberg et al., 1993). Models of the key components involved in resolving these problems have been developed and empirically validated (e.g., see Elliott et al., 2004; Greenberg, 2010; Greenberg et al., 1993; Rice & Greenberg, 1984). Six main markers and their accompanying interventions are described below.

1. *Problematic Reaction Point*

Marker: A marker for a problematic reaction is observed when the client expresses puzzlement about their emotional or behavioural response to a situation. For example, a client might say, "On the way home from work last night, I felt so down and depressed. I'm not sure why I was feeling that way."

Task: Problematic reactions are addressed through *systematic evocative unfolding* (Rice & Saperia, 1984). In a slow and deliberate manner, the therapist helps the client bring problematic scenes alive in the session

with the use of concrete, colourful, and expressive language (Elliott et al., 2004). The therapist uses evocative reflections and questions to bring the scene alive and heighten the client's emotional response (Watson & Rennie, 1994). The goal is to arrive at the implicit meaning of the situation that makes sense of the reaction (Greenberg et al., 1993). Resolution involves the client gaining awareness of their personal style or characteristic way of responding to certain stimuli (Watson & Greenberg, 1996).

2. *Unclear Felt Sense*

Marker: An unclear felt sense refers to the client being on the surface of a particular experience and unable to put the experience into words. The client also communicates distress or disturbance due to the experience (Greenberg et al., 1993). For instance, the client reports, "Something about this doesn't feel right, but I don't know what it is. It's really been bugging me."

Task: An unclear felt sense calls for *focusing* (Gendlin, 1981, 1996; Cornell, 1996; Leijssen, 1998), in which the therapist guides the client to approach the embodied aspects of their experience (e.g., internal physical sensations, images) with curiosity. Through a series of exploratory questions from the therapist, the client is eventually able to accurately describe the experience, which can lead to a "feeling shift" (Elliott et al., 2004). The feeling shift informs the creation of new meaning, which is carried forward as the client begins to explore wider connections and related issues, sometimes preparing to take new action (Elliott et al., 2004).

3. *Conflict or Self-Critical Split*

Marker: In conflict splits, there is usually one aspect of the self that is critical of or coercive toward another aspect (Elliott et al., 2004). There may be verbal statements of shame, such as "I feel like a failure," or self-criticism, such as "I should be further along in my career by now." There may also be a verbal statement from the client indicating that there are two aspects of the self that are in opposition, with accompanying verbal and non-verbal indicators of struggle and coercion. For instance, a client might say, "Part of me wants to leave my marriage, but another part feels like that's a bad idea."

Task: Two-chair dialogue is beneficial for resolving conflicts between two parts of the self, or when one part of the self dominates over another part that is disowned or disclaimed (Elliott et al., 2004; Greenberg, 1979; Greenberg & Dompiere, 1981; Greenberg & Rice, 1981; Greenberg & Webster, 1982). The two-chair task is set up by having two chairs facing each other, so as to distinguish between the two parts

in opposition (Elliott et al., 2004). The parts are enacted by the client and put into live contact by dialoguing with each other. Thoughts, feelings, and needs within each part are explored and communicated (Greenberg, 2010). Resolution of the conflict split involves a softening of the critical voice, which sometimes consists of negotiation between the two parts (Elliott et al., 2004). Rather than conflict or coercion, there is integration between the two sides, along with self-acceptance.

4. ***Self-Interruptive Split***

Marker: A self-interruptive split occurs when a client constricts the experience of a feeling or need and expresses distress as a result of the constriction, such as feeling squeezed, blocked, or stopped (Elliott et al., 2004; Greenberg, 2010). For example, when coached by the therapist to express anger toward their inner critic, the client states, "I can't. I feel so small and squished down, like I have no voice." Self-interruption usually serves the function of protecting the self from potential negative consequences of experiencing or expressing an emotion. Possible feared consequences may include: becoming overwhelmed by the emotion (e.g., "If I get angry I might lose control."); being unable to survive the emotion (e.g., "I feel like the pain is a black hole that will suck me in and I'll never be able to climb back out."); having one's self-image threatened (e.g., "Real men don't cry."); or being abandoned, rejected, or victimized by another (e.g., "I don't want to give him the satisfaction of knowing he's won.").

Task: Similar to conflict splits, self-interruption is addressed through *two-chair dialogue* (Greenberg, 2010). Each part of the self is enacted, and their respective thoughts, feelings, and needs are communicated through the dialogue. The self-interruption is resolved when the client is able to fully express, accept, and integrate the previously blocked experience.

5. ***Unfinished Business***

Marker: With unfinished business, the client makes a statement that shows lingering unresolved feelings toward a significant other in a highly involved manner (Greenberg et al., 1993). They may blame, complain, or express hurt or longing in relation to the significant other. For example, a person might state that "I never forgave my father for what he did to me." Although the unresolved feelings are currently being experienced, there are signs that the expression of these feelings is currently being interrupted or restricted (Elliott et al., 2004). For instance, the client is unable to express anger or resentment toward the other and instead expresses resignation and hopelessness, which are secondary reactive emotions.

Task: The intervention for unfinished business is *empty-chair dialogue*. Instead of dialoguing with a critical or interruptive part of the self, the client dialogues with the imagined significant other in the second chair. Experiential contact with the second chair helps the client activate their internalized view of the other and corresponding emotional experience. It is important to note that the therapist's role is not to facilitate a rational debate between two people; rather, the client needs to be helped to arrive at and express their unresolved primary emotions and unmet needs to the other. Resolution occurs when the client feels worthwhile and is able to let go of the previously unfinished business (Elliott et al., 2004). This can be accomplished through one or more of the following ways: 1) holding the other accountable for the violation experienced, 2) increased understanding of the other or viewing the other as flawed, or 3) genuinely forgiving the other for the past violations.

6. *Vulnerability*

Marker: Vulnerability is a state in which the client feels intensely fragile, ashamed, or insecure and is reluctant to expose a vulnerable part of themselves to the therapist (Greenberg, 2010; Sharbanee, Goldman, & Greenberg, in press). Vulnerable refers to being open to being wounded or hurt. An example of a vulnerability marker is the client stating in a fragile-sounding voice, "I feel like I'm finished. I can't carry on," or "I feel so separate from the human race."

Task: The intervention for vulnerability is affirming empathic validation (Elliott et al., 2004; Greenberg et al., 1993; Sharbanee et al., in press). In this task, the therapist helps the client gradually deepen their contact with the vulnerable aspect of their experience in a highly attuned and empathic manner. The therapist's responses reflect the client's experience and mirror how the client describes their experience (e.g., the client's vocal quality). The therapist's responses serve the function of soothing the pain and communicating that the client's pain is seen and valid. With this support from the therapist, the client's intrinsic tendencies toward growth and hope are eventually accessed and the client is left with a stronger self-organization and a decreased feeling of isolation.

With the advancement of research in EFT, a number of additional markers and interventions have been added to the original six, some of which are: trauma and narrative retelling, alliance repair at ruptures, self-compassion at markers of self-contempt, self-soothing at anxious dependence, and meaning making at markers of emotional high distress (Elliott et al., 2004; Greenberg, 2010, 2011; Greenberg & Watson, 2006).

EFT in Practice: A Case Example

Lidia,[1] a single mother, participated in an Emotion Focused Family Therapy parenting group in order to learn strategies to help with parenting her 17-year-old daughter, Deidre. Their relationship was strained and marked by frequent conflicts that resulted in yelling by both parties, followed by Deidre storming off to her room and refusing to speak to her mother for several days at a time. Lidia feared that some of Deidre's friends were a bad influence on her and felt the need to protect her by restricting her social activities and by encouraging her to focus on her schoolwork and extra-curriculars. Deidre often accused her mother of not understanding her, being over-controlling, and being unfair. This hurt Lidia, as she loved Deidre and only wanted what was best for her daughter. However, no matter how hard Lidia tried to protect her daughter, Deidre became increasingly rebellious, sometimes sneaking out of the house and returning home drunk in the middle of the night.

Over the course of the parenting group, Lidia became aware of how her own emotional responses to her daughter's behaviour contributed to issues in their relationship dynamic. In particular, she noticed how her fear of Deidre throwing away her future made her more stern and quick to lose her temper. In light of this realization, she also began participating in individual Emotion-Focused Therapy. Once Lidia developed a trusting relationship with her therapist, they began to empathically explore her fear of failure as a parent.

Lidia's therapist identified a marker of a critical split between the part of her that is critical of her performance as a mother and the adaptive part of her, commonly referred to as the "experiencing self," or the "experiencer." This prompted the therapist to initiate two-chair work, which started with Lidia enacting her inner critic in the second chair, as in the dialogue below.

Therapist: From what you're saying, it sounds like there's a part of you that is very hard on yourself as a parent.

Lidia: I guess that's true.

Therapist: (in a gentle tone) Could we try something that I think could be helpful here?

Lidia: Okay.

Therapist: (pointing to another chair in the room) Try sitting in this chair over here.

[Therapist places a chair directly across from the Lidia. Lidia moves to the second chair, or "critic chair."]

Therapist: I wonder if, in this chair, you can be the part of yourself that criticizes your parenting. Can you speak from that voice inside you and criticize Lidia as a parent?

Lidia: (as critic speaking to experiencer) Okay . . . Um . . . You've let the ball drop. How could you let her behaviour get to this point? She is out of control and you need to get a better grip on her.

Therapist: What should she do to get a better grip?

Lidia: (as critic to experiencer) You should come down hard on Deidre when she disobeys and remind her that you're the boss while she lives under your roof. You can't let her get away with things and do whatever she wants. You know what's best for her. Protect her from her friends who are a bad influence and don't let her go out with them. Keep her from going out on weekends so she can study instead. She can't lose her focus on her future. You know what's best for her—don't let her make her own decisions. Be stricter. Be firmer.

Therapist: Uhuh . . . She should be stricter and firmer. What could happen if she's not?

Lidia: (as critic to experiencer) Deidre will fail at school and she won't receive the grades she needs to get a scholarship for medical school. She could end up in a terrible job, living pay cheque to pay cheque like I do. She'll keep drinking late at night and eventually turn to drugs. She won't do well in life and nobody will respect her. You will have failed her.

Therapist: You're worried Deidre could fail at life if Lidia loses her grip and that means she will have failed her as a mother. (pointing at experiencing chair) What would happen to Lidia then?

Lidia: (as critic to experiencer) You would feel like hell. You'd know it was your fault for being a bad mother. It would mean you're a loser. She's already headed down that road. You're not doing well as a mother right now. You're already failing. (pause) You're a failure.

In the dialogue above, Lidia was able to experience herself as an agent of her own self-criticism. During this task, the critic revealed herself to be a worrier who feared the worst and warned Lidia to be vigilant and maintain tighter control over her daughter, so as to protect herself from imagined catastrophes and other negative outcomes (for more information on working with anxious processes in EFT, refer to Watson & Greenberg, 2017). Since this anxious process was conceptualized as a secondary reaction, the therapist guided Lidia to focus on her most feared outcome (failure) and, in turn, deepen her self-criticism. Subsequently, Lidia was invited to respond to her harsh and domineering critic from the experiencing chair.

Therapist: Now come switch chairs and be the other part.
[Lidia changes chairs.]

Therapist: What happens inside when she [the critic] says that you're not doing well as a mother?

Lidia: (as experiencer) (crying) I feel awful. I keep trying to do my best but it's not good enough. I feel like a failure.

Therapist: (in empathic tone) Uhuh . . . You're left feeling so ashamed. What does that do to you to hear this voice always whispering over your shoulder, telling you that you aren't doing good enough?
Lidia: (as experiencer) It's exhausting, demoralizing. It undermines my confidence as a mother. I feel crippled.
Therapist: (in empathic tone) Right, the pressure is crippling. It's too much.

By having Lidia respond to her critic as the experiencer, she was able to articulate the emotional impact of the criticism. Her underlying primary maladaptive emotion of shame (feeling like a failure) was expressed. All the while, the therapist used empathy to deepen Lidia's experience of her shame and to convey a supportive presence. Subsequently, the therapist facilitated the identification of Lidia's needs associated with her primary emotion of shame:

Therapist: It really weighs down on you. What do you need from this part then? (points to critic chair)
Lidia: (as experiencer) I need her to understand how hard I'm trying.
Therapist: Yes, you need her to understand how hard you're trying. Tell her. (points to critic chair)
Lidia: (as experiencer to critic) I need you to acknowledge my efforts. To encourage me, instead of putting me down.
Therapist: Yes, you need her to be less critical and more supportive.
Lidia: (as experiencer) I almost just want to tell her to get lost (laughing and gesturing with her hands as though she is pushing the critic away).
Therapist: (in an encouraging tone) Yes, tell her to back off!
Lidia: (as experiencer to critic) Back off.
Therapist: Again.
Lidia: (as experiencer to critic) (in a more assertive tone) Back off!

In expressing her need for support and acceptance to her critic, Lidia's anger, a dialectically opposing adaptive emotion, began to emerge. The therapist was attuned to the way she expressed this emotion and recognized her laughter as a sign of discomfort with anger. The therapist responded by reinforcing and amplifying Lidia's subdominant adaptive anger, which served to set healthier boundaries with her critic. Afterwards, the therapist had Lidia return to the critic chair to respond to the experiencer:

Therapist: Now come switch back again.
[Lidia changes chairs.]
Therapist: What happens for you when you hear Lidia saying that?
Lidia: (as critic to experiencer) I see how hard this is for you and I'm sorry that I'm not more supportive a lot of the time. But I feel like I can't trust that you will be a good mother without me. If

you relax then bad things will happen. (points finger at experiencing chair) I am doing this for your own good.

Therapist: Whose voice is that? Who has played that role in your life?

Lidia: (as critic) That's definitely my mom.

It is not uncommon for a client's critic to reflect an internalized message from a significant other, such as a parent. Once Lidia identified her critic as the voice of her mother, the therapist recognized this as a marker of unfinished business. Since the unfinished business was at the root of her critical split, intervening in this domain had the potential to lead to change at the deepest level. Accordingly, the therapist initiated empty-chair dialogue between Lidia and her mother. To start, the therapist instructed Lidia to enact her mother's critical messages, so as to evoke her presence:

Therapist: Can you be that part of your mom? How does your mom say that to you?

Lidia: (as mother to experiencer) You have to be the best. Nobody will respect you if you're second best. Work harder than everyone else. Don't let them beat you. There's no time to stop and relax. Keep working while everyone else is resting.

Therapist: Right, that's the message. That you can't stop, can't let your guard down. Keep working harder. Be the best. What would happen if she doesn't listen to you?

Lidia: (as mother to experiencer) You'll amount to nothing. You will be a failure and I will be a failure as your mother. We don't have losers in this family, only winners.

Therapist: Right, don't be a loser. That's the message.

Lidia: (as mother to experiencer) You're not where you wanted to be by now in your career. Your wife left you. You've made poor choices. I'm very disappointed in you. And now with your daughter, you're setting her up for going down the same path.

After Lidia enacted her critical mother, the therapist invited her to switch chairs so that she could respond to her mother from the experiencing chair:

Therapist: Come sit over here now.
[Lidia changes chairs.]

Therapist: What is it like to hear your mother say those things?

Lidia: (as experiencer) It hurts (sobbing).

Therapist: Uhuh, it hurts.

Lidia: (as experiencer) I can never be good enough for you.

Therapist: She leaves you feeling not good enough.

Lidia: (as experiencer) And also so afraid. Always so full of anxiety.

Therapist: Yeah, really afraid of . . .

Lidia: (as experiencer) Afraid of being a loser . . . It's awful.

Therapist: (in empathic tone) Yes, it's awful.
Lidia: (as experiencer to mother) (crying) Yeah, I try my best, but it's like that doesn't matter. You don't see that. You just run through everything I do with a fine-toothed comb. Always pointing out where I come up short.
Therapist: You're left feeling like you're not enough.
Lidia: (as experiencer to mother) (crying) It's awful. Just awful.
Therapist: (in empathic tone) Uhuh . . . Tell her about the most awful part about this.
Lidia: (as experiencer to mother) I feel like garbage. I feel like dirt and I'm always afraid of messing up. (in an angry tone) I'm always afraid of disappointing you.
Therapist: Tell her, 'It's unfair of you to put so much pressure on me.' Does that fit? Tell her.
Lidia: (as experiencer) Yes, it *is* unfair. It's not what a mom is supposed to do.
Therapist: Tell her what you resent.
Lidia: (as experiencer) I resent you being on my back all the time.
Therapist: What do you need instead?
Lidia: (as experiencer) I need you to encourage and support me, rather than squish me down. I need you to help in a way that's actually helpful. I need you to be the one who believes in me when I'm having a hard time believing in myself. That's what moms are supposed to do. I need you by my side, not against me.
Therapist: Yes, you really need that support and acceptance from your mom.
Lidia: (as experiencer to mother) (in a more assertive tone) I need your support . . . (pauses and starts crying again) now, but also when I was just a little girl trying to do well in school and make you proud. I remember so much pressure from you my whole life.
Therapist: (in empathic tone) So much pressure. It was so hard on you even as a little girl.
Lidia: (as experiencer) (sobbing) It was so hard . . .

In the dialogue above, the therapist encouraged Lidia to express primary maladaptive shame in response to her mother's criticism. The therapist also tried to draw out Lidia's primary adaptive empowered anger, a dialectically opposing and subdominant emotion, as well as her unmet need for support and approval from her mother. Once Lidia could own these unmet needs and hold her mother accountable for not meeting them, she experienced sadness and grieved the mother she needed. In a later segment, Lidia responded to her expression of unmet needs as her mother:

Lidia: (as mother to experiencer) I didn't mean to be hard on you or make you anxious. I just wanted to protect you from bad things happening. I wanted what I thought was best for you. My own

parents raised me to live in fear of failing and I guess that's just the only way I knew how to be as a mom. I was scared and I put that on you when I didn't know what else to do.

Therapist: What do you need her to know?

Lidia: (as mother to experiencer) That I'm sorry (crying). I didn't mean to hurt you. I love you. You have so many good things going for you and I never really think to say them out loud and let you know. It's hard for me to say out loud that I'm proud of you.

Therapist: What are some of those good things you're proud of her for?

Lidia: (as mother to experiencer) I'm proud of you for the way that you are strong, determined, bright, and smart. And you're probably also a better mom to Deidre than I was to you.

Through the above enactment of her mother, Lidia experienced a shift in view of her mother as less powerful and as having problems of her own. More specifically, the experiential task helped her gain new insight that her mother's criticism was rooted in her own anxiety and self-criticism, and early experiences with her own parents. The enactment also enabled her to experience her mother meeting her unmet needs for approval and support. Even though this interaction did not actually occur between Lidia and her mother in real life, the experiential enactment led to a new lived experience that would become incorporated into Lidia's emotional memories or emotion schemes. In a later session, Lidia was eventually able to forgive her mother and let go:

Lidia: (as experiencer) I know why my mom did what she did and I still love her.

Therapist: Tell her about that.

Lidia: (as experiencer to mother) Mom, I forgive you. I know why you did what you did. I love you . . . But I'm not going to wait for your approval anymore, or live in fear of not having it, because I can't keep living this way.

In working through her unfinished business with her mother, Lidia developed a better understanding of what underlay her own worry and self-criticism as a mother to Deidre, which in turn impacted her parenting. She recognized that her maladaptive shame and secondary anxiety were feelings that became reactivated in interactions with her daughter, and that they were not helpful in guiding her present-day decision-making. These insights were integrated into a revised narrative, one in which she was worthwhile and adequate as a mother. A new, more adaptive state of pride and self-compassion emerged, which was supported by her therapist, as seen here:

Lidia: I'm doing my very best, trying so hard. Parenting is not easy. But I show up every day and give it my all. I really love my daughter so much.

Therapist: (in encouraging tone) Yes, you love her so much. She is so lucky to have you as a mother.

Lidia: If she doesn't get into medical school, that doesn't make her or me a failure.

Therapist: Yes, exactly.

Lidia: I imagine that just the way that I needed my mom to tell me she was proud of me and to encourage me, Deidre needs the same things from me. (tearful) Maybe she's going through the same thing I did with my mom.

Therapist: What's happening inside right now?

Lidia: Well, that makes me really sad thinking that she could be feeling the same way.

Therapist: It's sad for you to think that she could be feeling the same way because you care about her so much. What do you think she needs from you?

Lidia: I think I need to ease off if I want to help her and have a better relationship with her. I think that's going to be hard for me, because easing off makes me anxious. I don't want to go too far the other way and let her get herself into trouble. But maybe I could try having more of a balance of the two extremes.

Therapist: It sounds like you know inside what she needs and you want to give that to her.

Lidia: Yeah, I do. I can do this. I just have to remember to reassure myself when I get anxious and that feeling comes up again.

Therapist: Yes, exactly. That voice [critic/mother] is trying to help you, but instead it leaves you so scared and acting on fear. This voice that you are speaking from right now, this is what you know inside to be true.

Lidia: I'm going to listen to my own voice from now on. I can do this. Deidre and I are going to be okay.

Practical Strategies: What to Do

- Develop a positive therapeutic relationship, applying Rogerian conditions of empathy, positive regard, and congruence.
- Establish a rationale for working with emotions.
- Promote the client's awareness of and a welcoming stance toward their emotional experience. Help them put their emotions into words.
- Listen to the client's narrative and stay attuned to the client's moment-by-moment emotional processing.
- Assess whether the client's emotional responses are healthy versus unhealthy. Determine which emotions need to be more fully expressed and which need to be transformed.
- Balance empathy with process-direction. Facilitate experiential interventions to address markers of problematic processing.

- Follow the client's pain compass to arrive at their core underlying painful emotions.
- Validate the client's feelings and needs.
- Support the experiencing of new adaptive emotions and associated action tendencies.
- Help incorporate new emotional information into the client's narrative.

Note

1 Names and other identifying information have been changed.

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