Best-selling author with over 1 million books sold worldwide

A Primer for Emotionally Focused Individual Therapy (EFIT)

Cultivating Fitness and Growth in Every Client

Susan M. Johnson and T. Leanne Campbell

ROUTLEDGE

"When the age-old internal battle between reason and emotion rages endlessly as it does in our patients seeking therapy, with emotion often winning, it only makes sense that the focus of therapy should be on emotion. Now two internationally acclaimed experts in the treatment of emotional dysfunction and its attachment theory underpinnings, Drs. Sue Johnson and Leanne Campbell, show how the successful emotionally focused approach that works so well with couples, has now been adapted to working with individuals. Every clinician will want to have this well-written and entertaining primer on Emotionally Focused Individual Therapy on their bookshelf."

David H. Barlow, Ph.D., ABPP, *Professor of Psychology and Psychiatry Emeritus; Founder, Center for Anxiety and Related Disorders at Boston University*

"Sue Johnson and Leanne Campbell have written a wonderful primer for Emotionally Focused Individual Therapy (EFIT). This book is everything one looks for in a primer; it is concise and well written, providing the clear conceptual base for this therapy as well as pragmatic directions about what to do in session. The methods described build on Sue's landmark widely disseminated evidence-based therapy for couples, bringing the insights from that work to individual therapy. Johnson and Campbell's methods are a model of how to work with attachment and emotion in individual therapy. It is almost certain that EFIT will soon occupy a central place in individual therapy, just as EFCT has become the most widely practiced couple therapy. This is certainly a book that should be read by every individual therapist and therapist in training."

Jay Lebow, Ph.D., *Senior Scholar and Clinical Professor; Editor, Family Process, The Family Institute at Northwestern and Northwestern University, Evanston, IL*

"… the new EFIT book, which I think is very good and quite important: This wonderful, inspiring book shares over 35 years of clinical experience in applying Emotionally Focused Therapy (EFT) to instill life-altering positive change in individual clients. The authors do a beautiful

job describing what Emotionally Focused Individual Therapy (EFIT) is, how and why it works, and what makes it such an effective new form of therapy. This is required reading for therapists as well as those interested in improving the mental and emotional well-being of others."

Jeffry Simpson, Ph.D., *Distinguished University Teaching Professor; Chair, Department of Psychology, University of Minnesota*

"In this sequel to Sue Johnson's seminal book on EFT, the authors convey, both an academic and a visceral sense about the theory and practice of this innovative emotionally focused approach to the healing of deep developmental wounds. In their dynamic approach, therapists are lead, at each-step, how to safely open their clients to their emotional wounds, and to increase their capacity for self-reflection and authentic relationships. Without any doubt, this is a most important resource for *all* therapists wishing to do depth work with their clients."

Peter A. Levine, Ph.D., *author of* In an Unspoken Voice, and Trauma and Memory, Brain and Body in the Search for the Living Past

"The emotional and clinical wisdom shown in the therapeutic dialogues will lift up and empower any therapist with an experiential bent. We have a lot to learn how best to use the science of attachment in psychotherapy, but you could not do better than to start here."

Steven C. Hayes, Ph.D., *Foundation Professor of Psychology, University of Nevada, Reno; Originator of Acceptance and Commitment Therapy*

A Primer for Emotionally Focused Individual Therapy (EFIT)

This essential text from the leading authority on Emotionally Focused Therapy, Susan M. Johnson, and colleague, T. Leanne Campbell, apply the key interventions of EFT to work with individuals, providing an overview and clinical guide to treating clients with depression, anxiety, and traumatic stress.

Designed for therapists at all levels of expertise, Johnson and Campbell focus on introducing clinicians to EFIT interventions, techniques, and change processes in a highly accessible and practical format. The book begins by summarizing attachment theory and science – the theoretical basis of this model – together with the experiential approach to change in psychotherapy. Chapters describe the three stages of EFIT, macro-interventions, such as the EFIT Tango, and various micro-interventions through clinical exercises, case studies, and transcripts to demonstrate this model in practice with individuals, highlighting the unique benefits of EFT as a cross-modality approach for treating emotional disorders. With exercises interwoven throughout the text, this book is built to accompany in-person and online training, helping the practicing clinician offer targeted and empirically tested interventions that not only alleviate symptoms of distress but expand the client's emotional balance, agency, and sense of self.

As the next major extension of the EFT approach, this book will appeal to therapists already working with couples and families as well as those just beginning their professional journey. Psychotherapists, psychologists, counselors, social workers, and mental health workers will also find this book invaluable.

Susan M. Johnson, Ed.D., is the leading developer of Emotionally Focused Therapy (EFT) for individuals, couples, and families. She is Professor Emeritus of Clinical Psychology at the University of Ottawa, Distinguished Research Professor at Alliant University, San Diego, and Director of the International Center for Excellence in EFT (www.iceeft.com). She has received many awards for her seminal work in couple therapy and attachment and is the proud recipient of the Order of Canada. Her book *Hold Me Tight* has sold more than one million copies world wide.

T. Leanne Campbell, Ph.D., is co-director of the Vancouver Island Centre for EFT and Campbell & Fairweather Psychology Group (a multi-site psychology practice) and is an Honorary Research Associate of Vancouver Island University. Initially trained by Dr. Susan M. Johnson, she has been working in the EFT model across modalities for the past three decades. She trains professionals around the globe and is a co-developer of various educational materials and programs.

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To my clients who constantly inspire and teach me, and to my colleagues who are my loving fellow-travelers in the search to find the secret of healing and growth in those caught in the web of human vulnerability and despair.

– Susan M. Johnson

To my clients and colleagues who continually inspire me to learn and grow, and to my family who have provided me the safe haven to do so.

– T. Leanne Campbell

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ABOUT THE AUTHORS

Susan M. Johnson

Dr. Sue Johnson is a leading innovator in the fields of couple therapy and adult attachment. She is the primary developer of Emotionally Focused Couples and Family Therapy (EFT), which has demonstrated its effectiveness in over 30 years of peer-reviewed clinical research. Sue's received numerous awards acknowledging her development of EFT, including the APA's "Family Psychologist of the Year" in 2016 and the Order of Canada in 2017.

Her best-selling book *Hold Me Tight* (2008) has taught countless couples how to enhance and repair their love relationships. The book has since been developed into an interactive relationship enhancement program, *Hold Me Tight Online*. Her newest book for clinicians, *Attachment Theory in Practice* (2019), delineates the promise of attachment science for understanding and repairing relationships and her seminal text, *Emotionally Focused Couple Therapy – Creating Connection* (2019), is now in its third edition.

As the founding director of the International Centre for Excellence in Emotionally Focused Therapy (ICEEFT), Sue trains counselors in EFT worldwide and provides guidance to over 80 affiliated centers. She consults for the US and Canadian militaries and is a popular presenter and speaker for the general public. You can find out more about Sue and her work at www.iceeft.com and www.drsuejohnson.com.

T. Leanne Campbell

Leanne Campbell is co-director of the Vancouver Island Centre for EFT and Campbell & Fairweather Psychology Group and is an Honorary Research Associate of Vancouver Island University. Initially trained by Dr. Sue Johnson, Leanne has continued to work in the EFT model and has

worked with hundreds of individuals, couples, and families over the past three decades.

In addition to maintaining an active and full-time private practice, with a primary focus in the areas of trauma and grief, Dr. Campbell currently manages a two-site practice comprising over 20 clinicians and is a site coordinator for an Emotionally Focused Individual Therapy (EFIT) outcome study. An active ICEEFT Certified EFT Trainer, Leanne has been providing trainings in EFT for many years and has similarly been involved in the development of various training materials including DVDs, on-line and other training programs, books, and workbooks.

Introduction

Introduction to EFIT

We are writing this book to do much more than give you a blueprint for a model of therapy based on the best scientific understanding we have about exactly who we are as human beings. We are writing this book to move and inspire you! We want to turn you on to the power of following the emotional charge in a therapy session and using it to color and frame a client's world differently, and to do this in an organic way that your client's brain is organized to respond to. We want you to know how to use the power in emotion to "move" clients in potent new directions. We are writing this book to challenge the world of individual therapy to take a new and long look at the mirror offered to us by attachment science and how that image clarifies human hurts and longings and gives us a direction and a destination for psychotherapy as a discipline.

More formally speaking, we might say that the purpose of this book is to share the wisdom gleaned in over 35 years of clinical experience using Emotionally Focused Therapy (EFT) with individuals, couples, and families as it applies specifically to shaping individual change. This experience has been enriched by our many research studies where we have pinpointed the process of individual and relational change, as well as many kinds of positive outcomes. The training of thousands of mental health professionals across the globe and the creation of a professional network for those professionals,

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the International Centre for Excellence in Emotionally Focused Therapy (ICEEFT, www.iceeft.com) has also enhanced this model, bringing wisdom from many cultures, ethnic groups, and ways of seeing the world.

Emotionally Focused Therapy is mostly known as a cutting edge, empirically validated couple intervention, though from its inception, has always been used with individuals, especially those facing depression, anxiety, and the effects of trauma. EFT has contributed much to the world of couple therapy but this book focuses on the use of this model with individuals. As EFT developed, it has become clear that the positive and lasting results found in EFT are mainly the result of two factors: the clear map to human misery and motivation provided to us by the developmental theory of personality we call attachment theory; and the focus on systematically reconstructing emotional experience as it occurs in session. The first author's most recent book, *Attachment Theory in Practice: Emotionally Focused Therapy (EFT) with Individuals, Couples, and Families* (Johnson, 2019), has outlined how these two factors offer the promise of real integration and coherence to the field of psychotherapy as a whole (Johnson 2019).

Having stated the formal rationale for this book, it is not, in fact, intended to be a formal text. The world of psychotherapy has become a bit of a circus. So many labels, disorders, models, and interventions, it is hard to know how to find our way. Attachment science tells us who we are and shows us how to befriend our client's emotions and use the power of corrective emotional experience to enable clients to find a new sense of self – a sense of competence and worth. This book is full of stories, images, and information that will make it possible for you to create moments of transformation in every session. It is written to be accessible, easy to read, even fun! A clear map shapes a sense of confidence and competence in a therapist that translates into more on-target interventions, better outcomes and less therapist burn-out. We hope to offer you a clear way home with each and every client. We would like you to feel as affirmed as we do when clients like Mary and James tell us, "You get me; you go to the heart of the matter," and, "I can't believe what a difference that last session is making in my life."

It is worth noting that the EFIT model fits well with the major concerns of the present societal context in terms of its stance on diversity and inclusion, and in the fact that it seems to translate very well to an online format. In fact, most of the sessions outlined here took place online. In terms of diversity, the core concepts and values of the general EFT model, of which EFIT is a part, are grounded in the humanistic experiential perspective of Carl Rogers, who insisted that respect for every individual and a full valuing of the person of the client was the foundation of good clinical practice. EFT is also founded on attachment theory, which views core emotions, vulnerabilities, protective strategies, and the need for safe connection with others to be universal. Belonging and becoming are two sides of the same coin and, in a truly

civilized society, all must belong. The EFT model, and EFIT in particular, is used in many different countries and contexts around the world with almost every possible cultural, racial, and diverse group of therapists and clients. Practicing in different contexts challenges us to renew our curiosity and learn to adapt our interventions in a more refined way to fit particular cultures and particular clients. The EFT stance on diversity and position statement can be found on the website, www.iceeft.com.

In terms of online practice, EFIT interventions appear to be suited to the very factors that clinicians worry will be hard to achieve in digital sessions, namely safety, full engagement and absorption in the tasks, and experience of therapy in a way that shapes effective change. As will be apparent throughout this book, the EFIT model has always focused on creating safe haven sessions and teaching therapists to exhibit authentic, real engagement with clients, the kind of engagement that crosses the barrier from live to on-screen sessions. The focus on emotion and on-target attuned intervention also lends itself to the shaping of engagement with a client's core emotions and significant existential dramas – the dramas that continuously define a client's sense of self. The first large study of EFIT referred to in this volume was also conducted online. Suffice to say here that there seems to be no problem using this up close and personal model of intervention in an online mode.

This text is designed as a primer – a way to orient you and get you started in EFIT. However, we hope that even if you are already an experienced EFT therapist who is using EFIT in everyday practice, this volume will deepen your understanding and expand your repertoire of EFIT interventions. We have deliberately included many transcripts of actual therapy sessions and have repeated key concepts throughout the book to enable you to take in this model and make it your own. There are Play and Practice sections at the end of every chapter to help you integrate what you learn and immediately translate it into practice. DVDs of EFIT in action are available from our institute, www.iceeft.com. As a general model of individual, couple, and family therapy, EFT offers you membership in a supportive professional organization. You are invited to look on the website for an EFT community near you or look for resources in your own language, whether it is Farsi, Romanian, Finnish, Dutch, English, or German.

There is much to do in terms of finally integrating research and practice in psychotherapy, finding ever more effective interventions for emotional disorders and training professionals for life-long creative practice. We know that you will find EFIT an exciting and effective way to reach even your most difficult clients. We hope you enjoy this primer!

1
What Is EFIT? Let's See!

This chapter will lead you through snapshots of the change process with an EFIT client suffering from very high levels of post-traumatic stress disorder due to extreme childhood sexual and physical abuse. In fact, Henny fits all the criteria for complex developmental post-traumatic stress disorder (PTSD). Therapist interventions will be outlined to give the reader a picture of what EFIT looks like in practice. The goal here is to give you a visceral sense of what EFIT is about before explaining theory and practice in more abstract terms.

The portrait of change with Henny will focus first on beginning sessions, then on transcripts from the end of Stage 1 of EFIT – Stabilization, and one point in Stage 2 – Restructuring, Expanding Models of Self and Other, where Henny makes significant changes in ordering her emotional world, and shifting her sense of self. In EFIT we think of our ultimate goal as *expanding the self*. This is in contrast to the *constriction* of the sense of self and engagement with others that is typical in chronic mental and emotional distress. The moment-to-moment attunement of the EFIT therapist is guided by the map to basic human vulnerabilities and needs set out by attachment theory and science (Johnson, 2019).

The macro-intervention sequence we call the EFT Tango is used in every session of EFIT, in the EFT model for distressed couples and in EFFT with distressed families. It will be briefly pinpointed and referred to in this chapter.

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These interventions and more micro-interventions will be clarified in detail in the rest of the book. There follows a case description. Specifically, examples of key sessions with a client conducted by the first author, Sue Johnson.

Henny bounces into my room, all blonde curls, big hiking boots, and giggles. She talks very fast and immediately engages with me. She tells me she is 50 years old, has had a varied career as a specialized editor and as a teacher of gymnastics, and has two adolescent children, Vinnie and Veronica, who now live with her since the breakup of her marriage 9 months before coming for therapy. She asked her husband, Tom, a dentist whom she met when she was 18, to leave because of his complete withdrawal into his addiction to alcohol, cocaine, and gambling. This was the third time she had left him. Twice before this had involved "running away" to new cities but this time was "final." She confides that she came for therapy because, "I have always lived in survival mode, just focusing on taking the next breath," but now she was, "tired out." She states, "I just shut down and sleep for a whole day now."

In a breathless rush, she then tells me that she was diagnosed with PTSD after the birth of her second child when Tom turned up high at the hospital and her parents, who live on the other side of the country, paid her a surprise visit to see the new baby. She reports that she went into a "trance" and was "catatonic" for a week in the hospital. Indeed, at the beginning of therapy, her scores on Briere's Trauma Symptom Inventory (TSI-2, Briere, 2011) were elevated and in the clinical range on all but one (i.e., suicidality) of the key factors on this test. After this catatonic episode she was heavily medicated but currently was taking a moderate dose of anti-anxiety medication only. She tells me that her symptoms had abated for a while but, since asking Tom to leave, she has suffered from nightmares and feelings of hopelessness, panic attacks, and intense flashbacks of her past trauma with her father, who would drug his two girls and repeatedly rape them until they reached puberty. He would always arrange where the girls slept and if you were the one in the most isolated room, then you were "hunted." Her mother witnessed many of these incidents but would then deny they had occurred.

In spite of this traumatic history, Henny immediately comes across as honest, vivacious, highly intelligent, and eager to grow. She is resourceful, telling me, "I can fix anything. I can rebuild a house if I have to." She describes holding down three jobs at a time and teaching gymnastics, stating that her skill at gymnastics was an ongoing joy for her. She shares that, as a child, she remembers moving a dresser in front of her bedroom door to keep her father out and other "victories." She says, "I want a life that feels safe, I want to break the pattern. But now it's hard – Tom was the only person who ever loved me. Seemed to love me. I don't trust anyone."

The goal of Stage 1 of EFIT, Stabilization, is to build a positive alliance and stabilize the client, pinpointing sources of strength and resilience,

shaping coherence and emotional balance, and formulating core treatment themes, dilemmas, and goals with the client. (See the list of EFIT Stages and the goals for each stage at the end of this chapter.) Henny tells me that her life was a "whirlwind" and indeed, she spoke very fast, moving from story to story and from childhood to recent events in an intellectualized, haphazard way that was very difficult to make coherent sense of. I struggled to piece together key events and timelines for childhood experiences, for her relationship with Tom, and for the recent breakup. We moved through assessment (see Chapter 6) and I stayed in empathic reflection mode for most of the first ten sessions, clarifying defining moments in Henny's emotional life, how she dealt with those moments, and also patterns in how she engaged with others in her life. (We call this process EFIT Tango Move 1 – more later.) If I tried to slow her down, go deeper into any particular moment or theme, she would stop and begin another story.

I focused on shaping a safe EFIT alliance – being emotionally open and available, responsive and engaged with her, normalizing and validating her pain and her dilemmas, and waited for a sense that she was ready to deepen her emotional engagement in the session. At one point, she said she could draw a traumatic scene for me where she was with her mother and sister outside a church. When she gave me the drawing it was simply of the church. I pointed out that the people and the meaning were missing and she laughed and then changed the subject. I continued with the focused attunement and relentless empathy that an attachment-oriented model fosters and waited for her to step past giving me pieces of information and let me into her life. As always in EFIT and in the general EFT model, I wanted her to move into deeper levels of experiencing in the here and now of the session; to move from the detached recounting of ideas and events to a fully engaged, alive, visceral exploration of her present experience. (This can be measured by the Experiencing Scale which we will discuss in Chapter 4.) The deliberate, gradual creation of an attachment-oriented EFT therapeutic alliance is essential to this process. The alliance as characterized by Carl Rogers (1961) is authentic, transparent, and accepting. As suggested by attachment research, the therapist attempts to be open and accessible, emotionally responsive, and fully engaged with the client (Johnson, 2019), in a way that parallels a stronger, wiser security shaping attachment figure.

Gradually, I was able to slow Henny down and help her deal with some of her grief and fear around the breakup of her marriage so she felt more grounded and able to do tasks like filling out the custody agreement with Tom and setting limits on him seeing the girls when he was intoxicated. We also focused on searching for *resilience moments* to serve as a safe haven – a refuge for her when opening up to a painful experience was hard to tolerate. Most often in EFIT this involves a positive moment with a safe past attachment

figure where the self of the client was recognized and valued. However, any kind of moment like this was hard for Henny to access so we searched instead for a moment when she felt "strong and competent." We found such a specific moment in gymnastics where she did well and was acclaimed. I asked her to close her eyes and I evoked a vivid, alive experience. I summarized this.

Therapist: So you are about 11 and you are up on the balance beam, feeling the beam under your feet, strong, sure of yourself. You run and leap into the air and turn your body, feeling the power, and touch the beam and leap and turn again. You know where the beam is. You know you can leap and curve your body into an arc and then leap again and land perfectly with your arms high. You see your coach's face smiling at you – at your skill and your courage and your fierce leaps – your risks. Can you feel that in your body as we touch it? (She nods emphatically.) Good. The leap, the turn, the landing. You knew where the ground was – what was real. And you were in your body. This is a good place to go when you are scared and unsure. (She nods again.) And you were just a child – a child who couldn't let go and sleep for fear of your father coming for you. But part of you was still strong and whole. Henny, you knew you could fly.

We return to this image and use it again and again all through the therapy process.

Gradually, Henny was able to be more emotionally present in sessions and begin to pinpoint key scenes in her childhood that continued to haunt her in nightmares and flashbacks. Her story became more coherent and we began to identify key traumatic scenes. She began to be able to enter and stay in deeper experiencing, which I would systematically assemble and deepen with her. (This is the Tango Move 2 process.) For example, she accessed dinner table scenes as a child when she was in her father's "strike zone," and would get so scared she would gag and throw up. There was "no safety anywhere." She was able to identify and begin to stay with and explore memories that induced "total panic," such as walking in as her father was raping her younger sister. Generally, she began to be able to connect with her "frightening, alien and unacceptable emotions," (Bowlby, 1988, p. 138) and to begin to feel them rather than "numbing out and fighting to cope, to fix stuff all the time." She told me, "Fight, Fix, Numb but don't Feel," wasn't working. She reflected that she wanted to "save others" and fix things in order to not feel so helpless and alone and to "matter to someone at least for a moment," but usually she would get hurt and numb out and "escape" into a new place or activity. I would help her turn her more vivid and alive emotions into interactions – dramas with key figures in her life (Move 3 of the EFIT Tango). The encounters we worked with were short, such as closing her eyes and telling Tom, "I can't fix you. I have to give up on us." After

telling me a dream where she was in a "trap" where she "treads water out in the ocean and swims to people trying to save them all the time," we also have an encounter between us where I ask her if she can be in the water and let me hold her up sometimes and she weeps and agrees she can.

I always ask her to process key emotional scenes (Move 4 of the Tango), inquiring as to how her body feels and what comes up for her when accessing these memories and relating them to her present pain. I also continually and explicitly validate her and her experience (the last move – Move 5 of the Tango).

After approximately 15 sessions, the process moved to Zoom meetings online due to the pandemic.

A Snapshot Excerpt from EFIT – The End of Stage 1

At the end of Stage 1, we typically see more emotional balance in a client, which translates into more focused awareness and acceptance of emotions, and more ability to reflect on emotional experiences and make coherent sense of them – a sense that challenges definitions of the self as inadequate, unworthy, or helpless. Clients move with the therapist, who is now a safe haven and a secure base, into active discovery mode, and at the same time their window of tolerance widens.

Henny comes into the session saying she is "bitter." It is her birthday and she remembers, like watching a film, a birthday party where her father started beating on one of her friends at the party. The girl's parents came to the house to complain but "As usual, NOBODY DID ANYTHING!" The other kids then ostracized her.

Henny: It was brutal. I can see it. He pummeled her. So I told Tom I didn't want to go out for a celebration. No more roller coaster where he is nice to me for an hour and then … Gone.

Therapist: Yes. A kind of bitter helplessness comes up when you think of your dad and when you think of Tom.

H: It was all pretending. I remember Mom making cookies! Little morsels of caring. When Dad was nice to you it was off, kind of scary. He was planning something. I'd refuse his gifts. And Tom won't accept he is an addict. He says it's me and my PTSD that is the problem, that I'm too needy. That I can't do regular things like close or lock doors. Always need an escape. Dad said I was crazy too when I resisted him.

Th: Yeah. He robbed you of your reality – denied the brutal reality that you were all alone and helpless and he was a predator – a terrifying, abusive dad. And Tom too … he let you down.

H: She, my mom, took me to the doctor once cause I was so sore and bleeding down there … but nothing happened. She made some excuse. I always

said I would escape … but … feels like I am still in prison. My sister says she doesn't remember anything but she is a mess so …

Th: How are you feeling as you say this Henny? You are telling me that you have had to deal with this, what did you call it – life sentence of fear – with no one to turn to, to see you and tell you your pain is real – that it matters – no comfort – and you are heroically fighting for your life again and again. All by yourself. (Tango Move 1 – Reflect emotional processes occurring within self and between self and others.)

H: I don't know. I've done pretty good – lots of jobs – I can speak languages …

Th: Yes. And we talked about how you are a fighter. An amazingly strong, vibrant lady. Remember our strong story? You can fly – you knew your strength – you were beautiful and you landed strong and balanced. (Evoke resilience image.)

H: (Her eyes fill with tears.) My inner child is broken. What did I do to deserve such horrible treatment? Wasn't good enough to be considered by my husband – I had a medical procedure last week and Tom didn't even ask me how it went – how I was doing. That was hard. (Trigger for emotion – invitation for the therapist to move into Tango Move 2 – Assembling and Deepening Emotion.)

Th: Yes. None of the people close to you in your life have seen you, have they – seen your pain and your fear and comforted you – showed you your pain mattered? That breaks us – that is so terrifying … to be so vulnerable and abandoned. Unseen.

H: It's difficult … (Basic perception element of emotion.) And it's sad. (Core emotion pinpointed.)

Th: Yes. Where do you feel that right now? (Body Response is key element in assembly of emotion.)

H: In my chest – here … (Hits her chest.) And I tell myself – I must fix it. Escape. (Body and Meaning elements of emotion, she adds them herself.) So I go to the gym or work on something but … (Putting in the Action Tendency element of Emotional Response.)

Th: (Softly and slowly, holding her with my voice.) Right, I'll fix it or I'll run, but inside the sadness and the fear breaks me. (Using proxy voice – speaking as the client.) Inside I am broken and alone. (She nods.) What did I do wrong? How can no one care about me and my pain? No one did anything to help me. Inside the vulnerable part of me is always fighting to not be destroyed by this sadness and fear. ('Broken' is an emotional handle – to be noted and used again and again to open door to the client's experience.)

H: (Very softly and with lots of hesitation.) It's a constant roller coaster – and my daughter Vinnie looks just like my younger sister did when she was little. She has little breasts now. She got mad at me the other day and

Tom isn't protecting her. He takes her to parties. (She goes very still and her eyes get wide.) I looked at her and I just got triggered. I just shut down. For a whole day. Spaced out. I was a zombie.

Th: Yeah. (Softly, slowly.) Can you stay with me right now Henny? Can you feel your feet on the floor? (She nods.) Can you look at me? If I was in the room with you, I would be laying my hand softly on your arm. (Comforting her and containing her emotion – she comes back to me.) That was how you learned to escape, wasn't it? To space out. To escape. That was the only way to survive – to protect little Henny. And now your body just does it for you. And you worry about if Vinnie is safe? (She nods and weeps.) And you saw your little sister being raped by your dad didn't you? (She nods.) And there was nothing you could do – you could not protect her. (She weeps.) You saw what was happening to you happening to her. You were a witness – a helpless witness. (She covers her face in her hands and weeps again. Long silence.) That is unbearable, isn't it? Like your dream of being in the sea holding everyone up. You were in a sea of pain and fear and you had to watch it happen to her – in front of you. That is overwhelming. (She has always stated that she does not remember any actual rape scene where she was the victim. This changes in Stage 2.)

H: (Very quietly.) Nobody did anything. (She holds herself – folds her arms around herself.)

Th: Yeah. Right. There was no safety – no protection. And you said in the last session that your goal was to find a way to have a safe life. Yeah. You couldn't protect your sister or you. You were broken and alone hiding behind your mom's curtains at night, yeah. No safety anywhere. And letting go into sleep is still so hard for you. What is happening Henny – are you with me? This is so hard.

H: (She looks up at me.) Yes. Part of me is rigid – tense. I feel the fear.

Th: I can't imagine how terrible this was for you – my heart breaks that little Henny had to go through this – all alone with no help anywhere. It is amazing that you made it through to be the you that you are now. I hurt for you. (She weeps.) Can you take that in? Can you feel me feeling with you – feeling your hurt? (Move 3 – Choreographing Engaged Encounters – with the therapist this time.) I see your terror and your pain. Overwhelming!

H: Yes. (She laughs.) So different. A switch. To feel that. (Pause.) Helps. (Long pause.) I was thinking that on Mother's Day I felt triggered all day. I couldn't call her. She denied it all.

Th: Yes. She left you – couldn't stand with you. Left you questioning your reality for so long – so alone in the face of all this fear. No one to even help you "know" what was happening. You didn't even have words for what

was happening. Just vague terror and pain. So then – as you said – you "doubted" yourself all the time.

H: (Very softly.) She was THERE!! When he would bring out the booze, she would ask him, "What are you doing?" She knew he was giving it to us to make us pass out. I thought I was crazy – broken. She was just stoic. I don't even remember her comforting me.

Th: Yeah. Do you remember a few sessions ago, you closed your eyes and talked to her? Can you do that now? Tell her what is real for you – you have the words now. (Tango Move 3 – Choreograph Engaged Encounters, this time with an attachment figure.)

H: (Closes her eyes.) You pretended. You left us alone with him – again and again. I wasn't crazy. You let it happen – again and again …

Th: How are you feeling right now, Henny, in your body? Do you feel angry right now?

H: No – I feel huge, huge sadness. That she could do that to us. Pretend. Leave us naked with him. She was afraid I think but …

Th: So helpless. So sad to be left alone in the face of all this darkness. No little one can stay strong in that – no one can hold another up in that. It was all desperate survival, struggle, wasn't it? (She nods.)

H: (Closes her eyes again.) YES. And I did it with Tom – what Mom did. I denied his addiction again and again. But I wouldn't do that with my kids. I reported him to the police for driving the kids inebriated. (Long pause.) But I won't call you on Mother's Day. I don't forgive you. You were not a mother. (She weeps. I say, quietly, "I wish I could put my hand on your arm, Henny. I am here.") You let him do it. No protection. I didn't have a mom. I had no one.

Th: Yes. That is unbearable. No one can tolerate that. You had to numb out. You were small, so vulnerable, and you faced terror every day all by yourself. (So much core grief, helplessness, and aloneness. I sensed Henny was moving outside her window of tolerance here so moving to Tango Move 5 – Validation and Integration.) But you found a way through. You are here. You are an amazing woman. You have faced so much in your life with so much courage. Look at what you did here with me today! You said your truth. It was clear. You walked into it and took a look at the "picture" you told me you could never bear to draw or see. (Recalling the picture of the church referred to above which was the day when services were cancelled and they arrived home to find her father raping her sister and her mother was silent.)

H: (Smiles.) I made it through. You get it. I always felt naked as a child but in my gym outfit, well THAT was like body armor.

Th: Yes. You were not in "prison" there, you learned to fly into the air and to land – on your feet, strong. And you still do that in the gym. You show

other kids how to fly. That's amazing isn't it? (She smiles.) You fly a little here and land – get a little balance. (She laughs.) Can the Henny who learned to fly – found her balance on the beam – landed strong – the Henny who is here right now talking to me, offer some comfort to that little broken girl do you think? Can you close your eyes and see her, hiding behind the curtains, afraid to go to sleep? Can you see her face? (Long pause.) What would the Henny who knows she can fly and land strong like to say to that little one right now? (Tango Move 3 with a vulnerable part of the self.)

H: (Closes her eyes. Very softly.) You are so small. You will find a way to be safe. You are strong. This pain and fear are not all of you. You can fly. (She weeps.)

Th: Yes. Can she hear you? (Henny nods.) What happens now?

H: She sleeps. She lets go.

Th: Yes – that is beautiful Henny.

We then debrief this enactment and the rest of the session shifts to the same themes but re Henny's relationship with Tom – this is less overwhelming. You see attachment theory in practice in the above session, for example, in the focus on aloneness and its impact on traumatic experience, and in the responsiveness of the therapist as a surrogate attachment figure. You also see the micro-interventions, both Rogerian interventions (such as accurate empathic reflections and evocative questions) and also systemic/relational interventions (setting up enactments). These are discussed in detail in Chapter 5.

Snapshot from EFIT Stage 2 – Restructuring

In Stage 2 of EFIT, the client has a secure base with the therapist to go deeper into difficult experiences – pivotal moments when models of self and other were formed. The process is more intense, clients become absorbed in new and emerging emotional realities, and the therapy takes on a more existential tone. Core experiences of sadness and loss, shame and catastrophic fear, are accessed and actively processed. A coherent new sense of self emerges here and new responses to self and to others become possible. Corrective emotional experiences are shaped and core vulnerabilities are moved into and are resolved differently. Once this stage is complete then Stage 3 – Consolidation is possible.

In this Stage 2 session, Henny goes, for the first time, into the only actual scene she remembers from her childhood where she was raped rather than previous scenes where she remembers only seeing her sister raped. This is an intense session where core emotion and traumatic experience is evoked, distilled, and processed. This transcript is faithful to what occurred in the session; however, in places, it has been edited for brevity. It might be interesting

to note where the therapist follows the client into less engagement with difficult emotion and where she redirects or holds the client in her emotion, as well as where she uses personal presence and the therapeutic alliance to create a secure base for the client.

Therapist: So when you're telling me about this recent solo trip into the wilderness, I get the feeling that I always get when I talk to you, which is … what an amazingly courageous, adventurous lady you are. You said last time we talked, "I want to draft a new blueprint for my life," and you are so brave in doing that! (She nods and smiles.) So what about more upsetting moments? You were going to look for your nightmare journal … How has that all gone? How is it with those flashbacks and nightmares?

Henny: They've been good, actually, I mean somewhat … On my trip, I thought of stopping by where I grew up and checking in with my sister and stuff … and I decided not to. (Starts to weep.)

Th: (Softly.) Help me Henny, what's happening right now? What's happening? Can you tell me? Can you just stay with that? I'm with you here … I'm with you here. What's happening? Right now?

H: I guess sometimes I … wish I had a family to go back to … feeling ashamed and alone.

Th: Okay so you help me … what's happening right now for you is all about being ashamed and alone? You got close to your family home … so maybe this feeling got triggered, of, "There's no one to connect with here. I don't really feel connected to anyone here. There's no one there for me?"

H: Yeah. I'm in a new chapter and I don't even know what home looks like now. And memories came up of that other city where everybody there knew my husband and our family.

Th: So this journey put you in touch with having lost that? You were hit by the loss of your old life, yeah? The losses in your childhood and the losses now with your own family. Am I getting it?

H: In that city with Tom, it was positive for us, our family seemed very healthy and connected. Tom was more present then than he'd ever been. It was a bit sad in retrospect. So then I was thinking, "Oh, I should put some energy into connecting," cause Tom always accuses me of being judgmental and dismissive … but I didn't want to just sit at parties and drink. I want to go and do things. Maybe what I really need to learn to do is to really enjoy being alone.

Th: Sounds like this journey brought back the loss of Tom, a memory of when he was present, was able to be there … a loss of that stability, where you didn't have to go and reinvent your life, right? A lot of sadness.

H: Well … I don't know, I guess it was sort of … and it made me really question reality … because I thought things were good there but then recently, I found out Tom had already started gambling when we were still living there and I had no idea, right?

Th: Yes. So you help me then, so you say to yourself, "Was it all an illusion?" Is that what you say?

H: (Long pause.) It's a little bit like my childhood … it seems like even the good memories were clouded with really terrible things … and really terrible betrayals … so I'm better alone … I don't have to … (Shifts into more detached voice.) I can do just fine on my own. I had a great trip in the canoe and … and … (She looks sad again.)

Th: (Softly.) Yeah … There's so much here, let's slow it down a little bit, okay? (Refocusing her – not following her exit from the difficult emotion.) Some part of you says, "I got out of all that, I'm better alone." But then there's another part of you that says, "What I wanted was connection. What I wanted was closeness and I have this memory of Tom and how I thought he was being close but … but things were going on I didn't understand." And even the good times in your childhood were all clouded by all these terrible nightmares and betrayals … all these terrible images that you have, right? What happens to you in your body when you talk about this? (Tracking and reflecting the client's emotional process here.)

H: I feel really rigid and tense … very, very held in tight, like I'm just squeezing all my muscles …

Th: Right, I got that. Is it kind of like, "This is all so scary … this is all so difficult, I just gotta hold on tight, "… is it like that? Or is it your whole body tensing up in fear? Can you help me? (Using proxy voice and getting more specific about her experience.)

H: It's more clenching up, like I'm going to be struck … like bracing to receive a blow …

Th: (Soft and slow.) Ah … this hurts … this hurts … this hurts … clenching up to receive a blow, right? And the blow is that you longed for this connection with your dad and with your mom … and what you got was terrible, terrible hurt … and betrayal. And the blow is that you remembered this good time with Tom and then what you remembered was his betrayal … his turning to gambling and drinking and drugs instead of being with you, right? So it is a blow, isn't it? Your parents let you down, betrayed you … and Tom too. You actually thought there was a promise of connection there. And then it all went wrong. Am I getting it?

H: (Pause.) Even though there was a lot that was good in our relationship, I always felt insecure and afraid. For years I thought that was the PTSD. I thought it was my problem, me not able to trust … but … There was no honesty, no safety … it wasn't my fault. (She weeps.)

Th: (Softly.) Yes, "It wasn't my fault," yeah? You help me, Henny, you said ashamed, you said alone and ashamed … and what you're telling me is that it hurts. I can feel that … I can feel that, to have moments of hope after your terrible childhood and to feel so alone and to feel, "It must be me, it's my fault, it's because I can't trust." Then to realize, "It wasn't me. It was that my husband was having an affair with drugs, gambling, and alcohol, and hiding and denying it. It wasn't me." All those years you had moments of hope but you felt abandoned and alone … and in fact, it wasn't you, it was the situation. That hurts, yeah?

H: And any time I would say anything he would say that I was wrong, that I was imagining it, jealous or whatever. It's just so crazy. (Long pause.)

Th: Yeah, and that's what little kids do, when terrible things are happening in their families. (Normalizing, validating.) Little kids don't understand, how could they? So they say, "It must be me. I must be a bad little girl if these things are happening to me." Because nobody helps them see … nobody says, "No, you're in danger. You're hurt, of course it hurts. This isn't your fault." Nobody says that.

H: My dad would say things like, "Nobody will believe you," and, "Nobody can hear you if you cry and scream." He would remind me of those things. (Weeps.) That my voice would have no … that the walls of the bedrooms were insulated!

Th: He would tell you, "You have no voice, there's nothing you can do. Even if you scream, no one can hear you," and when you used to try and talk to Tom about feeling so alone and so hurt, he'd say, "I don't hear you. There's something wrong with you." He dismissed you – made you feel like you were crazy. And your dad told you, "No one will believe you. No one will care," right? And your mom kind of proved that, she acted like nothing was happening, yeah? So you were really, really alone, weren't you? (Pause.) That's a special kind of aloneness, isn't it? That's what you touched on your trip. That's worth crying for, yeah? That's worth crying for, isn't it? Yeah? (She looks zoned out now.) Are you still clenched? Can you let yourself cry for that? I'm here … I'm here, can you cry? (Very softly.) That's worth crying for, being so alone and so helpless … What's happening right now? What's happening in your body right now?

H: I was just thinking about how I had thought of being happier alone. (She weeps.)

Th: Yeah. Your power moments have been you and your body, haven't they? You're safer in the woods, aren't you? As a child you were safer on the balance beam. You feel safer to canoe into wilderness because you have confidence in your body, right? I hear you. Some part of you says, "I'm safer alone." But that's difficult because part of you doesn't want to be

alone and it hurts to be alone. What you wanted was to be with Tom. Safe. Held. What you needed as a little girl was protection and love and safety … but you got a nightmare. The people you needed the most telling you, "Nobody will see or care about your pain." That's a devastating message … all we can do with that is to weep, yeah? Does that feel right for you?

H: Yeah. Now Tom says, "Get over it." Pretty hilarious exchange really. (She giggles and we both laugh.) He said, "Oh well, you don't know anything about love or caring." But I've forgiven him for things nobody would ever forgive … and I've endured. It's bizarre. My love wasn't ever reciprocated.

Th: He couldn't really respond, right? He was always trying to escape into gambling or drinking or drugs. He let you down. And again you were hurt and you had somebody saying it's your fault and no one cares. And that's what happened in your family too … your dad said, "No one is going to hear you. It doesn't matter if you hurt." And on that trip you felt that terrible, devastating abandonment … that these men that you've loved have delivered up to you. So you said to yourself, "It's safer out here alone." And both those people denied you your reality – that your hurt matters. This is worth crying for, Henny. This is worth crying for. (She comes back and takes a deep breath – is more emotionally present.) You're breathing now. It feels to me like you've unclenched a little, is that right? (She nods.) You've had to struggle so hard to even feel that your pain matters and it's valid. To be able to say, "My pain is real and it matters … and you're letting me down, you're hurting me, abusing me." You had to struggle to tell me that your dad was a predator and you were helpless. To accept the fact that you loved Tom but he was an addict. There was no one to tell you that your pain mattered. (She sighs a huge sigh.)

H: I just … keep … bouncing to this memory I have of … sort of my first experience of hopelessness … it was just so profound … when I started just sort of going into shut down, like a catatonic state … where time would kind of stop. (Long pause.) It came up … I was doing a kind of meditation …

Th: What was the memory? Can you stay with that?

H: (Speaking softly and with difficulty.) Sort of … the only clear memory I have of me being sexually assaulted … because most of my memories are of the things I witnessed. (Long pause.) In this one, I was being assaulted in a bathroom and I could see what was happening in the mirror … And so somehow, when the memory came back, it was undeniable what was happening to me and it's from a visceral perspective … and it's a visual memory of seeing what was happening. (Beginning

to weep.) My dad raped me. He threw me on the ground outside the bathroom. Then he yelled at me, "Aren't you glad you came with me to work today?" He was mimicking me, whining, "I want to go with you to work." I remember being hunched against the wall … all crumpled up in a fetal position and just kind of blacking out after that. I'd just been sexually assaulted, I was maybe six or seven years old. He laughed at me … and I totally blacked out. I don't remember how I got home from there … I don't remember anything. Think I remember the next day and bleeding and things like that … but everything stopped for me.

Th: (Very softly and slowly – trying to caress her with my voice. Holding and ordering terrifying experience.) Yes … This is what happened to you. You were abused and raped … physically hurt and wounded … and then you were somehow mocked. Like it was your fault for wanting to be with him … you were mocked, like you were nothing … like you didn't matter. And you were a little girl and all you could do was go tense … like you did here when we started talking about these go rigid moments, blackouts, escapes … because this was unbearable. (Long pause.) Can you see that little girl? Can you see her? Can you see her right now? In that moment before she blacked out, can you see her? She's seven … she's so small. She's gone to be with her dad … hopes there's going to be something good … a moment of connection. And instead … she's hurt, she's bleeding, she's scared. He's big, there's nothing she can do, she's helpless … and then when she's hurt and bleeding, he laughs and tells her, "I can do this. There's nothing you can do. Your hurt doesn't matter." Can you see her? Can you see her face? (She nods.) Yeah? (Very softly.) Henny, it hurts me, just to listen to you … so I can't imagine what it's like for you to feel that. It hurts me just to listen to you. No little girl should feel that – ever. Can you see her face? (She shakes her head.) Can you see her hunched on the floor? (She nods.) Are you still there with her? I want you to stay with me here … are you still there? Can you see her on the floor?

H: (In a calm, detached voice.) It's just safer to be alone, you know?

Th: Yes, I hear you … and for you, in lots of ways it is safer to be alone. But right here, you're with me, can you feel me with you? Right now I'm with you. Can you hear my voice? (She nods.) If I was there with you I'd put my hands on your arms … you'd feel my touch … feel me touching you … Yeah, I'm with you … But you're right, for you it was safer to be alone. There was no protection … he could treat you like you were nothing … BUT, BUT, that little one found a way to survive, she found a way … she blacked out, she went rigid, she went away… but right now we're with her. Right now, you survived and you're with her … and I'm with you here. Can you see her on the floor? She's all scrunched up … and

she's just about to go into the blackness because this is unbearable. You are there with her, the adult Henny. The one who survived, the one who fought … fought to believe in her pain … fought all through her life. The one who can go off into the wilderness and be fine. The one who found me and can now talk about this. If you're there with her … the little girl, so alone, like her pain's nothing, she's nothing … if you were there with her as she's all crumpled up on the floor, what would you do?

H: (Weeping profusely.) Pick her up and hold her.

Th: YES. Can you close your eyes and see that? Can you close your eyes? (She does this.) Pick her up and hold her… Yes. Pick her up and hold her. Can you feel that? You can hold her … I want you to feel that. I want you to feel you holding her against your chest … like you hold someone very precious … very precious … very small, very hurt. Pick her up and hold her … hold her against you. Can she feel you … you holding her?

H: I don't know.

Th: You can feel her, you're holding her. Can she let that in? Can she feel that, just a little bit, that you're holding her? You're holding her now. What's happening? You're smiling, what's happening?

H: I'd like to give her a soft kitten. Both my pets have gathered in right beside me right now. (Laughs.)

Th: Your pets know, your pets feel your hurt, they care. And you'd give her caring … you're holding that little girl and you're telling her … you're holding her … and you're telling her, "I see your pain." And that's what she needed but there was no one … there was no safe place. But now you can come and hold her. I'd like you to stay there just for a minute longer. I know this is hard … stay just a minute longer with her. You can feel her in your arms … Can she feel you a little bit? Yeah?

H: She's so sad that nobody ever … ever … Nobody ever hugged me. (Weeps.)

Th: Nobody ever held you and hugged you. In your mind can you … you don't even need to say it … in your mind can you say to her, "I see you, you so needed to be held, I see you. I see you, you so needed to be held … and no one came, there was no one." I want you to imagine yourself whispering that in her ear … I want you to whisper it to her … "I see you … I see you, I feel your hurt. You so needed someone to come and hold you … and no one came, and that's so sad. I'm holding you now. I see you … and no one came to hold you and that's worth weeping for." (Staying soft, slow, simple, and using repetition and staying with image and her emotional phrases – we call it RISSSC in EFIT.)

H: (She changes emotional level – calmer. Therapist follows, judging that the above experience was enough.) Did I tell you I went off sertraline? I think it's why I'm more emotional than before. There was a week where I kind of just was crying for no reason.

Th: That was a very brave thing to do, to decide to go off it … is that part of Henny saying, "I'm going to take back my life?"

H: It was, I think, a bit of an automatic weaning where I would, was just kind of feeling well enough and stable enough … Jan, my family counselor, said, "It's okay to feel, it's okay to cry."

Th: That was great that she said that. This is worth crying for … It's okay to feel, it's okay to cry and you're a strong lady … and you can cry with me, you can cry with Jan.

H: I just don't feel as numb… I feel like I cry, I laugh a little more, I have creative ideas again.

Th: It's sort of like you're coming to life. I want you to notice that you decided that just like you decided this morning … to talk about this with me, and to feel this … and to go and be with that little girl who was so helpless, so dismissed, so abused. And you decided to go and be with her and feel what that was like. You've talked to me before about seeing your sister being raped, but this is you saying, "This happened to me." And you decided to do that. That's a very powerful, brave decision, and you did that Henny. So that is kind of like coming alive, isn't it, starting to feel.

H: Yeah, when I went up North and was having time to myself … it wasn't easy. It was like hardcore wilderness experience but I could do it.

Th: This is Henny! This is the Henny I know. The person I know that has these dreadful wounds but she's a fighter, she's a survivor. Do you remember many sessions ago I asked how you survived, and were there moments when you felt powerful? And you told me, "I'm on the balance beam and I leap in the air … I trust my body, I leap in the air … I'm completely sure I know where the balance beam is … I land! I turn again, I feel my body in the air … I land, I do a perfect move." You told me that and I said, "Oh my god, in that moment you learned to trust you – you learned you could fly, you learned." And that's the thing about you, you have this amazing strength. But it takes courage to leap into the air … it takes courage to go into the wilderness alone. I couldn't do it! I'd be all quaking. And it takes courage to go into these feelings … and look at that little girl … that little girl on the floor and be able to go be with her and hold her and say, "You're mine. You're mine and you're special and I see your pain. I care about your pain, your pain matters. And I'm going to come and be with you now. I'm going to hold you, I'm going to believe you. I'm going to listen to you because you're mine." You claim her. That takes courage, Henny. Look at what you're doing. What does it feel like to you in your body when I say that to you? Can you take it in? (Deliberate move into validation and the use of a resilience experience/resource crafted in other sessions.)

H: Yeah … yeah … yeah. And now I feel really tired!

Th: I bet. I hope you're going to give yourself a break right here and do something that makes you feel good … be with your pets … walk in your garden. It's tiring to go and be with that little girl, isn't it? It's tiring. It's exhausting to feel these things. You've kept them away for so long … and now you need to move away from it … but now you've held that little part of you … you're holding her, you're listening to her and that's very powerful … but you're right, it's tiring. (Long pause.) Can you just take a deep breath with me? (She does.) Yeah, that was a good breath. I want you to take care of yourself right now … after this session, I want you to take care of yourself. I want you to kind of comfort yourself the way you've comforted that little girl. It's so hard to feel these things. I really respect you for doing this. You did something very huge today and very difficult. Adult Henny, the one who survived … you can hold little Henny. You know her pain – you believe in her pain … because she had nobody … she had nobody. How are you doing? How are you feeling right now?

H: Good, but … you know I've kind of spent my life trying to help people … but I've been unable to help Tom, I've been struggling with my own kids … I couldn't help my sister!

Th: Yes. This has come up before and we will go back to that. You're right you couldn't save her … no one could save her, except maybe your mom and she didn't do it. It wasn't your job to save your sister … but I don't want you to go and get lost in that right now. I want you to take care of you. Having touched that little girl, I want you to remember holding her, right, what that felt like. You're right, you've spent your life helping people … and from other stories you've told me, you've helped a lot of people in your life … but right now I want you to just stay with what we've done today … because we've done a lot of stuff and it's been a lot … and I'm worried that it's a bit overwhelming. Do you hear me? (She nods and smiles.)

H: (Calmly and smiling.) I will have a bath and eat something.

Th: Good idea! You know you can get hold of me if you need to? (She nods.) I really respect what you did today. I think it was really important. Thank you for allowing me to be there with you for that.

H: Thank you for being here. Thank you for being here now with me.

Th: You're most, most welcome. It's an honor to be with you.

In terms of follow-up to the session above, Henny decided in the next session to first focus on difficult interactions with Tom. She was able to access new emotions that enabled her to move into an imaginary encounter with him and tell him, "You don't deserve the kindness and love I have shown you all these years." She also told me that her life-long sleep issues seem to now

be improving. She remembered an encounter with her father when she had woken up to find him on top of her and had kicked him. He responded with, "Do you want me to kill you?" and she had told him, and now tells me with pride in her voice, that she had replied, "I don't care, cause I'll go to heaven and you're going to hell." So she tells him this again in the session. At the end of the session, I asked her about the session above and whether she thought about the little girl on the floor. Her face lit up in a huge smile and she told me, "Oh, it's so funny! That has sure changed. You see, she is not alone anymore. I am holding her! I imagine that a lot and it's kind of altered things. Now I feel like I have me!" We both beamed at each other and signed that we were giving a hug – I could feel the warmth even over Zoom.

We hope that the above has given you a visceral sense of EFIT and what EFIT looks like in practice. We decided to offer these initial snapshots of EFIT with a very distressed client to show how intense emotion and pain is addressed in EFIT. Many clients, of course, work at a somewhat less intense level. However, EFIT seems to be particularly effective with clients dealing with trauma, focusing as it does on key vulnerabilities and the iatrogenic impact of emotional isolation, which is traumatizing in itself.

The rest of this book will teach you how to practice this model in a way that fits for you and your practice. It will be useful to return to this chapter and read through these examples again later with a deeper understanding of what the therapist is doing. Training videos of EFIT in action can be found at www.iceeft.com.

BOX 1.1

Stages of EFIT

Stage 1 – Stabilization

Key tasks – Assessment. Pinpointing patterns. Alliance and Resource building. Affect assembly – restore balance.

Stage 2 – Restructuring

Deepen/distil engagement with core vulnerabilities. Promote self-acceptance/integration. Shape corrective pivotal moments. Change models of self and other.

Stage 3 – Consolidation

Integrate changes into identity and life story, action patterns. Consolidate new models.

2

What Is the Guiding Framework for EFIT?

Soundbite Answer to Question
EFIT is an approach to growing and expanding the self and its capacities grounded in attachment science and the power of transforming core emotional experience. Core chaotic, foreign, or denied emotional experience is evoked, ordered, and regulated to shape emotional balance and integration in each client. Clients move from chaos to order, reactivity to balance, from self-abnegation to self-acceptance, from helplessness to agency.

The mystery and magic of psychotherapy can, perhaps, be captured in the question that the first author's Uncle Herbert asked her so many years ago. After a very British alcoholic family lunch, he cornered her, his finger vibrating about an inch from her nose, and asked belligerently, "So just how is sitting down and just yacking away about your problems to some therapist who doesn't even know you going to help with anything at all?" People are still asking that very question.

The answer, of course, is in the focus of the talk – if it is on target for the problem at hand – and in HOW you talk! We know from over 35 years of research studies in various forms of therapy, and from our own studies of successful couple therapy, that if you dialogue with your therapist about tangential issues, staying in content, in factual information, rather than looking at how you construct your experience, or if you talk in an impersonal, abstract

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way, staying in your head and reciting your usual story of yourself and your life, then skepticism about effective change is valid. You might still comply and do what the therapist asks in session but, most likely, nothing much will significantly shift in your intrapsychic or your interpersonal world. We seem to be able to endlessly talk *about* ourselves and ventilate about our hurts and resentments while staying on the surface and dancing the same dance – the one that takes us down our own personal rabbit holes again and again. We have to be immersed *in*, or, if you prefer, be *with* our experience in a new way to change how we connect with ourselves and others, to open up new possibilities. Einstein said, "We cannot solve our problems with the same level of thinking that created them." He is right – to find new solutions we have to change the level at which we engage with our problems.

In EFIT, and when using the EFT model with couples and families, we assume that we have to change the level of problem formulation. We go to a *meta* level with our clients, or we dive in deeper and get way more specific and *granular*, really helping clients get a felt body sense of their difficult feelings and dilemmas. When we go to the meta level, we and the client step back and look at the self-defeating game, the patterns, the emotional processes they are caught in and connect them with the fact that, as humans, there are only so many games we can play. We all get stuck in self-perpetuating negative dances at times. As Amy tells me after a few sessions of EFIT,

> So what I am getting is that I am afraid that everyone is going to be rejecting. So I stay real guarded. I hide. But then I am alone and get more afraid there is something wrong with me. Then I take even less risks with people and they stay even more distant. It's kind of a trap, isn't it?

When we change level by going deeper, we dive in and help someone see the key sensations and meanings and motivations that construct their difficult experiences. Once you look closer and really open up to an experience, it starts to change. Amy also tells me,

> My family say I am distant and cold but really I am just sad, sad. Hurting. I wanted my Dad's approval so much and nothing I could do worked. I kind of gave up and closed down. I guess I am afraid that I will never have that – that message that I matter to someone.

At both levels, meta and under the surface or deeper, the way an EFIT therapist talks to clients constantly gives the message that, as human beings, we are always busy *actively constructing* our experience, putting it together, and deciding what it means to us. This focuses us on the *process* of construction within ourselves and with others. We could call this a meta-frame shift that is essential to EFIT.

Apart from changing levels, we also use a few different *orienting frames* to empower clients in this model and we will talk about them throughout this book. The first is the one above, the concept that experience and sense of self is a constantly evolving construction. Much of the time when we are in pain in our lives, it feels like things are simply happening to us. It's harder to tune into how we shape our own experience – the ways in which we make, and can therefore remake, our own reality. The second meta-frame that orients the EFIT therapist is the focus on the crucial nature of attachment and the traumatizing impact of aloneness. Third is the positive accepting frame for emotion – namely that it is an essential, positive, and logical information processing system that we cannot dismiss without negative consequences. Fourth, EFIT also ascribes to the Rogerian assumption that human beings are naturally oriented to growth and qualities like empathy for others. The therapist, then, does not need to teach qualities like empathy per se, but rather to discover the blocks to such qualities (such as constant vigilance for danger to the self), and help remove these blocks. The natural propensity of human beings if offered safety and support is to grow and expand. Lastly, we assume that corrective emotional experience is the royal route to significant change.

Before a therapist even reads about the ways of seeing human beings or influencing them presented in this book it is crucial that he or she is open to considering the five orienting frames outlined above, namely that: often it is not the content of our problems, it is the processes implicit in these problems – not the WHAT but the HOW. It is the way we engage with those problems that keep us stuck and with emotion and how we regulate it has priority in this process. EFIT adopts the attachment perspective that we are social bonding beings who need others even to hold onto a sense of self, and that everyone is oriented to growth in some way and can grow, especially by going into and exploring and engaging with previously avoided or denied emotions. The last point could be summarized by the two statements, "The only way out is through," (Hunt, 1998) and Alexander and French's idea that the essence of significant change is a "corrective emotional experience" (1946). We talk lots about how an approach to therapy has to "fit" the client but not so much about how models of therapy have to "fit" with the therapist. If, for you, emotion looks like a quagmire that always needs to be simply coped with or avoided, and the idea of needing others does not fit, then you might find it harder to tune into this book. We are going to try and open a few doors for you.

EFIT outlines for the therapist, an accepting non-pathologizing way of *seeing* clients – concise, theory-driven, and empirically supported ways of *intervening* with clients and a specific way of *being with* clients. Each of these is, in fact, a statement of values. The therapist's job in EFIT and in EFT in general, is to accept and believe in their clients as much as possible, to learn with and from clients in a respectful collaborative manner, to honor the

human drive for connection with others and positive dependency and to value science and empirical findings.

The Theoretical Base of EFIT

Let's get more specific. EFIT stands on three theoretical pillars. (See box at end of chapter.)

The view of human beings – their deepest longings, fears, strengths, and vulnerabilities – that permeates EFT in general and EFIT in particular, is the empirically based developmental perspective offered by attachment theory (Bowlby 1969, 1988; Johnson 2019). This perspective integrates a focus on inner life, especially emotion, with a focus on patterns of interaction with significant others. Bowlby (1973) noted that the therapist has to pay attention to the *inner ring* of patterns in a person's cognitive and emotional processing and the *outer ring* of circular interactional feedback loops with key others. As noted by Marcus Aurelius, "You cannot be a self all by yourself." Attachment theory, which has only actively been applied to adults in the last 20 years, has been noted as, "One of the broadest most profound and most creative lines of research in 20th century psychology" (Cassidy & Shaver, 2016, p. x).

Clinical intervention stands squarely on the humanistic experiential base first outlined by Carl Rogers (1961), and on the systemic base outlined by authors such as Salvador Minuchin (Minuchin & Fishman, 1981), who focused on self-maintaining negative patterns of interaction between intimates. It has been noted that our interventions are "like Rogers on steroids," perhaps because EFT primarily developed in the last three decades as a potent couple intervention and, in this modality, the therapist has to maintain a focus in the face of two clients in conflict. The typical EFIT therapist reflects more often and is more directive than Rogers in general. These two pillars of intervention, just like attachment science, integrate the intrapsychic and the interpersonal.

EFIT offers a unique combination of a broad, rich theory of human functioning with substantive empirical validation with classic methods of intervention made more systematic by years of outcome, follow-up, and process of change studies. The EFIT therapist has a clear model of who we are as human beings that fosters accurate attunement to clients, a clear understanding of dysfunction, and how to take different kinds of clients home to health and resilience. There is a *structure* to our emotional life and our relationships. With the map provided by the EFT model, and EFIT in particular, it is perfectly feasible to shape significant and lasting change in relatively few sessions with *on-target* interventions that are *organic* in nature – that is, they constitute biologically prepared learning. It seems to us that change events in EFIT are associated with lasting change (Greenman & Johnson, 2013) precisely because these events plug into core emotions, survival-oriented attachment

processes, and the core *existential dilemmas* that are part of every human life. As stated by the first author (2019, p. 5), "Over the lifespan, the need for connection with others shapes our neural architecture, our responses to stress, our everyday emotional lives, and the interpersonal dramas that are at the heart of those lives."

Attachment Theory and Science – The Way Forward for Psychotherapy

The basic tenets of attachment theory have been outlined in the EFT literature (Mikulincer & Shaver, 2016; Cassidy & Shaver, 2016; Johnson, 2019). We will summarize them here:

1. The longing for a felt sense of *connection is a primary need*, especially when threatened. This is a wired-in, survival-oriented response. Emotional isolation is inherently traumatizing. It primes helplessness and increases the likelihood of stress responses, depression, and anxiety while limiting resilient coping.
2. *A felt sense of safe haven* connection calms the nervous system and primes emotional balance. From a place of comfort and safe connection with others, distress is framed as manageable.
3. The emotional balance associated with a sense of secure connection confers a coherent, articulated, *positive sense of self*, and facilitates the congruent and coherent expression of needs.
4. A *felt sense of secure base* primes a sense of competence, autonomy – effective dependency. This base potentiates active exploration and learning. The more secure you are, the more autonomous you can be since you have an inner resource of secure attachment.
5. The key factors that define the quality of an emotional bond are ARE – *Accessibility, Responsiveness, and Emotional Engagement*. The key question in love relationships is, "ARE you there for me?" This translates into, "Can I count on you – do I matter to you and do you feel for and with me?"
6. *Separation distress* is primed when secure connection is lost. This results in a predictable process of protest (often angry), clinging, and, if there is no response from the attachment figure, depression, despair, and finally detachment.
7. Key bonding interactions are enshrined in mental representations – *mental models of self and other*. These show up as expectations, biases, beliefs, and habitual procedural strategies. They are experienced as reality itself.
8. In general, those who have experienced *secure attachment are more emotionally healthy and resourceful*. They are able to accept and acknowledge emotional needs, send clear coherent messages to others about these needs,

explicitly reach out to others, trust and take in care, and also give care with accurate empathy. They are more assertive and also more empathic.

9. There are *three insecure styles* or constraining habitual strategies. The first is *anxious or preoccupied* attachment. The anxiously attached are often hyper aroused, have high needs for reassurance and comfort, and are always vigilant for signs of rejection or abandonment. They often present as demanding and even angry, easily lapsing into separation distress and protest behaviors.
10. The second insecure style is *avoidant or dismissing*. Avoidants tend to try to minimize frustration or distress; that is, to stay in a state of hypo arousal by means of flight behaviors, the minimization of need, and avoidance of close connection. Perceived vulnerability in self or others triggers shut down and distancing.
11. A third insecure style most often found in people who have experienced complex trauma at the hand of attachment figures, is called *fearful–avoidant* or in children, *disorganized*. Since others are experienced as both a source of fear and of solace, the fearful–avoidant person tends to flip between the hyper arousal typical of the responses of more anxious individuals and the dismissing responses of avoidants.
12. Strategies can be adaptive or become insecure styles, often habitual, rigid, generalized, constraining. *Styles can change over time*. A recent study of EFT with distressed couples found that insecure styles changed over the course of couple therapy (Burgess Moser et al., 2015), and was associated with the occurrence of key bonding conversations in therapy. These styles remained changed in the direction of secure attachment at follow-up (Wiebe et al., 2016).
13. *Insecurity is a risk factor for almost all problems in adaptation* and all mental disorders. The severity of depression symptoms has been linked to insecure attachment in over 100 studies, avoidants tend to move into perfectionism and self-criticism, while more anxious folks tend to struggle with loss, loneliness, and a sense of abandonment (Johnson 2019). Borderline personality disorder is associated with extreme anxious attachment, while addiction is associated with an avoidant style. Anxious and fearful–avoidant styles have been linked to anxiety disorders. High levels of insecure attachment also seem to predispose someone to PTSD.
14. In adult relationships, attachment is reciprocal with both partners ideally reaching and supporting each other, while in parent–child relationships, the parent is the stronger, wiser other who shapes secure attachment for the child. In adulthood, attachment realities are held in cognitive representations or mental models so adults can be comforted by just recalling an attachment figure. *Adult attachment relationships are also sexual and concerned with caretaking*. "Secures" enjoy more satisfying sex (Birnbaum

2007) and security is closely linked to the quality of caretaking. Secure partners are generally more attuned and sensitive caretakers, being willing to offer closeness, and are less concerned with regulating their own anxiety so are more focused on the other. In relationship distress, a highly anxiously attached adult partner is often blaming or demanding in an attempt to get a more withdrawn and avoidant partner to respond. (See box at end of chapter.)

EFT in general and EFIT in particular capture the essence of attachment theory and its implications for practice (Johnson, 2019). Specifically, attachment theory stresses the crucial and central importance of emotion and the active processing and regulation of emotion. Co-regulation of emotion with another is seen as a baseline process and generally more efficient than relying just on self-regulation processes (Coan, 2016). The experience of, "frightening, alien or unacceptable emotion," is seen as key to clients' problems (Bowlby 1988 pp. 138–139).

There are many parallels here between Rogers and Bowlby. Bowlby, like Rogers, honored emotion and saw the inherent logic and reasonableness in emotional responses, taking an accepting and validating stance toward them. Bowlby suggested that a therapist not try to argue an angry grieving client out of their anger but join them in their angry response and accept and explore it. Both saw emotional range, variety, and flexibility as key to healthy functioning and the denial, fragmentation, and blocking of emotion as problematic. Attachment offers a map outlining the basic longings and fears – human misery and motivation – that is consonant with the humanistic experiential approach of Rogers.

EFIT as a Rogerian-based therapy also focuses on the creation of a particular kind of attachment-oriented alliance – a safe haven alliance with clients (more on this in Chapter 3). The therapist, like any good attachment figure, is ARE – accessible and genuine, responsive, and emotionally engaged. The focus of therapy is the personhood of the client, not his or her problem or coping per se.

There is also in EFT and attachment theory, a joint and interacting focus on both within (intrapsychic) and between (interpersonal) experience. Indeed, the self is viewed as an ongoing process rather than a product or object, one that is defined constantly in interactions with others. The dancer and the dance with others are constantly interacting. Relational dramas are the sea that we, as fish, swim in. It is hard to separate them in therapy and in life. Attachment links biology; for example, the functioning of the nervous system to patterns of interaction with key others. EFIT therapists are always process-oriented. They are focused on how patterns of affect regulation and expression prime and reflect patterns of connection and distance in key interactions with others.

Finally, both attachment and the EFT experiential perspective are research-oriented and empirically based (see www.iceeft.com for a summary of EFT research), and research is fostered by the clear relevant and coherent vision of healthy and less than healthy functioning offered by an integration of attachment theory and EFT.

The issue of the goal of therapy is also relevant here. It helps tremendously to have a clear sense of where we are headed in the journey called therapeutic change. What are we aiming for in an experiential attachment-oriented individual therapy and how do we know if we have succeeded? In terms of health and the goal of EFIT, the image of health offered by attachment theory parallels the goal stated by Rogers (1961) for experiential therapy. Secure attachment shows up as a felt sense of security which translates into a competent and worthy sense of self that is open to and can use the ultimate resource, the support of others, to take risks and explore the world (Feeney 2005). This echoes Rogers' concept of *existential living*. This is characterized by openness to the flow of experience, trusting this experience, and being able to use it as a compass – a guide in life – actively choosing perspectives and responses while taking responsibility and being open to growth and ongoing development. The goal is, then, not to simply increase our clients' ability to cope with or understand their problems but to shape a corrective growth experience that fosters development into a more fully functioning person. Rogers suggests that this is marked by an "underlying confidence in themselves as trustworthy instruments for encountering life" (p. 195). The way this confidence manifests is that clients begin to trust in their ability to grasp and make meaning of their own experience and to use that understanding to guide them through life.

Goals of EFIT

If we become more specific, then the goals of EFIT are:

1. To offer corrective emotional experiences that positively impact models of self and other and shape stable, lasting change.
2. To offer in session transformative moments where vulnerability is encountered with emotional balance and difficult emotions are ordered and made specific and coherent.
3. To enable clients to move into the accessibility/openness, responsiveness, and full engagement that characterizes secure connection with self and others, which in turn optimizes personal growth.
4. To enable clients to shape a coherent sense of a competent self that can deal with existential life issues and become a fully alive human being.

So Amy is able to tell the therapist at the end of 15 sessions of EFIT:

> I don't go down into that panic anymore, that sense that I am somehow the most defective person in the world and will always be alone. It's exhilarating somehow to make sense of all my turmoil and see that I am really not so strange. I like me more and l don't have to try to numb out all the time even if I feel down. And I can tell my mum and my boyfriend what is happening and ask for what I want now. So life is different. I feel more hopeful, and more … well … more me – the me I want to be.

Theory of Intervention – Rogerian and Systemic

As suggested above, we can imagine that EFIT practice reflects a conversation between Carl Rogers (1961) and Sal Minuchin (Minuchin & Fishman, 1981), while John Bowlby reminds them that human beings are bonding mammals who function in an inner and interpersonal context where their relationships with others are a dominant reality.

The key tenets of experiential Rogerian therapy most relevant for the practice of EFIT are the following:

- The focus of therapy is the whole person not the problem, per se. So therapy begins with joining the client in their distress and discovering their experience with them, not with pinpointing a problem to solve.
- The therapist focuses on *present process* – how inner and between realities are constructed and are constantly confirmed in the present, rather than the content of issues. The past also becomes present when infused with immediate emotion.
- The focus of therapy is on evoking and deepening engagement in new *experience*, not new explanations or solutions, per se. If the client does not go to the level of being absorbed in new experiences, then any change will tend to be temporary and superficial. It is potent new emotion that moves the client into new responses. Emotion orients and organizes dancer and dance.
- The acceptance of the therapist is an essential ingredient in the change process and a prelude to the client's acceptance of self.

So the therapist will look at the whole person in context, not just their presenting problems. He or she will redirect in therapy toward a focus on discovering and deepening felt experience in the present moment, as in, "What happens to you as you say this, right now? Where do you feel that in your body?" He or she will also constantly construct emotional safety and acceptance in the session with empathic reflection and validation, as in, "This is so hard. We all struggle with this. I can feel how sad this is for you and you have all the reasons in the world to feel this pain. You are so courageous to stay with this."

Therapists familiar with the typical interventions of experiential approaches will resonate when we say that empathic reflection and responsiveness is the most basic and constantly repeated intervention in EFIT. We call this a micro-intervention and will list these in Chapter 5 with other interventions typical of experiential approaches, such as *evocative questioning*. We will also outline the macro-intervention sequence, the EFT Tango. The reflections used in EFIT, however, seem to us to be more targeted, intense, and systematic than is often the case in Rogers' sessions. They not only create safety in session, they also better organize and distill core emotional experiences.

The key tenets of systemic therapy that are most relevant to EFIT are the following:

- There is a focus on self-sustaining interpersonal patterns and processes. Different contexts evoke different aspects of self and different strategies.
- Change has to focus on the *leading or organizing element* in a relational system to shape what Bertalanfy (1968), the father of systemic approaches, called second-order change, rather than just symptom modification. The EFIT therapist sees that it is emotion that mostly organizes our within and our between worlds. We should also note that classic Minuchin interventions tended to sideline emotion, missing the fact that they impel key patterns of interaction; this is a limitation from the EFT perspective.
- Open flexibility is a sign of health. In the systemic perspective, there is a focus on stuck negative circular feedback loops in experience and interaction and disrupting such loops in session.

Therapists familiar with the typical interventions of systemic approaches will resonate when we say that the EFIT therapist often reframes interactional dramas, as in, "Sounds like you had lots of impact on your mother really; she got so angry because you were important and hard to dismiss maybe, not because you were such a bad daughter." The therapist also shapes new kinds of interactions that clarify stuck places or turn new emotion into new signals – new moves – with key attachment figures. In EFIT, these interactions are mostly imagined since the attachment figure is not present, but they may also be with the therapist or a part of the client's self. These systemic interactions are also outlined in more detail in Chapter 5.

So the EFIT therapist might comment as follows.

Therapist: This is something that happens often isn't it? You worry about talking to your partner and lots of vulnerability comes up, not because you are somehow 'weak' as you suggest, but because you have been hurt so much in the past and want to protect yourself. So when you go to him you are, what did you say 'tense and curt' and unable to get clear, and then he

dismisses you – does not hear you. So you feel terrible, withdraw and become even more 'confused' is this right?

The client agrees with this description of a process pattern.

Therapist: So can you imagine he is here right now? Can you just try closing your eyes and telling him, 'I am so worried and unsure when I come to talk to you that I cannot find my words. Then you do not hear my message. And I kind of give up and go away and feel terrible.' Can you tell him your own version of that?

In light of the changes in the therapy world as a result of the pandemic, it seems important to say that, in the clinical experience of the authors and therapists in our practices and supervisions, the EFIT approach and its interventions work well in an online format (Johnson 2020 – Networker). In fact, the therapist's ability to create an ongoing safe haven alliance and evoke, heighten, and use emotion, as well as the systematic focus and nature of EFIT interventions, enables interventions to reach their mark just as in sessions in the office. This appears to be true across all three stages of EFIT – Stabilization, Restructuring, and Consolidation. Even in key change events in Stage 2 – Restructuring, when there are often intense and dramatic moments, therapists are able to keep the client engaged and to intervene effectively. EFIT interventions enable the investment and active engagement of the client in session even if the therapist is not in the room. It is also important to note that the therapist is attuned and emotionally present even when on a screen.

Why a Therapist Should Trust This Model – The Strengths of EFIT

What are the obvious strengths of EFIT as a model? They can be summarized as follows:

- EFIT is based on 60 years of attachment science which offers the therapist a clear developmental understanding of human personality. This science now constitutes thousands of studies across many different kinds of people, cultures, and clinical symptom groups. It has already revolutionized how we see and relate to our children and deepened our understanding of adult love relationships (Johnson, 2008; 2013), and has much to offer as an integrating framework for psychotherapy as a whole (Johnson, 2019).
- EFIT has benefited from research and more useful formulations of emotion that have emerged in the last few years (Barret, 2004; Johnson, 2009) and from the research on neuroscience (Greenman, Wiebe, & Johnson 2017; Johnson et al., 2013 – PLOS One).

- EFT has systematized and refined interventions in over 20 outcome studies which have also made it the gold standard for empirical validation in the couple therapy field. The data on the first study of EFIT, an online study, are very promising. (In progress.)
- There are nine studies of the change process in EFT for couples (Greenman & Johnson, 2013). It is clear that the variables, deeper emotional experiencing in session (an individual variable), and more authentic and engaged interactions with attachment figures (in couple therapy the other is present – in EFIT they are present only at the level of representation), predict success in EFT therapy. Specific change events that are saturated with attachment-oriented emotions and new, more open interactions with others have also been specified and shown to predict the outcome and positive follow-up. Follow-up studies have shown positive results for couple variables and for individual variables such as depression and anxiety.
- A groundbreaking study of the impact of EFT for couples on individual partners' attachment security was published in 2015 (Burgess Moser, et al., 2015). This showed that EFT interventions were able to produce an increase in attachment security in 20 sessions with distressed and insecure couples and this lasted through follow-up (Wiebe et al., 2016). We can assume that the myriad strengths associated with more secure attachment then became available to these partners. This includes a safe and sound sense of connection with key parts of the self and with others.
- EFT, albeit mostly in the modality of couple therapy, is used with reported success all over the globe across varying cultures, religious groups, and ethnic groups, as well as with clients of different sexual orientations and co-morbidities, such as depression, anxiety, trauma, and stressor-related disorders. The evidence is that it is a widely applicable and generalizable intervention.
- Training in EFT and in EFIT is standardized and systematic and is widely available online and in person (see www.iceeft.com). Research on trainings suggests that key trainings create shifts in perceived personal competence as a therapist and also have positive personal impacts (Sandberg, Knestel, & Schade, 2013; Montagno, Svatovic, & Levenson, 2011). There are also many resources to help therapists learn this model, including many training videos of real sessions. Over 80 professional EFT communities also exist around the world to support therapists to learn and explore this model (listed on www.iceeft.com).
- Finally, EFIT is one of the few therapies that offers a map to the phenomenology of key emotions and motivations, key self and relational system defining moments, and that also outlines tested, pivotal moments in the change process. As clinicians, we know that the EFIT perspective is relevant to clients, that they see it as on target. The frame offered in this

model fosters levels of accurate attunement on the part of the therapist that can be seen first-hand in training videos of live sessions.

In short, there are many reasons to believe that these interventions work, that we know how they work, and that they are highly reproducible with many different kinds of clients. There are also many resources and skilled teachers to help you learn them.

However, in the end, we hope that none of the above will influence you as much as your personal experience when you watch sessions of EFIT and even of EFT for couples and EFFT with families, when you read the transcripts offered in this book and others, and when you try out EFT interventions for yourself. This book is a primer but it will give you the basic framework for EFIT. We will point out common mistakes and stuck points as we help you out when you go down what we call "rabbit holes" and cannot find your way out. We also recognize that, like any complex activity, it will take time for you to be able to move fluidly through this model and make it your own. But you have already taken the first step!

Play and Practice

For You Personally

Exploring the Impact of Contact with an Attachment Figure

Find a quiet place where you feel comfortable and relax. Identify a person in your past or present life who you feel safe with or remember positive connections with. This can even be a spiritual figure if you wish. Sometimes someone can be important because they gave exactly what was needed, so this person could be a very temporary relational figure.

Now close your eyes and think of a vivid and upsetting personal experience/memory that still has the power to rev up your nervous system and make you uncomfortable. See if you can pinpoint the trigger – the moment or feature that really upsets you. Let yourself feel this upset in your body.

Still with eyes closed, imagine a situation where you are with your positive attachment figure – perhaps sitting opposite him or her. Make an effort to notice this person's face and general presence. See if you can, now, in a simple direct fashion, tell him or her in one or two sentences, the most painful part of this memory – the nub of it for you.

This is in your imagination so you can risk and be open. If this is just too hard to do, try telling this person what you want to talk about but that it is too hard to share it. See if you can imagine what happens if you share this reluctance.

If you can share more openly, imagine telling this person what you need right now – what would comfort and console you? Make this request as simple as you can. Imagine this person's response. What is the key message you hear?

Let yourself feel this in your body and check in with your emotional state. What impact did this imagined conversation have on you?

For You Professionally

What would you say if I asked you about your present theory of how things go wrong for people – how they end up depressed or anxious? What do you think the key factors are? See if you can write them down in one paragraph.

What would you say if I asked you about your theory of intervention and how positive change occurs? What do you think are the key factors that shape change? What therapist interventions are crucial and make all the difference to your clients?

What concept or set of ideas most resonated with you in the previous chapter?

What concept – if any – puzzled you or made you uncomfortable? See if you can formulate a key question for yourself around this.

BOX 2.1

Five Orienting Frames Guide the Practice of EFIT

1. Self and experience are actively constructed in the present. Past comes alive in the present – present process is the focus.
2. Attachment is wired in like our need for oxygen – isolation is traumatizing.
3. Emotion is adaptive; denial and dismissal have negative consequences.
4. Human beings have a natural propensity to grow and self-actualize unless blocked.
5. Corrective emotional experience is the royal route to change.

BOX 2.2

The Three Pillars of EFIT

1. The view of human functioning offered by attachment science.
2. The Rogerian experiential framework for intervention based on acceptance and safety.
3. The systemic/relational framework for intervention based on shifting process patterns structuring inner and between worlds.

The Integration of the Above Renders EFIT – On Target, Organic, and Existential in Nature

BOX 2.3

Key Concepts in Attachment Theory

- Connection is a primary need – loss is traumatizing.
- Safe haven primes emotional balance.
- Security shapes positive identity.
- Secure base primes exploration – autonomy.
- ARE – "Are you there for me?" defines attachment quality.
- Separation distress is a set process.
- Attachment shapes mental models of self and other.
- Secure connection is best and primes health and adaptation.
- Insecure styles are anxious, avoidant, fearful–avoidant.
- Insecurity primes mental health problems.
- Adult attachment structures sexuality and caretaking.

BOX 2.4

The Core of Clients' Emotional Problems, according to Bowlby

- Frightening emotion.
- Alien emotion.
- Unacceptable emotion.

These constitute a lack of emotional balance and agency.

BOX 2.5

10 Ways EFT Brings Attachment Science into Every Session

1. Create an A.R.E. alliance. Therapist as safe haven. To Belong leads to Become.
2. Eye on the prize. Goal is GROWTH — secure sense of self and other — balance — wholeness.
3. A focus on emotion — primary organizer of within & between realities. Evoke & Regulate "frightening, alien and unacceptable" emotions.
4. Specify observed process in present — patterns & cycles — inner & between circles.

5. Co-regulation is key. Use wiser self & attachment resource figures to shape resilience.
6. Non-pathologizing. Validate/Affirm stuck protection strategies as "perfectly reasonable," normal. Find rationality/order not pathology. Experiencing process is STUCK — person is accepted.
7. Attune accurately. Use the attachment map to longings, fears, needs and protective moves as COMPASS. Fear of rejection/abandonment cues existential isolation, emptiness, hopelessness.
8. Privilege disconnection — aloneness — isolation as traumatic — vulnerability that has no solution — iatrogenic.
9. Craft corrective moments — sing to the amygdela. Lead into and through vulnerability.
10. Get out of the way of organic wired-in growth process — dissolve blocks and let it happen, e.g., adult self offers helpless self a safe haven.

Attachment facilitates on target — organic — existential change.

3

Shaping Safety

How Does the EFIT Therapist Engage the Client?

Soundbite Answer to Question
The therapist enters into a genuine encounter with the client with the immediate goal of providing clients with a secure base from which to explore and grow. As the temporary attachment figure, the therapist is an ally and guide in moving the client toward a felt sense of security, in themselves and in their key relationships. The therapist is both choreographer and dancer, at times leading, and at other times following.

As stated in the basic text on couples EFT (Johnson, 2019), the therapist is not a coach correcting misguided assumptions or teaching skills or a wise creator of insight. Rather, the therapist is a process consultant who accesses and walks into painful experience *with* clients (as in the old adage, the only way out is through) and collaboratively joins with them in processing this experience more fully. As Rogers suggests (1961), the process of therapy is one in which the therapist and client can, "Enjoy discovering the order in experience" (p. 24). The normalizing of our limited ability to process our experience in the most constructive way, our blind spots due to our history and our inevitable struggles in the face of life's demands, is perhaps the key feature of the humanistic experiential or person-centered approach. Central also to this process for Rogers is the therapeutic alliance, characterized by empathy, unconditional positive regard and congruence.

Consistent with this stance and borrowing also from the wisdom of Bowlby, Accessibility, Responsiveness, and full Engagement (ARE) are considered

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the cornerstones of a *safe haven therapeutic alliance*. In this kind of alliance, the therapist first attunes to and meets clients where they are, in the present process, discovering with each of them how their "current dilemmas make exact and exquisite sense" (Johnson, 2019). In the company of a safe other, clients can then begin to explore unfamiliar or frightening territory, deeper feelings and experiences. As their awareness grows, so too does their capacity to manage vulnerability. Previously rigid and restrictive coping strategies become more flexible. Along with momentum, trust in the therapist and the therapeutic process builds. Blocks to growth are dislodged. New ways of engaging with self and others emerge. With a steady alliance as the core and grounding force, the therapeutic process gives clients the wings to soar and thrive.

The example to follow provides an illustration of a first session with a client conducted by the second author, Leanne Campbell. Transcript excerpts are edited somewhat for clarity and brevity. As highlighted above, a key goal here is to create a *safe haven alliance*. Here we introduce you to Sandy. We will be visiting her progress again in Chapters 9 and 10.

Sandy came to the initial session casually and neatly dressed, her hair nicely styled, and her attire tastefully accented with hints of jewelry. Her nail color mirrored her hair, both dark and shiny. She sat upright in her chair. She was open and forthright in providing a clear and coherent narrative of her history, beginning in childhood up to the present. In response to a few prompts and questions, she carefully chose her words and told the story she had told many times before. Occasionally, she was tearful but mainly she appeared stoic.

Viewed through an attachment lens, I hear about her childhood history in rural Canada, her development punctuated by various incidents of abuse, beginning with childhood sexual abuse, along with bullying in late childhood, later followed by a sexual assault in mid-adolescence. She generally paints an early childhood picture of family and social disconnection.

By the time she left her rural community to attend university in a larger center, her ability to manage relationships was marred by the past. "I didn't really know how to navigate intimate relationships," she said, and added, "I felt like anyone who was interested in me was just interested in sexual relations so I ended up using that a lot to guide my way through." She dated, some good and some bad, and one short-term relationship in particular involved stalking and intimidation. In her early 20s, she accepted a proposal to marry a "high school sweetheart." Soon after, she accompanied her husband to another rural community. Quickly disillusioned by the relationship, she left that marriage after about 18 months. "Looking for some validation, I guess, and some personal value," she explained, she moved on to another relationship that was both emotionally and physically abusive (including police involvement).

At the time of our first meeting, now in her early 40s and with a family she never thought she would have while in her 20s and early 30s, Sandy is now

with her "perfect" partner of about 13 years. She describes him as supportive, hard-working, and a "great dad" to their two young children and her now-young adult stepson. Though the current picture is much different than that of her past, she cannot find happiness. She feels undeserving of what she now has, her material possessions in particular but also her family, including her children. Caught in the thoughts that haunt her in the early morning hours, she is convinced her family would be better off without her. She believes that she is doing damage. Thoughts of suicide are pervasive. Her plan is clear.

Attempts to establish a safety plan and commitment to the process early in this initial session are met with resistance. She refuses to make any such commitments to her partner, in spite of his love and support. She does not share his views of her and she does not believe in his love. Attempts to evoke a commitment to her children are similarly met with an unwavering stance. She provides a clear and cogent argument, logically outlined, for the ways she is harming them. She is short-tempered. She is easily overwhelmed. She lashes out at them and her partner. Mornings are stressful and by the time she gets the children to school, she is exhausted. It is easier to park at the beach for long periods than to go to work. All such behaviors are evidence to her of her unworthiness, of her inability to cope, and the clarity she holds onto surrounding the option of suicide.

Drugs and/or alcohol have never been a source of refuge or a big part of her social life. No one has ever provided a specific diagnosis. She describes her struggles as indications of depression and "some category of anxiety." She has intermittently attended counselling since her early 20s, but nothing has helped.

Sandy: I feel like I've tried everything, every type of counseling, everything that is mainstream, everything that's not mainstream, books and hypnosis and talk therapy and tapping and I just feel like if it's out there, I've tried it. I've taken, it feels like, every kind of medicine under the sun; some made things worse, some made things better for a little while. I'm medicated now and don't feel like I could, that I would do well without it.

Sandy indicated also that though her partner would likely be there for her during times of need, she does not tend to ask. She does not want to be a burden. About six months prior to the initial consultation session however, she did confide in him.

Sandy: If I can't sleep, he'll wake up if I'm crying and we'll talk. I don't remember when it was, maybe six months ago … was probably as hard as things have ever been for me. I can't really narrow down why but it was

> the first time I was so low that I found the courage to tell him that I do consider taking my own life. Our family would do better without me.

She then goes on to say that he was compassionate, that he asked her to promise that she would not follow through on any such plans, and that she refused. In her words, during such times, she does not feel in control and she would not want to break a promise to him. Finally, she agreed to commit to a safety plan for the period we had agreed to work together (at that point, six sessions). Nonetheless, her sense of despair and hopelessness was palpable and her skepticism and dark piercing eyes filled the room (and my body) with a tight pressure. Her account of her history, while clear and cogent, was conveyed with a sense of detachment and with an undercurrent of threat and resignation. It was as though she had made a pact with herself.

As in other therapeutic modalities, the therapeutic alliance in EFT is paramount. It is particularly important when the risk of self-harm is high and resources, especially social support, are low. In this case, Sandy tells me her partner is "perfect" but somehow this does not make a difference. She does not want to rely on him or reach to him and when he offers gestures of love, she does not believe him. She cannot take it in.

With a focus on the primary goal in the initial sessions of EFIT, developing a safe haven therapeutic alliance, I am aware that it is easy for me to connect with Sandy. She is bright and captivating. She is engaged with me now and has committed to a series of six sessions but I also am acutely aware of the strong sense of hopelessness she feels, the destructive options she has considered, and the intellectual position she has taken on this and other matters, with herself and her family, and now with me. I could share with her the strong evidence base for EFT and couple therapy and my years of experience and positive outcomes working with individuals, couples, and families but this would undoubtedly take us down a "rabbit hole" and into an intellectual discussion – worst-case scenario, a debate, with Sandy likely to leave this initial session feeling that she had once again told her story to no avail. I could perhaps talk about the research evidence surrounding the impacts of suicide on children, with the hopes that I might outwit her propensity to rely on logic and try to convince her of a potential flaw/hole in her argument that her children would be better off without her. This too would undoubtedly take us "down a rabbit hole" and potentially leave Sandy feeling the same lack of control and helplessness she felt as a child, when she felt alone and misunderstood. None of this would provide Sandy with a sense of hope.

As I regain my balance against the gravity of her threat, I tell myself that the only thing that will breathe hope into the therapeutic process is to provide her with a *different* experience. With a focus on attachment and with the goal of harnessing the power of emotion, I endeavor to create some type of new

experience for Sandy that will give her both a felt sense of something new and provide a platform from which to delineate the therapeutic roadmap. To echo a previous client as he prepared to share his love with his disillusioned and mistrustful partner, I recognize that "words alone will not cut it."

Now almost 50 minutes into the first session, Sandy has returned to additional details surrounding her experience of bullying. She tells me about an incident. She "had had enough." She "walked up to the girl and pushed her down onto the ground and hit her." The other girls came and pushed Sandy off this girl. Hoping that things might be different, she recalls that she had told her mother, who was working at the school, about the bullying. All of the girls ended up being given "equal punishment," mostly detentions. Again, Sandy felt alone and dismissed. The bullying continued for another four years and in Sandy's words, "my mom's hands were tied." At this point in the interview, Sandy begins to tell me about the origins of her coping strategy.

Sandy: I thought if I just had a retort for everything they said or an answer for everything they came at me with. I was a bright student. Moving forward from there, I found and still find that knowledge is my best defense. If you have the right answer, then people tend not to make you the butt end of things.

She then continues.

Sandy: I tend to feel like the bad things that happen to me in my life are my fault. Even when people are mean to me, or take advantage of me, I tend to see their side of it and think, "Oh, maybe I did deserve that, maybe I did have that coming."

Indeed, as I sit with Sandy in this first session, I recognize this means of coping. From her detached and intellectual stance, her argument for suicide is loud and clear and now she is also giving me a glimpse of her model of self. I take note and continue with the session, now beginning to shape an encounter with this younger self who was bullied. The encounter provides a means of assessing the distance between these parts of Sandy (i.e., level of integration), as well as an opportunity to introduce the therapeutic approach. Sandy has the personal resources to handle it. Anything less than a *new experience* is going to fall short of having any impact. I proceed.

Therapist: Sandy, you were ten years old when you got those detentions? Can you see yourself at that age? (She nods.) What do you see?
Sandy: Very scared.
Th: Do you see her little face? Her eyes? (I focus on the eyes as a means of eliciting direct and explicit contact. Sandy again nods.) What do you see in her eyes?

S: Distrust. The other girls would pretend to be my friend and then the next day they're doing something mean. It was all a vicious little game.

Th: Sandy, will you share more with me, what you see? Do you have long hair, short hair? Dark hair? (Elicit details to deepen experience.)

S: No, sandy blonde and short hair, always short. (Therapist nods.) My mom cut our hair at home, it was fine and wispy. I was rail thin, tall, "Big Bird." I had to play Big Bird in one of our school plays and it stuck. Not a pretty girl at all, hand-me-down clothes and plain.

Th: Sandy, can you see her now? Do you see her? Can you see her eyes? Sandy, you did such a good job earlier of going to the gut part of you, the body part of you, if your body could speak to her, what would it say, in her eyes? What would you tell her? (I explicitly reference the body to take her away from her intellect.)

S: I don't know what to say. I don't want her to have to go through that. No one's going to help her … no one … she'll be alone.

Th: It's true, we can't rewrite history, but now she's not alone because she has you, right? Just now, in this room, I know it seems not true but it's sort of true, right? I feel like you're so good at being here with her and so good at describing her. I feel like I can see her beautiful little face also. That's right, as a little girl, she didn't have the adult part of her, she couldn't rely on the adults around her, she didn't have anybody. It's true that she was alone but now, maybe, we can go back there and revisit that moment. Now you are an adult, you have shown so much resilience, you are a parent to three beautiful kids, you've been an amazing caregiver to your father and a support to your siblings, to so many people. So, there's some part of you that still lives in her little body and feels like, somehow, if all these bad things happened, I must have caused it, but there's this other part of you that knows, of course, it's not true.

The interactional sequence above highlights the experiential aspect of the EFT model. With one of the key end goals in mind, to shift Sandy's model of self from feelings of worthlessness and self-loathing to a more positive, secure, integrated, and balanced self, and with the more immediate goal of instilling a sense of hope and diminishing suicide risk, I invite Sandy to enter one of the many poignant scenes she has described and that have shaped her views of self and others. To establish a safe haven therapeutic alliance at this point in the process, I tell her I will accompany her. I will be there too. I ask for details. I want Sandy to embody the scene as fully as possible, with all her senses, and I want to see what she sees and get a felt sense of her experience. As I ask Sandy to tune in at a deeper and broader level, away from her intellect and storytelling, I also stay attuned to these other channels characterized by attachment, emotion and context. I begin to see ten-year-old Sandy in more

vivid detail, in rural Canada, a harsh climate, miles of land between farms, a small school with few options, a young girl facing life alone. Her parents are hard-working and well-meaning but are not able to be fully present for Sandy during various times of need. As the session proceeds in the transcript below, we begin to shape a new story, one that does not leave Sandy alone. It instead introduces not only the therapist as an older, wiser other, but also an older more resourceful Sandy. With another of the key end goals in mind, to facilitate shifts in model of other such that Sandy might begin to believe some of what her partner says about her and take in the love he tries to provide, her partner is also invited into the scene as a resource.

I begin by encouraging Sandy to speak to her younger self from this part of her that she does not normally embody.

Therapist: Whatever is in your gut, you can just talk to her and I'll just be here with you both, whatever your gut would want to say to her … (I want to keep Sandy "out of her head" and instead encourage her to access and speak from a different part of herself, the more vulnerable part of herself that she does not normally engage with or rely on.)

Sandy: That I'm sorry that I can't go back and change it and make it better but there are good days ahead and bad days ahead too …

Th: Can you see her little eyes when you say that? What happens in her eyes when you say that? (This is a direct inquiry as to the impact that she can have on that younger self. Is she able to take in what older Sandy is providing?)

S: She's a little distrusting …

Th: She's scared to believe, there's a part of her who's scared to believe. Is there another part of her that might have a different reaction, or not so much? (I validate younger Sandy's fear to believe things could be different and legitimize her present sense of mistrust.)

S: She wants to believe, wants to think that it's true, that someone would care enough for her to want to make it right … but …

Th: Can you tell her what you feel about her?

S: I think she's awesome, she's really, really awesome. She runs around. She likes to play in the trees. She loves animals and dreams about being a veterinarian.

Th: Look at her again and tell her, "You're awesome."

S: I think you're awesome.

Th: It's good to breathe Sandy, you're doing amazing. (I notice her body language; she is restricting her breathing; I want her to fully embrace this initial attempt at challenging her longstanding view of herself.)

S: She should know that most people are going to underestimate her and she doesn't have to believe them.

Th: Sandy, is she taking this in from you? (She nods.) Is she? That's good. What do you see in her little eyes?
S: A little brighter.
Th: A little bit brighter? That's so nice. (Draw attention to/make explicit any shifts.)
S: I would hug her and hold her.
Th: You'd hug her?
S: She's so skinny.
Th: You could, in this scene, in this moment, you could hug her. It's so nice, this tiny little thing, what does she do when you hug her?
S: She hugs me back really hard.
Th: That's so good. That's perfect, Sandy. That's excellent. Does she breathe with you? And me, I'll breathe too. What do you see and feel now? (As she breathes, as we breathe, and as she makes space for this new experience, I ask, "What happens next?")
S: I don't want to leave her there. I don't want to leave her alone.
Th: That's a good idea, what feels right to you?
S: Just to keep holding on to her, to make her feel safe.
Th: That's perfect, that's right, because she was alone, you don't want to keep her alone. Sandy, do you have a sense of how you can keep her close to you in the days to come? (Rather than providing direction here, I follow Sandy's lead. I come alongside her and "work with her" rather than seek to provide advice. That is, as a process consultant, I attend to process and notice that Sandy is still tuned into these other channels – away from her intellect. While there, I know that she can begin to rely on this different way of being to guide herself and the therapeutic process as it unfolds in the here and now.)

At this point, I talk to Sandy about keeping that younger part of her close by. I then move to ask Sandy about her sleepless and tearful nights. She tells me that she awakens to bad dreams a few times weekly. Themes involve violence, either toward her or someone she loves. She is unable to stop it. She is unable to speak. She tries to scream. Viewed through an attachment lens, I hear Sandy say, "I am silenced. I am invisible. I don't matter. I am powerless." I then reflect, "You feel helpless." Sandy nods and explains that she then gets angry and frustrated. I reflect, "You feel out of control." I then inquire about her younger self. Sandy tells me she does not think about or dream about her younger self, about her childhood, during such times.

At this point, again, I could move to explanation and talk to Sandy about what we understand about dreams, what these dreams might represent and the ways that dreams help us process difficult material. This is another potential "rabbit hole." I decide against this. This would most likely take us into a

more theoretical and intellectual discussion. If I want Sandy to stay tuned in and focused on this encounter with her younger self, I need to stay there too. Having said that, if Sandy had said she dreams about her childhood, about that younger self encountered in session, this might have provided an opportunity to maintain the connection during times of need (during these sleepless nights). This was not the case. As I continue toward closure, I strive to maintain focus.

Therapist: Sandy, what feels right? When we wrap up today, is there somewhere you'd like to take her? Or something you'd like to do with her, that image?

Sandy: Just go home.

Th: Home is safe. (She nods, and adds, the kids will be home, her partner Jake will be home.) Sandy, one more thought, you can see her? Can you see Jake? Can you see him looking down on her, could you imagine that, both of you? (Sandy nods.) Sandy, you're so good at this, I think he's an amazing resource. (Sandy agrees.) You don't even have to say anything, whenever you can, bring her in the room, you don't have to tell anybody anything. You can just have her there at the dinner table and out for ice cream. Whatever feels right. And when the darkness comes or the helplessness comes, have both those parts of you in the scene and bring Jake in also. It's so impressive that she's so brave to take it in, she's so brave to accept it, she's so brave to let you hold her and hug her and tell you, "Don't let me go," which is exactly the right thing. You don't want to let her go … it's good … (Long pause.) Sandy, could you promise her you wouldn't hurt yourself? Could you promise her that?

S: I think, of anybody, she would understand the most, if I had to …

Th: Right, so that's not a promise you would make to her either? Okay, would she promise you? Sandy agrees that she would.

Assessment and treatment merge in EFIT. Younger Sandy was able to take in some of what her older self was able to provide. This is a good sign. Using a classic EFT intervention, to heighten and repeat key phrases, "You're awesome," little Sandy's eyes brighten slightly and so too, I am anticipating, does hope in the process. In the excerpt below, I check it out. Does this feel different? If yes, I want to be sure that Sandy leaves the session with this made explicit. The old templates (attachment strategies) are rigid and longstanding, and likely to quickly re-emerge in the wake of only a brief, albeit positive encounter and associated new experience. I also want to try to help Sandy build on the work she did here between sessions, not by providing classic homework per se, but instead by priming ongoing connection between these aspects of self and by ensuring that this younger self now feels held by others,

her older wiser self in particular, but also her husband, and as Sandy suggests, is no longer left alone.

Therapist: I don't know if this feels different than other kinds of therapy, understandably, it stirs stuff up, that's part of the reason I want to make sure that we keep you and her and everybody safe. I'm totally confident that there's going to be movement forward. I think there already is, do you feel that? (I share my confidence in the process as a means of instilling hope. Recognizing that "words alone will not cut it," I reference and draw attention to the felt shift as a means of building Sandy's trust in the therapeutic alliance and process of therapy.)

Sandy: Um … I don't know …

Th: It's okay, that's alright, that's the part of her that doesn't trust as well … (Here I convey my own trust in the process and what happened. I trust that tuning into a new, deeper part of her experience is the way out and wholly believe that Sandy got a glimpse of that. I also recognize, however, that if I don't illuminate this, she might not see it. Sandy nods in response to this reflection.) That's okay, so Sandy, now if we breathe together, what do you feel about all of this, about what happened today?

S: I feel like I've shared this story a lot of times to no avail, but on the other hand, not sharing it isn't getting me anywhere either. I don't know how to say it and not sound rude …

Th: No, no, that's okay.

S: It feels like a "last-ditch effort."

Th: That's okay, I hear you, I'm scared to trust, I'm scared to believe because that's going to hurt even more … that's legitimate Sandy, that's okay. What does the part of you that connected with her feel, the part of you that connected with her in that scene? (Again, I reference the "new experience." Sandy then reflects that this experience resonated with the part of her that felt hopeful coming in.)

S: This could be what works, that it would be different this time, that instead of just feeling good sharing, there would be something tangible that I could take with [me] and use when it's hard, instead of just feeling good in the moment having shared with someone. So, yeah, that part of me is with her, feeling hopeful … I'll try to remember to bring her around …

Th: When you go to that place with her, it's completely different, the whole room is different, that's good Sandy, that's exactly right, make as much space for her as you can because she deserves it. Of course, you have a busy life and a family. It can even just be a glance at her in the midst of a busy day. The more that you connect with her, from your body, the more that you go into that different space with her where she feels you. It's

so true, she was so alone and now she doesn't have to be so alone. And, as you need and want, you can bring Jake's image in too. He sounds like such a powerful, supportive force. (In these initial sessions, it is important also to identify, make explicit and guide clients in accessing various resources.)

As we move toward closing the session, I reflect/summarize and validate Sandy's ways of coping in the context of her history, and use her felt experience of the session as a platform from which to provide a roadmap for the therapy process. In addition to instilling hope, my intent is to provide Sandy with a sense of agency and predictability. This is important with all clients, and is especially important for those with histories or current circumstances involving chronic stress, trauma, betrayal, or violation.

Therapist: So Sandy, the thing I hear you saying is that those childhood experiences shaped your future in various ways, in terms of the way that you felt about yourself and the way that you've related with others and the way that you've felt able to assert yourself with others. Your resilience has been your work ethic and your intellect and your great ability to articulate yourself. Nothing has fully allowed you to move on from some of those poignant experiences. I recognize that, today, we focused on one or a couple of those experiences. The way that it works is we don't have to, necessarily, address every one of those incidents but enough that you have control of them, rather than them of you, and enough that that beautiful younger Sandy is not just an image from the past that you can connect with but eventually she becomes more and more a part of you, and things feel more whole and coherent and complete, and slowly she's able to appreciate and enjoy and find refuge in the arms of Jake and others that surround you. Is that getting it right? (Sandy nods.)

I am optimistic that the beginnings of a safe haven alliance have been established; that the seed has been sown. I also am aware that, like any relationship, this alliance will need to be monitored and nurtured. At various points throughout the therapeutic process, and especially early on, it is important to check in with our clients. What was the last session like for you? What stood out for you? How did it feel when … ? Was this a new experience or familiar? What is different about this experience of therapy and what is the same? Is anything changing? If yes, what?

Trust in the therapist and in the therapeutic process are paramount. Sandy trusted her parents. They were well-meaning. A trustworthy and well-meaning, empathically attuned therapist is necessary but not sufficient. The therapeutic process needs to be clear and, over time, the process needs to result in tangible and sustainable gains. In EFT, a safe haven therapeutic alliance

allows the therapist to lead and to follow. Ongoing attunement guides when and how. An ally in this process of self-discovery and exploration, the therapist remains emotionally accessible, responsive, and engaged (ARE), a temporary attachment figure in the therapeutic process and a guide that propels the process forward. As the therapeutic process unfolds, so too does the client's trust in the process and the courage to explore deeper and more painful material takes hold.

Early on, and particularly in cases involving trauma, ruptures in the alliance are common and especially when trust in the process and/or the therapist is low and when gains appear negligible and fleeting (and are easy to go completely unnoticed). Returning to one point early on within those first six sessions, Sandy declares with a tone of anger and harsh skepticism her disbelief that her ability to deal with being overwhelmed will ever improve. Her propensity to lash out at her children and her partner remains strong and her ability to pull herself from those familiar dark spaces remains highly limited. "What's the use? There is no point," she proclaims.

Another potential "rabbit hole." I tell myself to refrain from any kind of cheerleading or related claims that gains are being made from my vantage point. My vantage point does not matter. As Sandy aptly notes, I really do not know her or what she is like outside the sessions and, she says, the depth and breadth of her "character flaws." Initially, I feel jabbed. The tone of her voice and the look in her eyes are particularly jarring. Rather than respond quickly, I silently reflect that I might be feeling what Sandy's family feels during such times. Though tempted to reply to what I think is a demand for some type of response from me, I instead reflect and validate her frustration, her lack of patience with the process and her desire to be different with her family – I acknowledge the block.

Therapist: I hear you Sandy. This is difficult. It has been a long time. You have tried therapy many times before, to no avail, and this does not seem to be working in the way you had hoped. It is too slow. You still have bad days and you still find yourself prone to being overwhelmed and lashing out at your family. What's the use? I get it, you're frustrated.

I let her sit with this for a moment and then quietly ask, "From your point of view, has anything changed? Is anything different? Do you see any progress?" I also elicit her partner's point of view. "What would he say? What does he see?" I then reflect and summarize the therapeutic process to date, weaving in her and her partner's viewpoints, and highlighting again how she got here and where we are going. With attachment theory and the EFT roadmap as my compass, I highlight the small but significant steps Sandy has taken and

convey my own unwavering belief in the therapeutic process and in her ability to continue to move forward.

Concluding Comments

To summarize, a necessary requisite for effective EFIT is *a safe haven therapeutic alliance*. Effective EFIT maintains and builds trust in the therapist and in the therapy process. The case above highlights, in particular, the importance of providing the client with a felt sense of the mechanisms of change early in the therapeutic process as a means of establishing trust and safety. In other cases, clients might have difficulty sharing a coherent narrative or have few to no resources (either personal or relational), making it difficult to move so quickly into using interventions such as demonstrated here (i.e., an engaged encounter with her younger self). As was the case with Henny at the beginning of this book, trust and safety might best be established with a slow pace, careful attunement, consistency, and predictability, and with ongoing tracking and reflections/summary statements that help ground the client in her narrative in a manner that builds coherence and structure. Still other cases might require more explicit attention to the therapeutic relationship. The therapist might ask, for example,

> What is it like for you to be engaged in this process with me? How does it feel to be sharing your story for the first time? Is there anything we can do to make this easier, more comfortable for you? How will you care for yourself between sessions?

Recognizing that modifications are necessary with different kinds of clients and client problems, attachment science provides a template for a *safe haven therapeutic alliance*. The key elements of an effective alliance as guided by Rogers and Bowlby foster trust in the therapeutic relationship. Focused, on-target, and goal-oriented interventions promote trust in the therapeutic process. Any challenges from the client or ruptures in the therapeutic alliance are viewed through the lens of attachment and understood as blocks or fear. Addressed through validation and reflection as demonstrated above, the therapist is able to maintain emotional balance and stay on course. As the therapeutic process unfolds against the backdrop of an unwavering alliance and positive gains, clients begin to create such experiences in their key relationships, building additional "safe haven" platforms from which to grow and thrive.

Play and Practice

For You Professionally

Using the example of Sandy above, identify three key moments of alliance formation and maintenance. What were they?

1. _____
2. _____
3. _____

For You Personally

The EFT roadmap is clear and consistent across client problems in EFIT and accessibility, responsiveness and engagement (A.R.E.) are key elements of a safe haven therapeutic alliance with all clients. Having said that, each therapist will have a unique voice in the process and client will evoke something different from the therapist and/or will require nuanced responses to fit varying circumstances. Referring to the three points you identified above, is there anything you might have done differently? What might you have done?

1. _____
2. _____
3. _____

BOX 3.1

Shaping Safety and a Positive Therapeutic Alliance: A Summary of the Session

- Sandy is invited to share her story – what brings her to therapy.
- Therapist is authentic, emotionally present, respectful of present coping mechanisms, negative perceptions of self.
- Therapist sends a clear message of respect, acceptance – client's ability to change.
- Pivotal relational experiences are noted – put in context.
- Tracking and reflection are used to validate current experience in the context of client's history.
- A *new experience* is choreographed to instill hope, lower suicide risk, build trust.
- A rationale for the therapy approach is provided, with an invitation to commit to the process.

4

How Does Emotion Move the Client into Change in EFIT?

Soundbite Answer to Question
EFIT privileges emotion as a primary organizer of inner experience and interpersonal interactions. Emotion is the music that colors our world. It literally *moves* and motivates us. New emotional experiences open the door to new ways to see self and other and new ways to engage with self and other. Truth does not impact us unless it is felt – unless it registers for us on a visceral level and resonates as our own reality.

Excerpts from Sessions 5 and 6 with Kat and Sue – Working with Emotion
(Excerpts are edited somewhat for brevity and clarity.)

The EFIT therapist needs to get to know emotion, get comfortable with it, and make it a friend, a guide in the change process. Perhaps the best way to begin is to simply show a Stage 1 change event where emotion plays a key role. Please note how the therapist seeks out, tracks, evokes the visceral reality of and also regulates the client's emotion.

The client is Kathy (Kat), a nervous, intelligent young woman. The first excerpt is from Session 5. Kat is 25, working in a restaurant and presented with an eating disorder – anorexia – and anxiety issues. The eating disorder is contained at point of entry into EFIT. She stated that a clinic had coached her eating behavior and she had put on weight, but the anxiety she knew was

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the core of the eating problem, was a huge problem still. Being with Kat constantly reminded me of Bowlby's formulation that at the heart of all clinical problems we find, "frightening, alien and unacceptable" emotion.

In the transcript below the therapist's emotionally oriented interventions will be simply noted. These will be discussed in more detail in the next chapter. The transcript begins toward the end of Session 5, a live session in my office. I recap her key emotional images or, as we call them, her emotional handles from the last session. I begin by focusing on the image with the most emotional charge – the image of her creeping carefully into her mother's bed as a young child when she was scared of the dark, all the while knowing that she was not allowed to wake her mother up. One of her main complaints, even now, is that she has great trouble sleeping at night. I ask her how she feels about this image which represents a primal attachment scene – a deeply emotional drama with lasting existential significance. This kind of drama shapes models of self and other and the nervous system's ability to regulate emotion, especially threat.

Session 5

Kat: It's so sad. There was no comfort really. Mom had her back to me. She never even turned and said, "Are you okay?"

Therapist: Yes. Sad. Very sad. And scary. You had to be so careful. Not to wake her or "impose" on her in any way when you felt alone and when it was dark. That little girl was so alone. (Making the emotion specific. Using a soft, slow voice to evoke the reality of it.)

K: I am still careful in relationships. I never initiate physical contact. There is a barrier. I don't know how to give love or how to receive it. It's kind of unnatural for me!

Th: Yes. You learned back then to be careful – so careful. To expect, to make do with little comfort. Not to reach – not to ask. It was too risky. Loneliness and fear were what was normal for you. (She nods and tears up.) And you have told me that this would make you feel literally sick to your stomach, and when you felt sick, you couldn't eat. Then not eating made you thinner – more acceptable and feeling more in control. So developing an eating disorder was just logical wasn't it? (She nods. Normalizing and naming her ways of regulating her emotions – ways that were designed to protect her but have also imprisoned her and blocked her growth.)

K: Yes. It makes sense. And the clinic helped me change my habits but no one helped me with the feelings that were what it was all about. No one wanted to or seemed to know how to talk to me about that.

Th: Right. But here you are so brilliant at talking with me. So brave and so able to put your finger on the sadness and the anxiety – the loneliness of that little girl – little Kat. Let's stay with her. Can you tell me more?

How old was she when she was scared of the dark and crept into her mother's bed at night? (Evoking in the *present* the specific trigger for the fear that Kat lives with all the time.)

K: She was six. I'd hear noises in my room, my mind racing. I would wait and wait and wait until Mom was asleep. Slowly work up the courage to go into her room – knock very lightly – and whisper, "I can't sleep, can I stay?" She might say, "Don't bother me. Don't wake me up." There was a pillow between us. I'd get in but … but there was no warmth. I was still alone. But I'd finally fall asleep. A little relief but … no sanctuary. (She tears up.)

Th: (Reaching out and touching her knee, helping her stay with but regulate the emotion.) Right. No safe place. No comfort. No sanctuary from the fear, from the darkness. The rule was – mustn't impose on Mommy. If you push further, you are walking a fine line – and if you do?? (Regulating and holding her distress with my empathic touch and repetition.)

K: She will say, "Stop sleeping with me," or grab my arm hard and take me back to my bed and tell me to stay there.

Th: Hum … You will be rejected, in the dark and totally alone – yes? (She nods and is teary.) Scared – so scared and so alone. Overwhelmed by fear with no comfort. Can you feel that right now? (She nods.) Where do you feel it? (She touches her chest.) In your chest, and your mind says there is no comfort – no safety to be found. (Assembling the elements of emotion in the present moment – outlined in the next chapter.) The only way is to be so, so careful. (Kat nods and weeps. Long pause.) And if adult Kat was there with little Kat just before she knocks on her mom's door – oh so carefully – what would adult Kat say to her, the stronger, wiser Kat who is here now with me? Can you close your eyes and tell her that you see her … you are with her? (Moving to help Kat find a way to regulate the fear in the present in an organic attachment-oriented manner with the resources of her adult self, supported by the therapist.)

K: (Closes her eyes. Speaks very quietly.) I see you are afraid. You are not imposing. It's okay to look for comfort. (Opens her eyes – turns to therapist.) But why is she so afraid? (Kat steps aside from full engagement with the emotion.)

Th: We are all afraid in the dark – especially when we are little. We need to know there is protection – comfort. To not be alone. (Validating, normalizing an unacceptable and alien emotion.)

K: Yes. She is all alone – she doesn't have a word for that!

Th: But she has the feeling in her chest and her move into carefulness. You know she is afraid and sad. (Identifying core emotion.) Can you tell her?

K: (Closes her eyes, absorbing herself again in the emotion.) It makes sense how alone you feel. You should have someone! (She holds her chest.) It's sad, sad. I will comfort you.

Th: Yes – tell her again, "I can and I will comfort you." What do you do to comfort her?

K: I hold her to my chest – I can comfort you.

Th: How does she feel? Can she let the comfort in?

K: Yes. She can relax and let go. (She opens her eyes and turns to the therapist. She weeps.) It is so sad. It's such a simple thing. (Long silence.) I saw a kid yesterday. She jumped up and wrapped herself around her dad. Just like that – I crave that.

Th: We all crave that – long for that – need that, Kat.

Session 6

Therapist: So – what happens when you think of our last session, Kat? Think about little Kat going into Mom's room … (Returning to scene where core emotion is triggered.)

Kat: I get very emotional – it's a sadness – a hurt. But I can look at it now. I can kind of accept it. Not shut it down. Then it kind of comes to an end … (She is reporting that she can now tolerate, explore, and expand what before was overwhelming and had to be pushed away. Her relationship to and engagement with her fear and pain is changing.)

Th: Hum … You can go with the flow now and then it is kind of tolerable, almost complete? (She nods.) And last time you said in the past that you would fight it and try to dismiss it and then it would hijack you? (She nods.) Last time you used an image I would like to go back to – you used the image "starvation diet" for how things were with your mom and that hits me, seems to echo your eating disorder. I wonder, if you had reached for caring – nourishment, just asked her to hold you … (Kat looks horrified.) She would have pushed you away completely. So you were "careful" and you stayed "careful" with people. Right here, right now it seems like touching this is so hard. (Therapist uses a process-oriented reflection – what is it like to feel this right now?) What is happening in your body right now as we talk about this? (Beginning to assemble and deepen the emotion by focusing on the bodily felt sense element of the emotion.)

K: (Very quietly.) If I melted down she'd get angry and take me back to my room and I would lie there ALL NIGHT. Couldn't turn the light off till I was 19! (She is internally focused now – absorbed.)

Th: (In slow, low voice.) What is happening in your body Kat? Right now? (Staying in the moment and holding the client with a soft slow voice.)

K: (Very quietly.) I'm in meltdown.

Th: Help me feel that with you.

K: Spiraling panic – pure panic.

Th: Alone, in the dark, no comfort. Right now, where do you feel it, this panic? (Specificity of focus makes emotion less overwhelming.)

K: It's here. (She sweeps her hand across chest.) Like a cut on my chest, a singe, a burn. I cringe. (Therapist reaches out and lays her hand on Kat's knee and leaves it there. Contact comfort soothes. Kat weeps.)

Th: And what goes through your head? What do you say to yourself? (Focusing on the meaning aspect of affect assembly.)

K: (Very quietly.) I blame myself. "If you had done it differently you would be in there with her. I have messed up – failed."

Th: You say, "I should have been quieter. I did it wrong. Mommy leaves me in the dark – in panic, all by myself and it's my fault. I wasn't quiet enough." (Bowlby talks about how self-blame is almost preferable, more tolerable than the utter despair of abandonment.)

K: Yes. (Looks up at the therapist now.) I go into "what ifs." I get anxious. How to do this? So I plan and plan and plan about everything. It's pressure. Need to find the perfect formula. I planned and I didn't get what I wanted anyway. (Kat gives what we call the *Action Tendency* element of emotion habitually triggered by her panic. This is still the protocol she uses in everyday life to engage with others.)

Th: Yes. That makes sense. All the carefulness, the planning, and you were still alone in the dark! That is kind of a helpless feeling, isn't it? (Interpretation. Kat nods emphatically. Therapist then slowly repeats all the elements of emotion above in a clear coherent way. These are: alone in the dark, pain in chest, thoughts of no sanctuary – no solution, so must reflect a deficit in her, overwhelming panic, so move into planning every move with care – paralyzing.) In this helplessness, we don't know what to do. There are not many alternatives, especially when we are little. Better, less risky, to get angry at yourself than at Mom, right? (Kat nods again. Long silence. She looks up at the therapist.) But now you are stronger. I wonder what you would say to her right now – if she were here? (Again, moving to regulate and reprocess the evoked and clarified emotion by shaping a drama with the vulnerable self and the resource of the wiser and stronger adult self.)

K: (Smiles, speaks calmly.) Hum … Hum … I might say, "It's that Mom is not listening!" I'm screaming and she is not listening. Perhaps it's not a kid deficit – perhaps it's a Mommy deficit! (She laughs.) Cause I remember my dad holding me when I was sick. That was a small dose but not enough.

Th: Yes. Starvation diet. Kat, can you close your eyes now? Can you see your mom sitting with us? See what she is wearing, how she is sitting. Bring her into the room. Can you tell her, "I was – I am screaming and

screaming, in panic and you don't hear me. I tried to find the right way to get you to hold me but … I'm frantic, but I can never find the 'right way'." (Use of the present tense brings this alive.)

K: (Eyes closed, she enacts the now clear, regulated inner dialogue.) You don't listen to me. You say you only married Dad to have me, but you don't listen to me! I can't find you!

Th: You leave me in the dark. Alone. NO matter how much I worry and plan … I spend every moment of my life worrying and planning but … (This is the usual paradox – the way of coping with the abandonment panic has become a prison that perpetuates it.)

K: YES! Yes. You leave me in the dark and afraid all the time. You tell me that it was Dad leaving that sparked my mental health problems but … that wasn't true. (She weeps.)

Th: You are telling her what is true for you, Kat, and doing it so honestly, so brilliantly. Putting all your emotions together and saying what you could never say. (Validating and exiting from intensity so as not to overwhelm Kat, moving to titrate risk.) How are you feeling Kat? You are working so hard here. (Entering into a more reflective mode.)

K: This is a lot to take in – this hurts! (Therapist nods and touches her arm.) She takes no responsibility. She explains stuff and I end up comforting her! I am not assertive.

Th: She doesn't see you. It's hard to find the courage to stand up and say, "You don't see my pain. I got so anxious I couldn't eat and you are still not there. You left me all alone in the dark." (Using proxy voice – speaking as if you are the client – to distil the emotion and its consequences.)

K: YES. I never had anyone to hear me – even at the clinic. I tried to show her, tried to show them but …

Th: You are saying, "I have been all alone in the dark with my fear." That is so hard. We are all afraid of that. None of us can bear that – we do anything to not feel that. (Normalizing which helps regulate fear, making Kat less alien to herself.)

K: I wish I could say this to my mom for real. But it would be me out there … Too risky. (She shakes her head.)

Th: Well, you were pretty real here. And maybe it's good she isn't here then … (Kat laughs.) You need to get clear and sure of yourself first, maybe.

K: This helps me get clearer. Helps me make sense of things.

Th: Right. You are so mature and wise to have figured that out, Kat. And you are so brave here with me. (Sue then again recaps the whole of the above as a narrative including key emotional handles and images.) You are really brilliant in therapy, aren't you? (Kat's self is reflected as competent and worthy and vulnerability as manageable.) How are you feeling right now?

K: (Giggles.) I feel light and okay. Last time I sang in the car all the way home. It's funny cause we talk about hard things but … I used to dread talking to the counselors at the clinic. It never went anywhere. I write things down when I go home from these sessions. Coming here, well, it's kind of … Exhilarating.

Th: (Laughs.) Yes – for me too. You work so hard. It's a pleasure to work with you.

Now lets us examine the phenomenon of emotion – the structure of emotion in a little more depth to help you understand the map that the therapist was using in the above process. First, we need to answer some basic theoretical questions.

What Is Emotion?

William James (1890) noted that emotion was a set of "adaptive behavioral and physiological response tendences" primed by evolutionary significant situations. (Not bad for someone commenting over 120 years ago!) Emotion is then a high-level, bodily centered information-processing system focused on survival and the fulfillment of needs. It involves cognition in that the search to assign meaning to experience is part of the construction of emotion. Bowlby (1991) noted that, "The main function of emotion was to communicate one's needs, motives, and priorities to one's self and others."

In general, emotion offers us a compass in life. It colors our world, orienting us to what matters at any moment. It is a potent bodily felt sense priming the nervous system to ready it for dealing with a perceived reality. It motivates us; it literally *moves* us and – primes us for action, especially for fight, flight, or freeze responses. It also communicates with others and sets up their response to us. In all experiential therapies, emotion is privileged and seen as, if not the primary organizer of experience and key interactional patterns with others, then as essentially adaptive. Actively engaging with one's emotions is viewed as the royal route to change and growth. As the inspirational writer Glennon Doyle puts it, "If I can sit in the fire of my own feelings, I can keep on becoming" (2020).

To be cut off from emotional experience, to deny it, or have access only to fragmented or chaotic elements of emotion is to essentially live life without an internal compass. To be constantly on the verge of being overwhelmed by emotional cues and to constantly have to fight to avoid or contain one's feelings is also hugely problematic. The suppression and avoidance of emotion is a physiologically effortful and costly endeavor that is at the heart of so many mental health issues and ends up making us more sensitive to the very thing we are trying to avoid. Avoidance also narrows down our responses and our lives so that protecting ourselves from our own emotions becomes

a constraint, blocking adaption and growth (Gross, 1998; Johnson, 2019). Health is to have access to one's emotions, to be able to trust the signals they send, and to be able to regulate them; that is, to *order* them into a coherent whole. The therapist's goal is to shape the client's sense of *emotional balance* in every session of EFIT. This balance is the essence of attachment security and positive adaptation as laid out in attachment science.

Many psychotherapy models focus on the containment and control of emotion, which is generally distrusted in Western societies, while rational cognition is elevated and respected. In EFT and EFIT, emotion is honored and viewed as essential to full adaptive functioning and to change in psychotherapy. This view fits with research on the nature of change in successful psychotherapy (Castonguay et al., 1996; Greenman & Johnson, 2013; Pasual-Leone & Yeryomenko, 2016), which pinpoints deepening engagement in emotional experience as the key ingredient in the change process across different models of therapy (Coombs, Coleman, & Jones, 2002). *Emotion is at once the target of change and the primary agent of change in EFIT, priming and reshaping core cognitions, including the client's model of self, and habitual action responses*. As noted in the general EFT literature, "Working with emotion in EFT is an organic process in which technique can be held to a minimum and the innate power of emotion can be used to take a client to another universe" (Johnson, 2019). The therapist does not have to persuade and endlessly coach a client to access, remember, and use powerful emotional experience. Our nervous systems are set up to give such experience priority; emotional learning is biologically prepared learning. *Emotional shifts and epiphanies stay with us and re-organize us for future action*.

Just How Complex Is Emotion?

Estimates of the number of emotions vary from 84,000 (Goleman, 2003, p. 78), and this is just for negative emotions, to 6 core emotions (Ekman, 2003). Obviously, the latter is more practical and is used as the basis of all therapy modalities in EFT. These core emotions involve distinct facial expressions that can be recognized and ascribed common meanings across cultures and continents. Such emotions appear to be universal and to be associated with specific neuroendocrine patterns and brain sites (Panksepp, 1998). Emotions often have "control precedence" (Tronick, 1989), easily overriding other cues. These core emotions are found below:

Approach emotions:	Joy, evoking relaxed engagement and openness.
	Surprise, evoking curiosity.
	Anger, evoking assertion and moving toward goals.
Avoidance emotions:	Shame, evoking withdrawal and hiding.
	Fear, evoking fleeing or freezing.
	Sadness, evoking withdrawal or comfort-seeking.

Obviously, these emotions can be differentiated further. Shame, for example, has also been viewed by some theorists as including disgust and guilt at specific acts or thoughts. Sadness can include grief and be part of what we normally call "hurt feelings." The emotion we refer to as "hurt" in and of itself is a conglomerate emotion rather than a core affect. It has been unpacked into its core elements, namely anger or resentment, sadness and loss, and a feeling of vulnerability or helplessness that involves fear (Feeney, 2005), specifically the *fear* of not being valued by key others and so deserted and rejected. Fear, while always involving a sense of threat and emerging helplessness, can be expressed in terms of a reactive fight response, shutting down or freezing, as well as a mobilized fleeing from danger. All of these emotions have a logical (no emotion is inherently irrational in nature) connection to how the self and significant others are engaged with. Some therapists ask which is the most destructive emotion. While this depends on the specific client, it does seem that shame, which can be thought of as fears and negative attributions about the self, can be especially problematic in that it elicits hiding and withdrawal. This then cuts off the client from any corrective emotional experience and from the healing comfort of others.

But it is not enough to outline six core emotions. We need to consider the structure of an emotional response if we are to purposefully *restructure* it in a therapy session. Every emotional response seems to be made up of five key elements (Arnold, 1960). Once we know what these are, we can search for them, evoke them, pinpoint them, order them – that is, we can literally *assemble* them with the client. These elements are:

A trigger or cue: there is a shadow in the darkness.
A fast, very basic perception: this is bad – dangerous.
A body response: heartbeat rises, pupils dilate, blood goes to feet.
A cognitive meaning making response: the prefrontal cortex notes, "I should not be here alone."
Action tendency or priming: I speed up and begin to run.

So Kat tells the therapist that she cannot flirt or date, even though she has many potential admirers. She simply recoils from this kind of attention. The therapist then evokes a specific situation (her last outing with friends where an attractive acquaintance suddenly came into the bar) and assembles Kat's emotion with her, unfolding the elements and making the experience come alive in the here and now. It becomes clear that the key moment, when the urge to move away occurs, is when someone (in this case the attractive man in the bar) moves close and looks directly into her face (*trigger*). He is inviting closer contact. In response to the therapist's questions (for example, "So what is happening right now as this comes up for you?") Kat reports that some part of her

brain shouts, "Don't! This is Bad!" Her body then feels "sick" and goes still. She feels "careful." She says to herself, "I can't do this. If he really sees me, he won't like me. It will hurt" (*meaning making cognition*). She then goes silent and looks away from him, retreating into herself and ignoring his overtures (*action tendency*). When she goes home, she feels even more alone and "unlovable." This then generalizes so that when she sees him again, she completely ignores him and feels even more alone, finding more and more reasons why she would not be wanted by him or anyone.

The way that Kat encodes and processes her emotion and then regulates it by withdrawing and hiding constantly exacerbates, strengthens, and maintains this negative response sequence. Her general response is then to numb out more by eating less and less, so she presents with the problem of an eating disorder. Her life coalesces around the themes of isolation, sadness, and hopelessness, and the fear of rejection and abandonment. The EFIT therapist joins with Kat and walks *into* the emotional process that underlies her stated problem, and then *through* it into new ways of ordering and regulating emotion and new models of self and other. The way out of problems is to make their structure clear and bring them alive, shaping new corrective experiences in the therapy session. As previously noted, "The only way out is through."

If we understand the structure of emotion, we can unfold it with precision and predictability, distilling the key emotional dramas where a person decides who they are, how to engage with others, and what their life story will be. It is important to note that, at first, when Kat says that she "cannot" date, she is vague and evasive. She is just shy or she "doesn't know why." The therapist becomes focused and specific, asking present process-oriented questions such as, "When does this happen? When was the last time it happened? What does it feel like? What happens to her body as she says this? What does she say to herself? What does she do then?" The therapist is attuned, persistent, and evocative. An experienced EFIT therapist is hard to resist as they gradually change the client's level of emotional engagement. When emotion is encountered with a safe other who orders the experience as they unfold it, even the most shut down or numbed out of clients find it harder and harder to continue to suppress and avoid. However, the therapist often begins in a frame of *accepting* and *validating* the client's evasiveness and reluctance. We all hang back and tread carefully when in alien, foreign, or dangerous territory. As blocks are accepted and owned, they tend to be less rigidly held and so more easily modified.

Levels of Emotional Processing

To change emotion, you have to first allow yourself to feel it. Then you need to tolerate it, unpack it, take hold of its essence, or distil it and then reshape it. The concept of *deepening* affect captures this process, helping the client go

beneath the obvious and surface chaotic reactivity or numbed suppression. This is a move from the reactive, automatic emotional response to a more profound, elemental, or core affect. The most common example here is that the therapist helps a client move from habitual rage or numbing, to an awareness of the threat – the fear that triggers these more surface responses. The therapist tracks how emotion arises in a client and how the client deals with that emotion in key existential situations when *core vulnerability* is present and compelling.

It is easy to identify four universal existential fears. First, our deepest anxieties involve fears about death, the finiteness of life, and the inevitability of loss. Second, we all have concerns about how to make life meaningful although it is transitory. Third, we have concerns about freedom and agency; that is, making choices which always involve potential loss or error, and involve taking responsibility for constructing one's life. And fourth, we all have concerns about isolation and aloneness (Yalom, 1980). An attachment-oriented therapy incorporates this existential philosophical perspective on human vulnerability but stresses the overarching primacy of emotional isolation as the core of helplessness. The chronic fear of rejection (and so the self is unlovable and will never find connection) and the fear of abandonment (and so the self and the pain and need of the self will never matter to another) make our sense of vulnerability into a no-solution dilemma and generates intense pain. This isolation primes the sense of danger and links to the fear of death. It also primes a sense of meaninglessness (after all, if we do not matter to another …) and undermines the ability to be grounded and make clear choices. A felt sense of secure connection with others, on the other hand, is seen as our species' most adaptive way of effectively dealing with such existential vulnerabilities. This plays out in the change events constructed in EFIT sessions (see following chapters) and the creation of new and corrective encounters with parts of self and others.

Many studies of EFT have focused on delineating this process of deepening into core vulnerabilities as central to the change process (Greenman & Johnson, 2013). These studies have measured this deepening process using a scale created by Klein et al. (1969), the Experiencing Scale (EXP).

Experiencing Scale

This scale describes seven levels of depth of client emotional engagement and involvement with one's ongoing felt experience.

Levels 1–3 – talking is objective, intellectualized, reactive.

- Talking about events, ideas, or others.
- Talking about self without emotion – flat, static.
- Narrating/reporting/talking/recounting about feelings in a more removed way that relates to external circumstances.

- Detached from inner experience.
- Low level of engagement with emotion.

Level 4 – beginning of "direct reference" to felt experiencing.

- Client turns inward for self-description.
- Begins to recognize, explore, and make bodily feelings more explicit.
- Attention turns to emotions and thoughts about self.
- Full attention is given to felt "flow" of inner experience (client is "in the zone").

Level 5

- Elaboration and further exploration of inner experience.
- Increased self-reflection and curiosity.
- More immediate, present-tense quality; metaphorical ("the feeling is like … ").

Levels 6–7

- Emergence of a "felt shift."
- Client is fully "present."
- New meanings; heightened awareness of previously implicit feelings; accessibility of new perspectives to solve problems.
- Expansive, fresh way of knowing, vivid, "alive."

(See also Johnson, 2019, pp. 50–52.)

Therapists need to be able to differentiate levels of emotional engagement so they can systematically evoke deeper levels and recognize all the levels when they occur in their clients. The EXP scale helps us capture this concept of levels of emotional engagement and pinpoint what deepening engagement actually looks like. This is described in the above scale, which measures client movement across seven stages of engagement. In the early stages, clients often have low levels of engagement with their emotions; they make mostly impersonal, superficial, or abstract discursive remarks about their experience. Later, clients begin to recognize bodily feelings, stay with them, explore them, and make them more explicit. The therapist particularly notes when clients can fluidly move into and out of a Level 4 of experiencing, trusting the flow of emotion and where it takes them. Then, in the more advanced stages of experiencing, new corrective compelling experiences set up new meaning frames and clients actively use emotion as a guide that takes them into new territory. As emotional experience deepens and is expressed through these stages, interpersonal connection in interactions between client and therapist and imagined interactions between parts of self and with attachment figures evoked in the therapy process, also become more open and authentic.

As set out previously in the book *Attachment Theory in Practice* (Johnson, 2019, pp. 50–51), James, who complains of depression, tells me in a first session that all people are narcissists and that this is because of the political climate and economics. He has obviously used this speech before and his tale is remote and distancing. This rather impersonal conversation would be coded as Levels 1 or 2. Later, as James' treatment progresses, he moves into Level 3, exploring his relationship with his mother who is dying. He tells of specific events in adulthood where he felt angry and scolded just as he did as a child, and then lists all the actions he took to contain the impact of these incidents, such as giving up on others and distrusting their positive intentions. As therapy progresses, James enters Levels 4 and 5, moving into a more personal recounting of such events, setting out his assumptions in detailed personal statements. He now recognizes and pays attention to soft vulnerable emotions in the session, pointing out that he feels "small" around his mother and wants to keep his armor on and "hide," even now when she is so frail. Ultimately, as he enters Levels 6 and 7, James actively explores and *discovers* his immediate feelings and his grief that he never felt loved as a child, the hopelessness and helplessness he felt then, and is able to outline the impact this emotional experience has had on his life. Emotional experience is now vivid and concretely felt, and James presents it in a way that evokes compassionate empathy in me. James can now tolerate and keep his balance in his vulnerability. He is fully *present*. New levels of awareness become a springboard into new motivational states, realizations, and existential positions.

James: I can't grieve my mom. I never had a mom really. (He weeps.) She never showed up for me. She couldn't do it, I guess. I grew up alone and thinking there was something wrong with me. That I can grieve – for little James who felt so cold and small in the world. And I am still hiding out. It's hard to hope again. Right now, I look at you and see that you are sad for me. That feels good but I need to weep for a while. Maybe I want to go and find what I never had.

James ends up being much more open to experience and equipped with emotional balance and trust in his newly emerging experience as a guide to future action. In attachment terms, his framing of this experience is *coherent*. The formulations here are expansive – the client is on a journey rather than being stagnant or stuck. This new level of emotional engagement changes the color of James's relationships, opening the door to more authentic connection with others, more compassion for himself and others, and the ability to risk, reach and respond in close relationships.

One way of thinking about levels of experiencing is that people often start on the outside looking in, talking about their experience in a general way.

They offer information – data. When they move deeper, they are not only in their experience but it is evolving and changing as they reshape it. There is an element of *flow* (Csikszentmihalyi, 1990) in the deeper levels of experiencing. In this state you are totally absorbed by and deeply focused on something, beyond the point of distraction. Time slows down and your senses are heightened. Some people describe this feeling as being "in the zone." As the client moves into and beyond Experiencing Level 4, not only does emotion change (from shame to deep grief at deprivation, for example) but the self of the experiencer changes and the person is more able to define, tolerate, and trust their evolving experience. Experience then becomes more coherent and more integrated into a competent sense of self.

What does an Experiencing Level 5–7 look like? This can briefly occur in Stage 1 of EFIT but is seen most often in Stage 2 – Restructuring change events. This kind of change event was outlined in Chapter 1 and will be discussed again in Chapters 9 and 10.

The following chapters will show you how to shape change events and the specific interventions that shape these events but, in this more general discussion of emotion, it is useful to outline some general process principles – a kind of blueprint for HOW to work with emotion. In EFIT these can be summarized as:

- The client is led gently to the leading edge of their experience – to the discovery of the unknown or unknowable, but the therapist is always careful to TITRATE RISK, to modulate the client's engagement with difficult emotions. The therapist is careful to not overwhelm. Pacing matters in terms of when and how much to intensify emotions and how long to sustain engagement. It is a key way of maintaining a *working distance* from difficult emotions (Gendlin, 1996). The client's tolerance level is always respected. A trauma client may only be able to tolerate three minutes of contact with a trauma scene and the attuned therapist then summarizes this experience and moves the client into reflection or into an image or experience that evokes the client's strength and control. (You can see this happening in the last transcript of a therapy session in Chapter 1.)
- The therapist does not enact a technique *on* the client, do something *to* the client, but rather unfolds and discovers underlying experience *with* the client in a collaborative partnership. There is a constant attempt to actively foster collaboration in EFIT sessions. The therapist leads and follows. He or she accepts the client's corrections and status as the author of his or her experience. Therapists find their own style here. The first author has a habit of explicitly asking for the client's help in grasping their reality for example. This collaborative, curious manner is a key part of the legacy

of Carl Rogers who was always in discovery mode with clients. In EFIT you, the therapist, and the client are always discovering what it is to be human and just how challenging and glorious this can be!

- In terms of the general process, in successful deepening moments or emerging emotional dramas the therapist goes slow and uses repetitive reflection to keep focus and engagement (particularly, see the RISSSC process described in the following chapters). In general, *slow down and repeat is a good mantra for working with emotion in EFIT*. This allows the client to begin to hold and piece together what is fragmented, to taste and accept what is alien and strange, to tolerate what is terrifying. This takes TIME. If we watch an attuned mother introduce a new and scary object or experience to a child, she typically slows down and drops her voice and repeats herself, calming the child's nervous system as he encounters the new stimulus. Our attachment system is wise. One of the main reasons emotion can be so overwhelming is that it is, by nature, fast. If fear was not able to immediately take us over and mobilize us, we would never have survived. However, to reprocess emotion, expand it into new forms and integrate it, we first need to slow it down. We also need to make it specific – which is the next point.
- When deepening emotional engagement and expanding awareness into what is implicit or hidden or denied, we need to always STRIVE FOR SPECIFICITY (note that we have now added a fourth "S" to the usual EFT acronym, RISSSC, for *specific*, see Chapter 5). The general, especially if it feels catastrophic, is too hard to take in. Medical personnel know that when they tell a patient exactly what to expect at key moments during a procedure, the patient calms down. Pilots in turbulence do the same thing: "There will be bumps for ten minutes now; it's just the plane hitting the air stream of another plane," is manageable while, "We are flying into some kind of strange air storm," is much less so. The research of Lisa Feldman Barrett on emotional specificity or what she terms *granularity* (2004) illuminates differences in how people experience, perceive, and understand their emotions. Feldman Barrett suggests that those who can put emotions into words, constructing their experience with a high degree of specificity in the face of intense distress, are less likely to use negative self-regulatory strategies such as aggression, self-injury, or excessive drinking. They also demonstrate less neural reactivity to rejection situations and suffer from less severe anxiety and depression. One study found that recounting a difficult situation in a diary and precisely pinpointing the emotions that arose seemed to lessen stress and allowed people to cope better, as compared to those who were less able to clearly specify and differentiate their emotional responses. When people can put together more finely tailored emotions, this also seems to offer them more

precise tools for making choices and effective problem solving (Kashdan, Feldman Barrett, & McKnight, 2015).

This means that the EFIT therapist does not much tolerate the vague and general. He or she searches for *when*, *specifically*, do emotional shifts happen – what is the key moment when things change? He or she asks, "*What specifically* happens to you in these difficult moments and *where* do you feel this? *How* does your perception change or *how* does your body feel?" *Tying emotion down tames it*. You know when you are specific enough; it is when you can feel the client's experience with exquisite accuracy, that is, when you can taste it. The therapist is always striving to make emotional experience visceral and concrete, constantly turning elusive and fuzzy emotional hints and whispers into a concrete and specific experience. He or she is a granularity expert!

- Lastly, the whole process of deepening experience is based on the therapist's constant attunement to the present moment. To stay in the present is key to the process of emotional engagement and regulation that is happening in the session. This focus on the present moment as a microcosm of the client's ongoing construction of his or her life experience – the way this person dances with the self and others and navigates being human – is the hallmark of EFT in general and EFIT in particular. Emotion turns the past into the present and discovery and change happen in the present. You will often hear the EFIT therapist say, "And right now what is happening for you," or, "Can we stay here, right now, with this moment?" The therapist is a process consultant who tunes into and catches the moment, the fleeting glance downward that a client makes, or the momentary change in the client's voice. It is easy to see parallels here with the process of mindfulness (Germer, Siegel, & Fulton, 2003) in the focus on tuning into and accepting present experience without judgment while not becoming caught and overwhelmed by it. Staying with a specific present moment together with a therapist who helps to order difficult experience is a way into that experience but also calming in itself, since "right now" is more manageable than confronting a whole lifetime of pain or a trauma that feels endless.

You will find this principle, as with the others above, noted and illustrated in many chapters in this book and the points about slowing and specificity paralleled in the process-oriented acronym RISSSSC that is outlined in the upcoming interventions chapters. The above EFIT principles for working with emotion are listed for your convenience in a box at the end of this chapter.

All of the above is consonant with the general research on the regulation of emotion (Johnson, 2019, Chapter 3) and the research on successful change events and processes that predict success in the general EFT model. Regulation is the ability to *access* and attend to a range of emotions, clearly

identify those emotions, *modify* them by either reducing or amplifying them in oneself and another, and *use* them to ascertain meaning, as well as to guide our thinking and prime actions in a way that fits our priorities in different situations. Emotion regulation plays a critical role in the etiology and maintenance of psychopathology. Suppression, rumination, and avoidance are associated with a range of psychological disorders, especially problems of anxiety and depression. More adaptive strategies such as acceptance (leading to reduced experiential avoidance) and reappraisal are not (Mennen & Farach, 2007; Aldao, Nolen Hoeksema, & Schweiser, 2010). Many of our clients are caught in a process where they avoid engaging with their own feelings; they blame themselves for perceived rejection by others and enter an ever-repeating cycle of rumination and catastrophizing. They are vigilant for and only see rejection and proof of personal inadequacy and failure. All this undermines any sense of efficacy in dealing with emotion and generates an absorbing state where everything leads into overwhelming negative emotion and depression and nothing leads out. The goal in EFIT is to shift these negative patterns of affect regulation and interpersonal interaction to shape more emotional balance and integration. Further, it is to distil and address the core emotional pain that underlies presenting problems and finally, to *harness* the power of restructured core emotion in the service of the creation of new perspectives, cognitions, concrete actions and attuned responses to others, helping our clients grow into fully alive, emotionally empowered human beings.

Play and Practice

For You Personally

Can you think of a key emotional moment in your life that was life changing for you?

What was the core emotion in this event? Choose from the list given here: joy, surprise, anger, sadness, shame, fear.

How did you deal with it? How did you regulate this emotion?

What impact has this had on your life?

For example, the first author remembers standing on a pitching ship in the middle of the Atlantic emigrating to Canada all alone. The core emotion was fear. Fear of the sea, of her ability to handle this and upcoming challenges, and fear about the overwhelming choice she had made to leave all things familiar to go out into the unknown. She began to lose her balance and feel dizzy and said to herself, "What am I doing here? I can't do this. I am so alone." Then she heard her father's voice in her head telling her, "Remember, in a storm, stand and feel the ground under your feet, look at the horizon and

listen to my voice saying that you are strong and I will always be there with you." Somehow her trip then became an adventure. She still uses this experience as a secure base in all kinds of storms.

If you wish you can choose a more positive experience (as above) and/or a negative one. If you choose a negative one, see if you can identify your favorite affect dysregulation strategy. The first author's go-to strategy is very fast creative catastrophizing in an unending series of negative "what ifs."

For You Professionally

What is your greatest anxiety about evoking and deepening emotion in your sessions? We invite you to catastrophize; as one student once told the second author, "My client will have a psychotic break and it will all be my fault – I will know I am a bad clinician."

What attracts you to working more intentionally and systematically with strong emotion? What do you hope will happen with and for your clients and for you as a therapist?

What do you suppose will be your greatest challenge in working with emotion?

The tender-hearted therapist who feels protective of their clients may at times find it difficult to allow clients to contact real pain. It is important to remember that our clients are in pain already and to change something you first have to connect with it.

In various parts of this book, we refer to rabbit holes – typical places where we make mistakes, get stuck, and find ourselves in dark holes in a session. The first box below lists some of the rabbit holes therapists find themselves in when learning to work with emotion in EFIT.

BOX 4.1

Rabbit Holes We All Fall Down

1. We do not choreograph the sessions, instead we allow the client to continue to give data/explanations/stories without sorting for or evoking emotional charge. We fear interrupting or damaging the alliance.
2. We get enthusiastic – intensify all emotion, including surface reactive anger – rather than reflecting/going underneath it (catharsis is not helpful).
3. We get caught in our own/client's explanations, stories – forget to press the elevator button down into felt EXPERIENCE. We stay in Levels 1–3 of the Experiencing Scale.
4. We do evoke felt experience but speak fast, using complex terms, in a cognitive voice that misses the mark or overwhelms the client. We ask for too big a leap from where the client is presently.

5. When clients resist our interventions, we give up. Do not reflect their difficulty, validate their reluctance to go into foreign or difficult territory.
6. If the client exits from accessing emotion, we do not persist with evocative questions or use emotional handles.
7. We judge ourselves, cannot acknowledge we are in a rabbit hole and redirect, as in "Somehow I am confused here, so can we go back to … "

BOX 4.2

TIPS: Working with Emotion in EFIT

- Titrate risk at the leading edge of emotional experience.
- Construct emotion WITH clients – COLLABORATIVELY.
- Slow down and repeat what is new and scary.
- Strive for specificity – until you taste it.
- Stay in the present.

5

What Is the Macro-Intervention Sequence, the EFIT Tango?

Soundbite Answer to Question
The EFIT Tango is the basic set of therapist macro-interventions used across the stages of EFIT and in all modalities of EFT. It consists of five moves. A tango is a dance based on attunement and mutual resonance structured by emotional music. At first you have to learn the steps but then you dance it from muscle memory and can flexibly play with moves and music.

The conceptualization of an attachment-oriented psychotherapy leads naturally to prioritizing certain processes in session with clients and calls for a particular sequenced set of therapist interventions to create these processes. Any set of interventions in an experiential therapy is, of course, improvised on and used with different pacing and intensity at different stages and in particular sessions. This set of macro-interventions and associated client change processes is called the *EFIT Tango* and is most easily described as a set of five "moves," namely:

1. ***Mirroring Present Process*** – where the therapist attunes to, empathetically reflects, and clarifies cycles of affect regulation (e.g., numbing flips into rage, which dissolve into shame and hiding and more numbing) and cycles of interactions with others (as I hide, you harangue me and I shut down and shut you out more, triggering increased aggression and criticism in you, so I hide more). The focus here is on how clients are, in the present, actively

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and most often without awareness, constructing inner emotional and interpersonal interactional realities into self-perpetuating cycles. These cycles confirm clients' negative sense of self and other and perpetuate problematic attempts at coping and self-protection that lead to more symptoms.

2. ***Affect Assembly and Deepening*** – where the therapist joins the client in discovering and piecing together the elements of emotion and placing them in an interpersonal context that renders them coherent and "whole," often resulting in an expansion of awareness into deeper elements or levels of emotion. As noted elsewhere, deeper emotional processing is associated with a significant change in psychotherapy (Castonguay et al., 1996) in general and in EFT in particular (Greenman & Johnson, 2013).
3. ***Choreographing Engaged Encounters*** – as new emotion emerges or is distilled and made poignant, the therapist sets up the disclosure of these expanded and deepened inner realities in structured guided encounters with parts of self, significant others, and, at times, the therapist. New inner processes become alive dramas, new ways of interacting with and relating to real or imagined others. For example, the remembered helpless young self may be comforted and held by the now-adult and more resourced self, or the ashamed self may look into the therapist's face, ask a loaded question regarding identity, and receive an accepting reply.
4. ***Processing the Encounter*** – here the new interactional responses and dramas are explored and integrated and also related to presenting problems. If a negative non-accepting response comes from another part of the self or an attachment figure, this can be contained and processed with the therapist. Often the client's ability to simply say their now coherent truth congruently to an important other is celebrated and its implications for the client's sense of self are explored. Being able to move into a place of offering caring comfort and support as an adult for a vulnerable or unaccepted part of self so that this vulnerable self is not experienced as alone, is powerful, especially with traumatized clients (see the Stage 2 transcript in Chapter 1). Clients can also, often for the first time, enact a clear sequence of attachment responses where they can, in session, feel their longings and fears, state them clearly, ask for connection and take in care. Blocks to the healing process can be explored in this move. Such blocks include: an inability to exit from denial and tune into emotional awareness or distress; an inability to order and clearly formulate longings, needs, terrors and vulnerabilities or move into any kind of emotional balance; an inability to own and express these vulnerabilities to another; an inability to accept the response of this other – whether dealing with a rejecting or abandoning response or letting in and integrating a positive response; an inability to integrate new emotional experiences into the sense of self; and, an inability to interact with another or a key part of self in an open, attuned, and

responsive manner (see also Johnson, 2019, p. 33). These blocks to connection with self and other can all be seen live in the attachment dramas that Bowlby and Ainsworth originally captured many years ago in their Strange Situation experiments where mothers left children alone, invoking vulnerability, and then returned to be with them.

5. ***Integrating and Validating*** – here new discoveries and new positive interactional responses are highlighted and reflected and validation is offered to build competence and confidence. This process highlights inner experience and how it shapes interactional patterns in a self-reinforcing manner, and interpersonal connection and how the nature of this connection reciprocally shapes inner experience and the sense of self. The most often used validation is to simply outline for the client the specific changes they have made in the session. This reinforces the fact that they are already moving and growing and builds confidence.

Let us now look at these moves in a little more detail. They are captured in Figure 5.1.

Tango Move 1 – Mirroring Present Process – Within and Between
The first step taken by the therapist, and this occurs in the context of a growing therapeutic alliance, is to offer the client an attuned, simple description

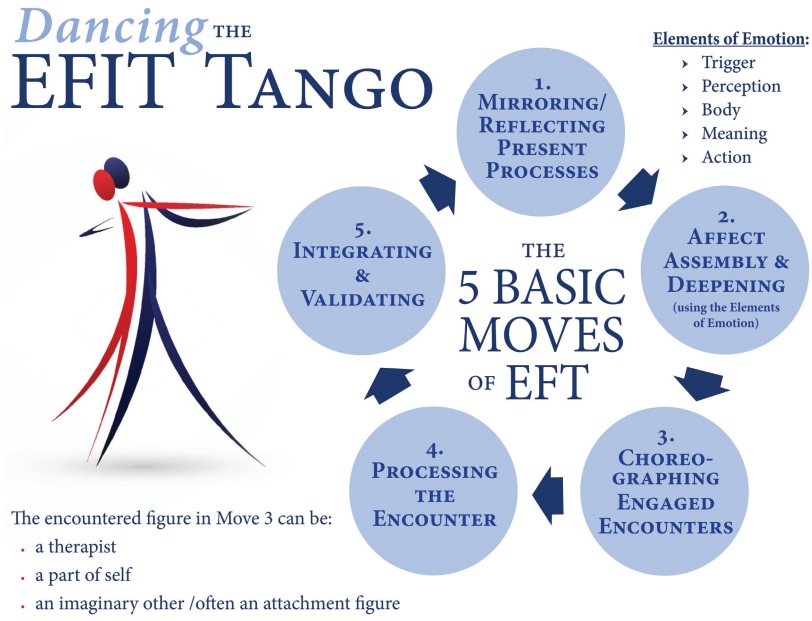

Figure 5.1 Dancing the EFIT Tango – The five basic moves of EFT. © 2021 Sue Johnson.

of the process that is occurring in the present, in front of the therapist's face. Doing this requires tracking and collaboratively naming the experiential and interactional processes that occur – both those within the client and in interactions between the client and the therapist or an imagined other from the client's present or past life. It is essential that this is done in a descriptive, normalizing, and evocative manner (without evaluative comments or advice) that fosters engaged exploration at the cutting edge of a person's experience or awareness of inner affect regulation or interactional patterns, rather than in an intellectually discursive or rationalizing mode. The client's emotional expressions/messages and associated thoughts, sensations, actions, and interactional moves and positions are tracked and reflected, beginning with those at the surface (mentioned explicitly by the client) and then carefully moving into those that are implied. Interactions, whether held in the client's imagination or played out with the therapist, are described in simple language and framed as having their own dramatic momentum and self-sustaining nature. *Each client is the author and the victim of the drama that is laid out and distilled to its simplest, most essential elements here.* The therapist captures and reflects the drama as it unfolds, both the emotional flow the client is caught in and the patterns of engagement and disengagement with others and invites clients to stand back and look at these from a distance, and frames these within and between feedback loops as self-sustaining – as having a life of its own.

In a session in the Stabilization Stage of therapy, this first Tango move might be very brief and simple or more complex. If simple, it might look like this:

Therapist: So, Sam, please tell me if I am getting this right. You are so sure others will hurt you that you end up guarding yourself and staying distant. But this leaves you full of conflict because you constantly swing between sad loneliness and longing for closeness and the fear of being controlled and "used" and wanting to run. Is this right? And when others do stay away, this actually frightens you and so you go off again, inviting closeness but you can never trust it and let it grow.

A more complex Move 1 might look like this:

Therapist: (At the end of Session 1.) So Amy, you talk about very difficult distressing things in your life. You lost your job. You are not sure if your boyfriend is still interested in you. And you say you are down, lonely, and worried. But then you kind of smile and dismiss this distress – move away from it and say very negative things about yourself, like you can never get things right and you are a "nutcase." It feels like you touch all this distress for a moment and then that is so hard that you kind of

try to shut it down and avoid it. You kind of spend a lot of your energy constantly running from all this distress. (She agrees and comments. Therapist outlines the negative cycle of affect regulation that paradoxically keeps the distress intact and active.) With your mom and boyfriend too – hurtful things happen so you just stop calling or watch lots of TV – you withdraw. So you end up all by yourself here, trying to push away all this distress. (Therapist outlines the negative cycle between Amy and others.) But my sense is that it keeps coming back and you have to struggle more and more to keep it away – you feel more and more negative about yourself and you get lonelier and lonelier and that is kind of consuming your life. Have I got it? (The therapist frames the process of emotion regulation and negative interactions as iatrogenic.)

Later in therapy, in Stage 2 when the client is already aware of his or her looping inner processes and related circular dramas with others, Move 2 may look like this:

Therapist: Right Jane. You reach out for your dad, hoping that he will respond this time and acknowledge you, and when he doesn't, you go into the spin we talked about, right? Here is the spin, right here. You pick up on something that looks positive, begin to hope – to long for his love. Then you are "crushed" all over again when you do not get this comfort. And you spiral into the old, "It is me, I didn't do it right. It's my fault, what is wrong with me?" You go into depression and despair and try to numb yourself out. Till next time. The longing keeps this dance going. Can you feel it now – what do you call it, "the ache?" Can we stay with this longing for a little? There is nothing strange or "wrong" about this longing, is there?

Tango Move 2 – Affect Assembly and Deepening

How do we help clients discover their emotional experience in a way that is tolerable, tangible, and relevant to them? We focus on the core elements of emotion and then put them together. That is, we *assemble* them *with* the client into a whole that creates a sense of completeness, a "Yes, that is it – that is how I feel and it makes sense" experience. This then opens a door for further discovery and a deepening awareness of more hidden or unacknowledged emotions. Assembling a client's affect is a relatively simple concept but proves to be extremely useful in clinical practice. To address emotion effectively and systematically, to be able to access and name it accurately, turn it up and turn it down, or to order it when it is chaotic, can seem like overwhelming tasks. This is perhaps why directly working with emotion has tended to be dismissed or sidelined in many therapy models. It is useful to remember that, as

discussed earlier, there are really only six basic emotions – anger, shame, sadness, fear, joy, and surprise. The softer emotions, sadness, fear, and shame, are most often less accessible than the others. Clients often present with reactive anger or a numbed-out lack of feeling (which shows up in repeated intellectualization and shallow, detached descriptions of problems.) There are of course many more than five labels for emotion that clients can use but as Sun-Tzu, the Japanese sage who wrote *The Art of War* (5th century BC) said, "There are not more than five musical notes yet combinations of these five give rise to more melodies than can ever be heard."

As noted in Chapter 4, we can think of emotions as comprising components or core elements. The most parsimonious delineation of the core elements of emotion comes from Magda Arnold (1960). Arnold's synopsis of elements is a powerful tool that allows the therapist, piece by piece, to discover, delineate, and unfold an emotional response, distilling its essential nature. The therapist's job is then to help the client shape this experience into a unified coherent whole and link it to habitual ways of engaging with self and others in their life. The process itself not only raises awareness but also improves emotional balance. The phrase, "What we can name, we can tame," comes to mind. The elements of emotion that Arnold lays out are:

- Trigger or cue.
- Initial perception.
- Body response.
- Meaning creation.
- Action tendency.

This final element moves emotion into the realm of motivation. Emotion prepares us for action; it can then be used to propel us toward new actions. In fact, in many contexts it has control precedence and so can be a more potent motivating force than cognition or a key element in what feel like purely cognitive decisions. It also moves us to respond to others and so links to the interpersonal realm. Emotion organizes action and organizes actions toward others, and emotional signals set up and constrain the responses of others to the speaker. These signals also set up habitual interaction patterns, or "dances," that then feed back into and frame the experience of each of the dancers. Each emotion is linked to a discernable action tendency. So anger is an approach emotion that sets up the assertion of needs and the removal of blocks to satisfaction; sadness elicits support from others and withdrawal in the service of letting go; shame elicits hiding; surprise elicits exploration and engagement; joy provokes openness and engagement; and fear elicits fleeing, freezing in paralysis, or a fight response. To reiterate, *emotion can then be elicited to literally move people into specific kinds of action*.

The process of eliciting and unfolding each of these five core elements and then assembling them into a simple, tangible whole, brings implicit emotion out where it can be recognized and identified, explored further, added to, and deepened. Each element has first to be evocatively probed for and made concrete and then linked to the other elements. The process of unfolding can begin with any element but often begins with the therapist focusing on and slowing down an obviously significant but unheeded emotional response (for example, a brief shift in emotional expression) and attempting to pinpoint the stimulus (core element #1 – the *trigger*) that cued this response with reflections and evocative questions.

The eliciting process might look like this:

Therapist: Can you help me Darcy, you just turned away and shook your head and took a deep breath there, as you talked about your ex-husband's huge intellect. What happened there? What is it that has you shaking your head like this?

Darcy: Oh nothing really. He was a great intellectual, you know. (She smiles.)

Th: Yes. But for a moment there you looked like there was something so difficult here – about his intellect. You shook your head and breathed deep. And I know that relationship was painful for you and is still. What happened just before you shook your head so vehemently, I wonder? (Therapist goes into the moment and asks the client to focus in and find the trigger for a response.)

D: (Looking teary.) I fell in love with his intellect but he was just so, so … unavailable, I guess. But he wasn't cruel or mean and, in many ways, I was lucky!

Th: Yes. So you thought of his intellect and then a sense of how … maybe how that was somehow not enough – that was a problem in the end? Is there a moment when your sense of his unavailability really hit home – a moment that stands out for you – or an image that came up for you just before you sighed?

D: (Sighs again.) I would ask him to listen to my feelings and ask for a hug. And this look would come over his face and he would turn away. I guess that is what I was sighing about. (She has identified the trigger but the therapist had to persist. She sighs huge sighs again.)

Th: Yes – when you think of this, him turning away, what happens in your body – right now?

D: (She rubs her hand across her chest.) I feel this ache in my chest. (She tears up.)

Th: (Making her response complete and coherent – recapping.) So you loved his intellect – but you suffered tremendously from his distance – his turning away – that was obviously very hard on you – painful even, and

even now you look pained and … my sense is, very sad … when you say this? (Therapist conjectures about the core emotion – sadness. Darcy nods.) And this ache spreads across your chest. (She nods again.)

D: (Exits into cognitive discussion.) I was young and he was the great professor and he was so … well … impressive … and …

Th: (Redirects.) Can we just stay for a moment with the ache in your chest? Can you feel it right now? (She nods.) Where is the ache? (The more tangible and specific the cues, the better.)

D: Right here. (Points to the middle of her chest.) And it is sad!

Th: Yes – you told me last session that you just had to leave – it became "unbearable" for you. And the sadness of that is still there even after all these years. (Evoking a key emotional word – an *emotional handle* – the client gave in a previous session.) What do you say to yourself as you feel the ache in the middle of your chest? (Therapist is going for the meaning making that is part of the emotion.)

D: (Tearing up.) That it was always like this – in my family – with men – with my husband. I was always on the outside, no matter how hard I tried to please. And so I can't risk it – can't let anyone close anymore. Not going to … (She weeps.) But that isn't what I want really …

Th: YES – connecting to others is so scary, has been so painful for you so you say to yourself, "It's too dangerous." But a part of you wants that closeness. (She weeps.) It's hard to even stay with this and talk about it with me, isn't it? (She nods.) And when you feel this way – this ache – and say to yourself, "Letting anyone in is too big a risk," what do you want to do? What do you do when you feel this way?

D: (Laughs.) OH, I call up the guy I was talking to on the internet and tell him I am going traveling and don't want to meet up. And I distract myself with booze. (Her face goes still and flat now.) I guess, if I am honest – I run and zone out – I numb out. (Sighs.) I guess that closeness is not for me! It's too hard for me. And that is my life! I numb out a lot!

The therapist now takes all of the above and evocatively reflects all the elements, putting her emotional response into a clear, concrete, and coherent whole. He or she is open to the client's correction here. In the end, the core emotion – sadness (but there are implicit elements of fear as well) – is clear, as well as how her emotional response organizes her relationships with others, her sense of self, what she can and cannot safely do, and also her existential frame for her life.

The therapist constructs Darcy's emotional response with her, enhancing focus, specificity, and "granularity" as she does so. Darcy becomes absorbed in this process and, finding *order* in this experience, her window of tolerance widens. She can then move to own and integrate this experience. The

therapist most often then goes on to provide affirmation of the client's ability to do this and for the "reasonableness" of his or her experience. *Being able to grasp, make sense of and trust one's own experience is the ground on which positive adaptation stands*. Once Darcy can do this, she might be asked to declare it to her ex-husband (see Tango Move 3, below), for whom, even after a decade, she still has so much unresolved ambivalent grief.

The discovery and assembly process regulates emotion at the same time as it elicits and distils it. As they occur, key emotional responses are made coherent and integrated into self and relational system. Once therapists have a core set of emotions to focus on and a clear list of the elements that make up any emotion, they can put all the pieces of a complex emotional response together and place it in the context of the interpersonal attachment dramas where this experience originates and still occurs. In this way, reprocessing and expanding emotional awareness becomes a systematic, intentional, but relatively simple and predictable task. This new formulation of emotion can then be used as a source of relevant new information about the nature of self and others, about the forces that constrain growth and keep a client stuck in depression and anxiety, and provide clarification about what one needs to grow and thrive. New emotion opens the door to new meanings and new sources of motivation. If we hear new music, we naturally find ourselves moving differently.

However, assembly is not the whole story; it is the prelude to the next part of Tango Move 2 – Deepening engagement and exploration of emotional experience. Once emotional elements are named and made sense of, the therapist concentrates on increasing engagement with deeper core emotions. *If the problem involves "frightening, alien and unacceptable" emotions, then in the deepening process, core emotions become much more manageable, normalized, integrated and accepted, even valued as part of self.* These deeper emotions, most often fear and its attendant helplessness, shame, or sadness, may be relatively easy to access and engage with or they may emerge only with significant effort. In Darcy's case, the rejection she experienced in her family of origin, especially from her mother, was crucial in setting up a distrust of others and a sense of the self as unlovable and unworthy. In deepening, she was able to grieve the manner in which this had framed her life and relationships and confront her fear of depending on others and risk being controlled and defined. The pace and level at which this "deepening" is done depends on the openness and ability of the client to recognize and tolerate emotions that are unfamiliar, fragmented, or frightening. They also depend on the stage of therapy and solidarity of the therapeutic alliance. The therapist often simply touches on or leads into a "new" and deeper emotion, and then guides the client into the process of distilling the essence of this emotion (or acknowledging blocks to this process). Once this is done, then the therapist will encourage the client to stay with and explore the emotion on a deeper level. The goal is to discover

and clarify the emotional reality – the engine of fears and longings behind the narrative that the client brings concerning their problems and dilemmas.

In Stage 2 – Restructuring, this deepening might look like this:

Therapist: Darcy, can you stay with that image of your mom wagging her finger at you? Telling you to go off and live with your friend and her family – that no one would miss you at home. What is happening here? Is this one of those times when you, as you put it, "are crushed and full of darkness?" When you say to yourself, "She will never accept me – doesn't want me?" (She nods emphatically.) "What happens at this moment?" (Note, the therapist places responses in the everlasting present.)

Darcy: It's terrifying – overwhelming. Everything is pointless? (She sinks down in her chair and curls up.)

Th: (Very softly and slowly, evocatively using the client's images and emotional handles. Also using repetition and proxy voice – speaking in the client's own voice.) Yes. That is so terrifying. You said before it's like hitting a wall. In that moment there is nowhere to go and nothing you can do. And you say to yourself, "She will never accept me." Your father is gone – she is your only chance at comfort and caring. You told me, "I was too difficult. I was too feisty." And you decided, "No matter what I do, how hard I try, she won't hold me." She would never give you the message that you were/are "precious," which is what you said you longed to see in her eyes, just once. So much longing – it's still there 50 years later – and so much despair. The wall still looms when someone begins to get close. You say to yourself, "I will never feel this kind of love. I have to give up the hope. I cannot face that wall again. It just hurts too much." (Darcy weeps.)

D: That kind of love is not for me but I can't breathe without it. (This is a key existential dilemma for many clients.)

To summarize, what does the therapist do to deepen a client's emotion in Stage 1 or 2 of EFIT?

She uses herself – her tone and her presence in what we call RISSSSC (connoting a response to client risk taking). It matters HOW the therapist says things here; the music of emotion matters. He or she reflects, uses evocative images, uses the 4 S's as a style (note we have now added a fourth "S" to the acronym for *specific*); that is, she stays *slow* and *soft* or low in tone, uses *simple* and *specific* words, massages and repeats key phrases, and uses words and images that constitute emotional handles for the client – repeating the client's own words. To move into emotion, we will reiterate again and again, the therapist has to *evoke* experience and stay soft/low and slow. *Connection and comfort and the movement into deeper experience are offered simultaneously.*

To expand on this acronym a little more in terms of the technique of intervention:

- Reflection is more intense and more frequent here. The goal is to hold the client in the emotional experience; to have the client stay at the leading edge of their experience and keep a specific focus. This fosters a deep engagement in *absorbing* inner exploration and discovery. Clients have sometimes told us that this is a trancelike state.
- Repetition is also more persistent and deliberate in deepening. The metaphor many EFIT therapists use is that it often seems to take up to five repetitions to gentle the amygdala into accepting a more intense and difficult emotion. The first time it is offered, it is often rejected and pushed away. But it gradually becomes more familiar and less threatening and is considered and even accepted and explored.
- Images may evoke emotion directly and work at a visceral level and capture so much of an experience that they are invaluable in deepening. Metaphors capture complex realities in a way that primes the nervous system and brings it online.
- The therapist notes, (literally, usually writes down and keeps to hand) key handles – client words and phrases – and then employs them here, as well as keeping focus and redirecting when necessary. The therapist also uses proxy voice – speaking as the client to intensify the deepening process.
- The therapist sometimes takes a step beyond the explicit stated experience and adds to it in terms of implications or meanings. This is done carefully, not straying too far from the client's experience and always trying to stay attuned and noting the client's level of tolerance. If the therapist offers a too overwhelming interpretation or one that is too far from where the client is in the moment, then the client cannot follow and absorption is lost (this is a rabbit hole moment).

As a result of the above assembly and deepening of emotion, clients move into deeper levels of experience – Level 4 and up (as described in Chapter 4) is where change occurs. Assembling and deepening emotion in the above manner is an essential and signature element of EFIT.

Tango Move 3 – Choreographing Engaged Encounters

In this step, the client's internal drama moves out into the interpersonal realm and clients are guided to share with the therapist, with an imaginal significant other, or with a part of self (for example, the vulnerable child part of self), the assembled and distilled (and sometimes deepened) emotional realities engaged with in Tango Move 2. In the course of the client's sharing that emotional experience with a significant witness and enacting their inner reality in

an alive drama, new or *expanded emotional realities are made explicit, concrete and coherent*, and the client comes to own them.

Of course, this other in the encounter is actually present in couple and family interventions but imaginal representations are extremely powerful, loaded as they are with attachment survival significance and hot emotions. The imaginal others may be emotionally accessible, responsive, and engaged and so a source of comfort and reassurance, or they may be unable to be so engaged and may even be hostile or traumatizing. In either case, the client's connection to this other is explored, moderated, and given direction by the therapist. Whether the encounter is positive or negative, new emotional music invites the client to try a new kind of dance with this other person, often at a different level of connection. Sharing newly accessed vulnerability with a significant other, even on an imaginal level, expands a person's behavioral repertoire and also has the potential to pull new, much needed responses from the other. Sharing a genuine encounter with the surrogate attachment figure of the therapist can also be very significant. For example, in the training video, *Emotionally Focused Individual Therapy – Working with Anxiety and Depression*, the first author suggests that the client ask her if she is ever caught in bottomless self-doubt, since he believes that only he is so inadequate as to be so caught. When he manages to bring himself to ask and she tells him of an instance where she dismissed her achievements and doubted her abilities, he bursts into tears – realizing that he is not the only one who does this. Self-disclosure of this kind on the part of the therapist is deliberate, disciplined, and always designed to have a specific impact on the client – in this case of containing his shame and normalizing self-doubt. Being able to own vulnerability with an imagined parent who then responds negatively with rejection enables a client to move into asserting their legitimate hurt and need, accepting their loss, and taking a new position with this internalized parent. Asserting an emotion with another also deepens engagement with this emotion and allows it to be integrated. In these enacted dramas, models of self and other become accessible for revision.

Tango Move 3 can be viewed as a form of exposure therapy. In a safe environment, with the protection and direction of a professional, clients move into challenging interpersonal encounters where they may have been wounded or threatened in the past and negotiate this territory differently and with different consequences. As in formal exposure therapies, the therapist titrates the risks a client takes and often uses the *Slice the Risk Thinner* intervention. Suggesting, for example, "Perhaps this is too hard. Can you simply just tell him then, 'It is just too hard to tell you about … I cannot do it right now'?" Here speaking and owning one's resistance is the beginning of the ability to actively engage in difficult emotion. These encounters can also be viewed as a

key ingredient of a corrective emotional experience, where key life dramas are returned to and transformed.

In Stage 2 – Restructuring Tango Move 3 may look like this:

Carol, a depressed client, has her eyes closed.

Therapist: So Carol, can you see your mom? Can you tell her about this desperation? (She does this with deep feeling.) Can you tell her just how hard this is for you and how it leaves you with, as you said, with no oxygen, always fighting for breath or looking for ways to not feel – to numb? (Carol explores her "numbness" and "aloneness.") What do you – that numb part of you – want to tell her?"

Carol: (To the therapist.) I want to tell her, I had to shut down cause this hurt so much and cause I thought it meant that there was something wrong with me. But shut down is no way to live your life!

Th: So close your eyes and when you can see her, tell her, tell her that.

The above is a relatively simple Move 3. This move can last for just a few minutes or it can take almost a whole session. It can be relatively superficial, especially in Stage 1, or more intense, as with Henny in Chapter 1 of this text.

Move 3 works when the therapist has evoked and clarified the client's emotional state beforehand, often bringing up key emotional handles, and is attuned as to the client's resources and vulnerability in such an encounter. To prepare for a client to become present with a traumatized younger part of self, the adult part of the client has to be resourced by contact with a stronger, wiser adult self (see Henny in Chapter 1) and the therapist has to titrate the risks taken by the client – the intensity and level of the encounter. The more on target and poignant the emotion and the messages the client can send to a part of self or an imagined attachment figure, the more potent Move 3 will be. These enactments recreate the arena – the crucible where key parts of the self and key models of other were generated and allow for revision.

This EFIT macro-intervention, the enactment of one's emotional reality with imagined or real others, has its roots in the techniques of Gestalt therapy and the work of Fritz Perls (Perls, Hefferline, & Goodman, 1951). The EFIT version of this is less cognitive and technique oriented than other approaches that use this kind of intervention. We do not ask people to change chairs, for example, but might simply ask them to close their eyes or go inside, and we do not focus on identifying many parts of self and their different roles. The process is a natural development from EFT for couples where new structured dialogues (new music) create corrective experiences that change the nature of the relationship (the dance between partners). It is based in the concept that the self is an evolving process, not a product, and it is one that evolves

in relation to others. An enacted drama heightens this relation and makes manifest more implicit realities. It is guided in EFIT by the attachment map to longings and vulnerability.

Tango Move 4 – Processing the Encounter

In the fourth Tango Move, the therapist reflects and summarizes the process of interaction – the transactional drama that arises from the client's newly accessed emotions being directly stated, owned, and shared in an engaged way. With the client, the therapist explores what enacting this emotion was like and how the responses of the other (whether therapist, imagined attachment figure, or even unfamiliar or disowned part of self) were heard and integrated. In six sessions, Fern, the client in Chapter 5 of *Attachment Theory in Practice* (Johnson, 2019), encounters her own guilty judgmental self, which then turns into an encounter with her judgmental older sister and key encounters with her unsupportive ex-husband and with her father. Key moments are when Fern feels entitled to be mad at her demanding perfectionistic father, when she confronts her sister and tells her that she can now forgive herself in spite of her sister's condemnation. Fern is able to congruently and authentically tell her sister that her pain matters and that from now on, she will be herself and define her own worth. Mostly, Fern's process was about going through the emotional turmoil to be able to encounter these figures and asserting her reality in the face of their stonewalling. With her ex-husband, she also went into a struggle to allow his more positive messages in. Blocks to speaking one's truth to the other, in taking in the other's positive response, or dealing with a negative response from others are also explored.

New emotional experience then becomes a new interactional drama where the self is defined differently and now this drama has to be reflected on, explored, mined for meaning, and integrated into the formal cognitive representation of self, of other, and the client's general orientation to relationships. It is important to note in terms of possible performance demands that there are *no failures* here. It is just as useful and interesting if a client cannot set up or move through an encounter as when they can. As noted above, in these cases the therapist uses the *Slice the Risk Thinner* intervention. In EFIT, this is used when a client who can formulate their emotional message cannot bring themselves to be explicit and give this message to the imaginal figure or even to the therapist. The resistance, the block, as with other blocks in the process of EFT, is simply accepted, normalized and worked with as a process, as in, "Can you close your eyes and tell your father right now, 'I can say this with … [the therapist] but it's just too hard, even in my imagination, to tell you this. I am not ready to do it'?" Then therapist and client can explore the anticipated emotional consequences of

taking this new position with the imaginal figure, using the affect assembly and deepening process. The provision of safety, structure, and reflection offered by the therapist allows for the building of momentum; clients can take greater and greater risks in these dramas and process the new information and experiences that arise effectively.

Therapists become very concerned about how to decide which figure to set up Move 3 encounters with. In practice this is not really a concern. The choice seems to flow naturally from following the client's process. Also, if one suggested encounter has no "juice" or does not "take"; that is, the client does not respond or become absorbed in it, then the therapist tries something else. In general, interactions with the therapist are used to counter shame and normalize responses (as mentioned above) or provide validation, as in, "Can you look at my face right now, what do you see? Do you see how sad this makes me feel that you were so hurt? Can you take that in? What happens to you when you see this?" It is also true that with traumatized clients, the process, especially in Stage 2, often naturally moves to encounters where the stronger adult client holds and reassures the wounded and helpless child self (as with Henny in Chapter 1).

Bowlby talked about an attachment figure as a resource – as a perceived stronger, wiser other – and the adult client in therapy supported by the attuned therapist can be this. Some encounters must be undertaken with particular care; for example, any encounter with an abused child and her abuser. If undertaken, these may be kept short, especially at first, or set up only when a client has the resources to tolerate such an encounter. As you see in the first chapter, the therapist can also contain and ground the client by breathing with them or using a soothing voice and images.

To give another example in the restructuring stage, a Tango Move 4 intervention might look like this:

Therapist: (To Carol, who has been imagining an encounter with her mom.) So how does it feel to say to Mom, "I am not going to creep around and beg for your love anymore. I needed it and you couldn't give it. It wasn't about me." (Carol beams and flexes her muscles.)

Carol: (Laughing.) It's new; it's dynamite, that is what it is.

Tango Move 5 – Integrating and Validating

In the final move in the process of new and deeper engagement with one's own experience and with significant others, the therapist reflects the whole process of the previous four moves from a meta-perspective and highlights the key significant moments and responses, using them to validate the client's strength and courage. The message clients receive from this intervention is

that they can change their ways of experiencing and dealing with emotions, understanding themselves and others, and moving in the key relationship dances that shape their lives. In Tango Move 5 the therapist brings coherence and closure to the whole Tango process so that it becomes a building block for continued progress in therapy. The therapist also builds on the positive emotions often expressed in this move, heightening them and finding images for them. Positive emotions have been shown to broaden attention and conceptual breadth, increase creativity, relax vigilance, and so motivate approach and explore behavior (Frederickson & Branigan, 2005). Ideally, the Tango sequence ends with a moment of positive *balance and accomplishment*. Indeed, the neuroscientist, Jaak Panksepp (2009), actually calls experiential therapies "affective balance therapies." Each time this tango sequence unfolds, it then creates momentum for change and boosts clients' sense of mastery and confidence. In this sequence, they can understand their inner life and their relationships and they can make new choices to shape and change both.

In the stabilization stage, this move may look like this:

Therapist: That is amazing Carol, you have just taken all your "weakness," as you call it – all your pain – and faced it, stating it clearly to your mom and now you are beaming at me! Seems like you can deal with this now. You have found the oxygen you need.

Or like this:

Therapist: Wow Henny, you amaze me. Your dad did everything he could to make you small – to destroy you, and look who you are – what you were able to become! All the exciting and creative leaps you have taken – just as on the balance beam in those gymnastic competitions. Look at what you do here in these sessions! Today you … (Summary of process of session here.) You are so brave – you face such pain so bravely. Walk into it and shake it so it's not so powerful or so lethal. It's an honor to work with you.

Going down the Rabbit Hole (à la Alice in Wonderland)

What are some of the common mistakes that therapists make in the moves of the EFIT Tango? Here are some of the main ones we have observed:

In Move 1, therapists may not get specific enough. They may stay close to the client's experience and avoid big leaps, conjectures, and explanations, but they do not specifically outline the patterns of affect regulation surrounding the presenting problem or the patterns in the client's relational interactions

and link the two. It is important to outline the beats in the emotional music the client plays as they walk through life.

Therapist: So you are always worried about not measuring up and you walk into situations watching for disapproval and moments where you could 'fail.' And then it happens and you get a bitter taste in your mouth and you shut down and run. And each time this happens you feel more hopeless and helpless – and more watchful for when it will happen again, yes? It's like you spend your life just waiting for and dreading those moments and now you are getting more 'paralyzed' about trying anything at all? And this happens in your relationships, too – at the first sign of disapproval you run and each time feels more definitive. You say to yourself, 'That is who I am. Alone.'

Please note the specific moves are set out in simple terms and linked together into a clear image or story of a self-fulfilling perpetuating circle that traps the client in her depression.

The therapist then does the same with relational cycles.

Therapist: So you reach out on the internet because you long for connection – not to be lonely. And it's fun – you can play and flirt. But then when someone wants to meet or you do meet, all the warning signals go off in your head and you can't open up to them – you are on guard. Just as you learned to be in your home as a child. You freeze up and find yourself being critical and the person feels the chill and moves away, which confirms for you just how unreliable people are. So you give up and say, 'I can't do closeness,' and go off to try to distract yourself from your loneliness. Am I getting it? And all this then starts the spin of anxiety you talk of – the ache in the stomach, the longing, but then the catastrophic expectations and the withdrawal into numbing and drinking. Am I getting it?

The therapist maps the PROCESS whereby the presenting problem emerges and takes over the client's life. And then, just as the EFT couple therapist does with relational interactions, the therapist portrays the client as the unwitting author but also the victim of this process.

The most common rabbit hole in Move 2 is that therapists talk about emotions rather than systematically evoking them. To change emotion you need to be in it – to feel it. Doing the affect assembly sequence methodically when first learning EFIT seems to help therapists both tune into client's emotion and create clarity for their clients. Ideally, you want a, "Yes, that is it. I never really saw it that clearly and I can feel it here," response. In deepening, we

find that at first, therapists are reluctant to use repetition as much as seasoned EFIT therapists do. Perhaps we think of this cognitively where repetition is tedious and unnecessary. But if we think of it as the client tasting and moving into the sensations of a threatening experience, it is easier to see how important repetition is. When you hear a piece of music for the sixth time, you literally hear more of it and take it in on a different level. When you see something strange or alien, you need to see it a number of times to take it in. Therapists are also sometimes reluctant to use RISSSSC – to go *slow* and *soft* and *simple* and really reach to make emotion *specific.* As discussed in Chapter 4, what is specific is embraceable and manageable, the general does not touch us so much and may seem too distant or too overwhelming to really connect with.

Some therapists are simply reluctant to take people into their pain. It is useful to remember the pain is already there and clients need your help not to avoid their pain but to go into it and through it and out the other side.

In Move 3, therapists may not have set up or recalled a poignant Move 2 so there is no emotional intensity and momentum in the encounter. Clients may also be reluctant to move into encounters at first and the therapist needs to be accepting of this reluctance but persistent. It is also important, in the beginning of therapy, to set up this kind of intervention as a natural process of therapy. The clients become accustomed to this process and move into it more naturally.

In Move 4, the therapist can become discouraged by the blocks that arise when the client cannot immediately accept or integrate new experience. They do not then go into this block, validate it, and use it to continue exploration. In Move 5, therapists are often simply reluctant to validate enough. The validation offered to the client must be genuine, and it must be specific, but it can be about relatively minimal achievements. It might simply be about the client coming for therapy in the first place or simply having survived a particular trial in their life. The authors think of it in attachment terms as similar to a parent constantly creating a safe haven by acknowledging a child and the child's efforts, no matter how small. What is in the way of this is often a cultural admonition to be modest (this is particularly applied to women!). As the first author's mother used to say, "Just who do you think you are?" or, "You will get a swelled head." We suggest it is better to assume that the client has been starved of the acknowledgement – the "I see and honor you" response that is typical of really secure attachment. This kind of validation is a powerful and useful builder of self-confidence and self-respect that is best used liberally and generously.

This EFIT Tango process orients the therapist. When a therapist finds herself lost or confused, she can simply return to this core process as a meta-framework – a basic set of foundational interventions – and begin to orient

herself again. Please note that *the moves of the Tango are intended to be a guide, not a rigid formula*. Please bear in mind that all five moves of the Tango are not always fully played out in a session. They are also not slavishly executed in exact order every time. Sometimes a leap into the validation of Move 5 is called for, for example, or a stuck place in Move 4 where a client cannot process an encounter, may require a return to the systematic affect assembly process of Move 2. Each of the moves, especially in the most intense sessions in the restructuring stage of therapy, could take up a large part of a session itself. In the softening change events (laid out in research studies of EFT couple therapy and discussed more later), moves 2, 3, and 4 of the Tango are intensified and often repeated a number of times to shape specific new levels of deeper experiencing and discovery.

In all the moves of the Tango, the therapist strikes a balance between safety and challenge, titrating the risks he or she asks the client to take and paying attention to the client's window of tolerance. In all Tango moves, the EFIT therapist takes the stance of a *curious explorer* of the client's world, a process consultant who stands with their client, moment by moment, as they touch and organize their experience finding the fragmented, denied, and avoided elements in that experience, discovering the experience and the story the client constructs about their life. Both client and therapist are then in a process of collaboratively exploring the common dilemmas of being human. The therapist, however, is the client's secure base and the safety of the alliance allows the client to attempt a new level of engagement with his emerging experience *as it occurs and is being encoded in the brain*. Neuroscience suggests that this deeper engagement allows for the optimal shaping and reshaping of neural circuits as they are being challenged (Coan, 2008, personal communication).

Once the basic sequence of these moves in the EFIT change process is mastered, therapists can improvise with creativity. The therapist can become more and more authentic and present in session; indeed, he or she can play! In all of these processes, therapist and client listen to and modulate the emotional music, shape new interpersonal responses and positions, and choreograph specific corrective emotional experiences to evoke adaptive shifts in patterns of affect regulation, models of self and other, and key relational patterns.

To reiterate, a Tango is a dance between two people based in attunement and co-ordinated responsiveness. It is danced to the music of emotion in a way that unites the dancers and creates a new reality – synchrony. Moving together in synchrony is a natural source of positive emotion, even joy, for all living beings who bond together. As Melinda Gates so powerfully states in her recent book (2019), the tipping point in real transformation, that is, the "moment of lift," is always a connection.

This chapter has outlined a meta-framework sequence of interventions, the moves of the Tango, and associated processes of change.

Chapters 7, 8, and 9 will show the Tango and the above macro-interventions in the three different stages of EFIT with a particular client.

Play and Practice

For You Professionally

A depressed client, Martin, tells you the following:

> I know you will say that this has happened before and I guess it has, but I got just wiped out by a woman again — at a party on Saturday night. So I just crawled off with my tail between my legs as usual and then spent the next day listing all the reasons why I seem to have such a total failure rate with women. It's hopeless. I am just not what women want. It's just never going to work for me. Some of the women there were friendly enough, I guess, but … well I tried coming on to one of them, made a sexy remark or two. Disaster. She just changed the subject on me. I felt so stupid that I felt sick. So I just up and left the party. What is the point! It is just the way it is with me. I can't stand this anymore. Maybe I should just blow my head off or something. (Laughs but then closes his eyes.)

How might you, in very simple terms, reflect this (Tango Move 1) in a way that helps Martin begin to see this drama (i.e., how the way he deals with his anxiety at the party and after he leaves confirms and maintains all his worst fears) and also validates his painful feelings and conclusions?

The "diagnosis" Martin arrives with from his doctor is depression but we can also see the key elements of debilitating anxiety here, intense emotion and vigilance to threat, coping mechanisms and attributions that exacerbate the problem and avoidant strategies related to inner feelings and interpersonal situations.

How would you then help him systematically assemble his emotions here (Tango Move 2), using the elements of trigger, initial perception, body response, meaning creation, and action tendency?

Try writing out what you would say. (This is play so there are no wrong answers!)

For You Personally

Think about your key relationships and identify some emotional responses that you have never shared with an important person in your life. As you assembled your emotion clearly, and distilled it, can you write out what you might like to say to this person in your life? Try to include sharing your vulnerability

and what you need from that individual to feel more secure. Reflect on how it feels to do this.

To deepen your understanding of the EFIT Tango, an extended play and practice exercise is provided at the end of this book as an appendix.

BOX 5.1

Choreographing the Encounter (Move 3) – General Principles

- Follow and build the intensity of the emotion/emotional charge.
- Look for doorways – emotional handles, key pivotal moments.
- Consider therapeutic pacing/client's capacity. Do you need to resource client, with aspect of self/significant other?
- Consider immediate goal – e.g., remove block, resource client, build trust.
- Anticipate outcome/imagine encounters, e.g., is it necessary to confront an extremely abusive parent?
- Facilitate closure with a key other. Help client send key message, especially about sense of self.
- Keep the drama simple/focused.

6

What Are the Key Micro-Interventions Used in EFIT?

Soundbite Answer to Question
A Tango is a sequence of structured interventions. What we are considering here are more discreet, smaller therapist responses that are continually used to address the client's inner or interpersonal experience in a way that moves the session forward. These interventions come from traditional humanistic Rogerian therapy and from more relationally orientated models of family therapy. The focus is always on the present and on process variables.

The main micro-interventions used in EFIT, and indeed in the EFT general model, are listed below:

- **Reflection** – to capture, order, and distill inner experience. Best if immediate, vivid, and alive. Imbued with relentless acceptance and empathy.
- **Validation** – of protective strategies, perspectives, stuck places, and needs.
- **Evocative questioning** – a what, when, how, process-oriented exploration with the client.
- **Heightening** emotion or deepening engagement in experience using techniques such as repetition, imagery, or the use of proxy voice.
- **Interpretation** – small conjectures that stay close to the client's experience – at the leading edge of this experience. Made tentatively.
- **Reflection** (version 2) – the mirroring of interactional patterns and the self-reinforcing nature, as well as the impact of these patterns.

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- **Reframing** – of attachment meanings, life events, responses in the service of the acceptance and the expansion of self.
- Setting up and **shaping encounters** with elements of self, significant others, and the therapist. Here the therapist may use other interventions such as *Slicing the Risk Thinner* and contain emerging negativity by *Catching the Bullet*; that is, framing a message in terms of the limitations and blocks of the sender when messages with or from imaginal significant others become negative.

These micro-interventions are used continually in EFIT sessions and become part and parcel of the EFIT Tango. Some techniques may fit especially well with particular Tango moves and therefore be used more frequently with different moves. Some are used constantly, for example, the EFIT therapist takes every opportunity to use reflection and validation from the first meeting with clients until the last handshake. Evocative questions are used generally as part of the model but are particularly useful in the Affect Assembly and Deepening move of the Tango. The micro-intervention, validation, is an obvious and central part of Tango Move 5.

When combined, these techniques interact and mesh to construct different interventions, just as discrete ingredients combine to make different kinds of bread. Reflection, for example, can be empathic and soothing, a tool to summarize in the service of creating coherence, or it can even be a confrontation if it is describing behaviors that a client does not want to own.

What Do These Interventions Look like In and of Themselves In EFIT?

The micro-intervention *reflection* attends to emotional processing as it occurs. The goal is to focus on inner experience and make it explicit, concrete, tangible, and alive. Bowlby spoke always of significant inner experience as a "felt sense," that is an embodied experience, rather than focusing just on cognition or information processing. For example, the therapist might say, "As you tell me that you are now fine with how this loss of your best friend occurred, I notice how very still you are and how you seem to be holding the arms of the chair very tight."

The goal of *validation* is to affirm and *normalize* clients in their struggles, protective stances, and attempts to grow, building a sense of constant safety in the therapy session. The therapist especially validates habitual patterns of emotional regulation and attachment longings and fears. This reduces the debilitating sense of aloneness or shame many clients associate with their problems. The therapist might, for example, the following.

Therapist: This must be so hard for you, Tim. As you say, you are in foreign territory here. You have never had the experience of staying with and making

sense of your feelings, and what worked for you in the past was just to distract yourself and turn off. So, of course, that is the first place you go.

Evocative questions and responses are used to elicit underlying emotions and thoughts – ways of constructing experience. Key moments are replayed and key experiences that shape self and system are delineated from the most basic process elements of experience – sensations, perceptions, and emotions – that is, from a bottom-up, rather than from an abstract, top-down cognitive perspective. Almost every concrete question is asked but not the question, "Why?" Examples include the following.

Therapist: What just happened to you, when I commented … ? When does this sinking feeling, this helpless feeling come up for you in your life? How do you do that – just 'turn stuff off,' as you say? Where do you feel that in your body right now? How can your partner help you with that feeling in this moment?

Deepening engagement in inner experience involves heightening the salience of a moment or a response and delineating the response further. Repetition and evocative imagery or questioning are particularly useful here. It is helpful to think of skillful repetition as wearing away at the muscle required to suppress emotion and, also, as gradually rendering what is new and strange as more familiar. This deepening technique is a key part of the Tango Move 2, but it is also a general experiential technique. For example, a therapist might use a particularly powerful evocative image in setting the tone for and bringing drama to an enactment (Tango Move 3).

Therapist: I hear you. This feeling of wanting to hide, to just keep everyone out, is so compelling. It's urgent. So part of you says, 'This is life and death.' Life and death. If someone sees you, something dreadful is going to happen, yes? You can't risk that. It will be terrible – a catastrophe. You are not sure you would survive – being really seen. It's dangerous? Yes, dangerous. The only way is to be invisible. Unseen, that is safe. It's protection – but protection that becomes a prison.

The therapist uses interpretation at the leading edge of a client's experience. Here the therapist ventures an extension of the client's expressions. Care is taken that such conjectures are framed tentatively. If the desire is to increase intensity and deepen engagement, then these interpretations can be offered in a proxy voice – that is, they are framed as if the client himself is stating them. If interpretations are too far removed from the client's present state

or understanding, they evoke resistance. The key is to stay close to the client's experience so that the client is not asked to stretch too far or too fast from what is familiar and safe. A therapist might reflect a client's word like "uncomfortable" and add the words, "difficult," "hard," or "a little scary." If the client does not adopt any of these conjectures, the therapist will often back off and wait for a better time.

Therapist: So, can you help me, Jim? When your son reaches for you, you kind of freeze up, yes? You go still and silent. You don't know how to respond perhaps? This is not a dance you know – you didn't grow up with people making these kinds of appeals and others responding. Perhaps you say to yourself, 'If I move, I am going to get this wrong. I am going to blow it with my son and my wife and everyone will get upset with me. I will hear that I have failed again. Best to be quiet and hope this blows over.' Is that it?

Reflecting and tracking interactions and interpersonal dramas as they occur in session with the therapist, in a client's narrative, or in imaginal encounters is a key part of EFIT. The goal is to identify and outline significant responses and the patterned steps that typify distressing or stuck places in these interactions and to bring into high relief the nature of self-generating cycles of interaction.

Therapist: So this happens a lot. As you portray this dialogue with your wife, you are always insisting and pushing for her to hear your point of view. You want a response. But she 'refuses' to be persuaded and 'dismisses' you. And the more she shuts you out, the more you push and demand, until you are completely exhausted.

The use of reframing in order to shift the meaning frame of an interactional response or cycle is also part of EFIT. The desired shift might be from helplessness to agency, from negative and dangerous to positive, from critical and hostile to desperate. Reframing is used at moments of emotional intensity when negative interactional cycles are being addressed or when negative models emerge as to the nature of self in such cycles. The goal is to shift a client's perspective from a problem-reinforcing mindset to a frame that expands awareness and acknowledges underlying attachment vulnerabilities.

Therapist: Your father would get 'big and loud' and tell you that you were just a bad kid in these situations and there was nothing you could do. And this figure of your father stands behind your husband, Bill, and you hear the same condemnation. (Client nods in agreement.) But maybe Bill

is calling to you because he needs you to turn towards him right now. Maybe he is loud because he is desperate for your help; because you are so important to him, not because you have made a mistake. He might be asking for your help. Can you see that?

At another time, the therapist might say it differently.

Therapist: You are telling me that you see yourself hiding from your father as proof of your cowardice. That is strange isn't it? It was your way of saving your life. It was a brilliant move at a terrible time. What a clever thing to do.

The direct choreographing of interactions and responses can be used in three ways. First (in Example 1 below), in order to pinpoint reoccurring problematic moves that are resistant to change. This technique helps bring these moves into the light so they are clear and more available for modification. Second, the therapist might also use direct choreographing to exemplify and dramatize new responses; after all, what is admitted to another becomes more real. Third, this technique is used frequently, especially in Tango Move 3, to turn new emotional experience into new signals to others that then potentially evoke new responses and so set up new kinds of corrective experiences and change the drama of self and other.

Examples of these three uses of shaping interactions follow.

Example 1

Therapist: So as you say, you have only anger for him right now. So you cannot do anything but tell him his mistakes. Can you simply tell him, 'Right now, I am so angry, I want to push you off balance, maybe I want you to hurt, to know I can hurt you. So I just keep lashing out at you. I want to have an impact on you – to make you see my pain.

Example 2

Therapist: So you are talking about feeling small in the moment before you move into making all these threats. Can you simply tell your mother as if she were here right now, 'I do judge you but in the moment before I puff up and criticize, I feel so, so small'?

Example 3

Therapist: So can you hold onto that amazing crystal clear statement and turn your chair, look into his face as you see him in your mind's eye and tell him, 'I show you my armor and tell you my reservations but inside I am so scared to risk and ask for your love. A voice in my head says you will not want that small scared me.'

The exact nature and quality of all these interventions depend on the specific context in which they are used. Whatever form these interventions take, it matters how they are done.

The Tone – the "How" of the Technique

It is important to repeat that, as previously stated, interventions are only effective if they are delivered in a particular way. As with any intervention that privileges secure connection between therapist and client, the non-verbal communication from the therapist – how things are said – is of crucial importance. Communication theory stresses that there are always two levels in a message. One message offers informational data. The second message, which is often implicit rather than explicit, carries messages as to the relationship between the speaker and the listener. This second level of communication seems to take precedence in terms of how we take in information. Health professionals are often so focused on offering information that they neglect the emotional context in which that information is received. The EFIT therapist constantly pays attention to this context. The relational messages conveyed in the non-verbals of the therapist's message to the client are, "You are seen. You are safe. I am with you. You are not alone." This is the best way to be heard, especially when clients are feeling vulnerable.

In particular moments of emotional vulnerability, when clients are risking new levels of engagement with inner experience or with imaginal others, the therapist interacts with clients keeping the acronym RISSSSC (outlined in the previous chapter) in mind. The elements in this acronym stand for: *Repeat*, *Imagery*, *Simple* Words, *Slow* Pace, *Soft* Voice, and *Client's* Words. We have, of course, added another "S" to this acronym for *Specificity*, as mentioned elsewhere in this text (Chapter 4 in particular). Other clinicians have noted that the music of a message – the prosody – speaks to the nervous system of the client. Tone, tenor, and pacing particularly impact the client (Hughes, 2007). Clinical wisdom from many years of working with highly distressed individuals, couples, and family members has shown again and again that these stylistic features make a significant difference in therapy. Clients, for example, will most often not take the risk of deepening their engagement with their vulnerabilities or hanging out at the leading edge of what is known, to discover new territory if the therapist goes too fast, uses many abstract intellectual words, or speaks in a high or impersonal, externally oriented tone of voice. The latter are sure rabbit hole techniques. It has become somewhat of a cliché in EFT training for novice therapists to murmur the mantra, "Soft, Slow, Simple," and more recently to add, "Oh yes – and Specificity." If we need a model for this style, we only have to turn once again, to an attachment image – the image of a security priming mother interacting with an anxious child. A parent can be making positive comments but unless they calm the child's nervous system,

that is, unless the pace is slow and the prosody is soothing and the focus of the message is specific, the positivity is most often lost and the child's response is difficult to predict.

It is worth repeating here that in all these interventions, repetition is often used but it is not offered in the spirit of skill building but in the spirit of aiding real listening. To reiterate this point, James Gross (1998) stresses just how much effort the suppression of emotion involves. This effort is undermined by repetitive reflections and evocative images. After some five or six evocative repetitions (for example, calmly restating a client's reluctant admission of possible inferiority), which, contrary to the client's expectations, do not trigger any catastrophes, the client's fearful resistance of exploring this sense of inferiority begins to wane. Suppression then simply dissolves. Repetition is also absolutely necessary to enable the client to orient to and take in strange, foreign information. Using the client's words also evokes acceptance and familiarity. Images also move us and pull us in, capturing complex realities in simple powerful ways.

This chapter has outlined the general micro-interventions used in an experiential attachment emotionally focused model.

The next three chapters will show the Tango and the above micro-interventions in the three different stages of EFIT with a particular client.

Play and Practice

For You Professionally

For this exercise, refer to the transcripts of Sessions 5 & 6 with Kat in Chapter 4.

1. Look back at the transcript of Session 5 with Kat and put your finger on Move 1 of the Tango – Reflecting Present Process, as it relates to her eating disorder. Then see if you can put your finger on Move 2 – Assembling Emotion and where exactly the therapist discovers trigger, perception, and body response. What are the evocative questions the therapist uses in this process? The meaning Kat makes in this experience is all about aloneness and lack of safety. Identify the action tendency which translates into the rule by which Kat lives her life.
2. Find where Kat is invited into an encounter with a part of self. See how the therapist sets this up and find your own words for how you might invite Kat into this drama. What are the two core emotions that Kat and the therapist identify in this excerpt? Note that this journey takes Kat into identifying her core need.
3. Find two specific places where the therapist uses the micro-intervention, validation, to support and to normalize Kat's struggles.
4. In Session 6 with Kat, find a place where the therapist uses proxy voice – speaking as the client – to heighten emotion. Find an interpretation the

therapist makes and two instances of validation. Identify the place where the therapist very simply states/reflects Kat's basic existential fear/reality (one that John Bowlby would not be surprised by).

5. Now think of one of your own clients and see if you can imagine what the elements of affect assembly might look like with this person at the end of Stage 1 of EFIT. How might you do this and how might they respond? Can you think of at least two encounters you could set up with this client that would be meaningful given their history and their emotional reality? Set out how you would focus the emotion and invite them into one of these encounters.
6. See if you can imagine an encounter that you, as the therapist, might have invited Kat into with you in one of these sessions, perhaps to normalize her feelings or simply to give her a message about how you are seeing and reacting to her.
7. Given your style and orientation, can you imagine a point where you might get stuck – go down the rabbit hole in the Tango process with this client? How would you recover and get back on track? What exactly would you say?

For You Personally

We would like you to think of a situation where you feel stuck or become distressed and an emotional cycle you enter and habitually repeat in this situation. For example, the first author became airplane phobic and would become caught in the following: days before the flight she would begin to catastrophize about the flight, feel ridiculous and silly, and so try to suppress it and hide it, find more reasons to be worried and avoid getting ready for the flight, become even more anxious, be unable to eat or sleep, and on it went. Each step in trying to deal with anxiety simply fed it until the airport waiting room was the gateway to hell. An interpersonal dance would accompany this and add to it. She did not share or ask for support and so felt more alone and ridiculous in the face of her partner's calm and confident attitude to flying.

See if you can identify a similar situation in your present or past life and the associated interpersonal cycle. Then try to imagine how an attuned accepting therapist might reflect this experience to you.

See if you can then take the situation or distress and identify the elements of emotion and imagine how the therapist might lay out this emotion to identify the core vulnerability and make it more cohesive. A key revelation for the first author doing this for her airplane phobia was that she was indeed afraid but her fear was not about the plane crashing at all! For an experienced therapist, the ultimate cliché was to discover, to her surprise, that it was all about an experience of abandonment as a four-year-old, when she was sent on

a journey that she experienced as traumatic and where she developed somatic experiences that had persisted all her life.

BOX 6.1

EFIT Micro-Interventions

WITHIN FOCUS

- **Reflection** – to focus, order.
- **Validation** – to make safe, strengthen.
- **Evoke/question** – to unpack, specify.
- **Interpret** – to expand meaning and implications.

BETWEEN FOCUS

- **Reflect** – to outline patterns, clarify identity dramas.
- **Reframe** – to shift meaning frames, contain negativity.
- **Shape key interactions** – to create corrective experiences.
  To shape key change dialogues, we also use:
  - *Catch the Bullet* – reframing negative responses in terms of a speaker's inability to attune to another.
  - *Slice Risks Thinner* – acknowledging an inability to risk as a starting point for disclosure.
  - *Seed Attachment* – stating attachment realities while honouring a client's inability to accept these realities.

7

How Does the EFIT Therapist Tune In and Find Focus – Assess the Client?

Soundbite Answer to Question
The therapist's goal in EFIT is to tune into the struggle that brings a particular client to therapy, along with the strengths and resilience that this client exhibits. The primary goal is to gain an initial picture and felt understanding of how clients' current circumstances and histories have shaped and continue to influence central aspects of their present self and social and emotional functioning. The therapist immediately attempts to connect with the client and notes key factors, such as emotional tone, central aspects of the client's story, and the goals that bring the client to therapy.

The image of health offered by attachment science, a felt sense of secure connection with self and others typified by emotional balance and cognitive flexibility, offers the therapist a benchmark by which to compare the client's present functioning. The therapist always keeps in mind that the goal of EFIT is not only symptom reduction but the optimal development of a client's personal self, including the ability of the client to cultivate positive close relationships. Bowlby depicted healthy working models of self and other as flexible, adaptive protocols that are subject to ongoing revision and change in light of new meaningful emotional and relational experiences. This developmental perspective suggests that health is the ability to constantly adapt and grow, to be open and aware, and also, to embrace and learn from new experiences. The self, then, is ever-evolving toward more depth, complexity, and coherence.

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With this image of health in mind, the key goal of assessment in EFIT is to begin to understand clients' vulnerabilities and strengths and to identify the key factors and pivotal emotional and relational experiences that have restricted growth, and, conversely, those that have promoted resilience. Against this backdrop of understanding and with the destination of health in the horizon, therapists can then begin to formulate a plan for moving forward. The three-stage therapeutic roadmap is clear, as are the interventions that will propel this process forward. Assessment provides the therapist with the understanding necessary to chart an initial case-specific route to health. Ongoing assessment offers refinements to this chart, and similarly continues to guide therapeutic pacing and clinical decision making. Once again, assessment and treatment merge.

This chapter provides a framework for gaining an initial understanding of the EFIT client. First, we will briefly review the attachment perspective on distress. Next, the CARE model is introduced. This model offers a guide to assessment and case conceptualization and also represents a therapeutic stance that is held throughout the process of psychotherapy. Following the introduction of the CARE model, "the nuts and bolts" of the assessment interview are described. Sample questions are provided, along with a clinical example, including summary comments regarding case formulation. Final remarks pertain to contraindications, goal setting, and treatment planning.

The Attachment Perspective on Distress

The EFIT therapist focuses not on disorders or diagnoses but instead on the core vulnerabilities that keep people stuck and prevent them from living fully. Although information about previous diagnosis and treatment provides useful information in the assessment phase of Stage 1 of EFIT, the goal of assessment is not to define and categorize mental health issues and problems in formal diagnostic systems, such as the various reiterations of the DSM. The descriptive labels of such systems can be useful in that they offer the therapist an initial picture of the symptoms the client struggles with.

In a similar vein, brief screening questionnaires, such as the Beck Depression and Anxiety Inventories (1996; 1993), may orient the therapist and aid in initial assessment. When a more comprehensive assessment seems warranted, measures such as the Trauma Symptom Inventory (TSI-2; Briere, 2011) may also be helpful in establishing a baseline to monitor progress over time, based not only on the symptom picture but also the fundamentals of attachment (i.e., view of self, interpersonal functioning and affect regulation capacity) captured by this tool. In general, *in EFIT the therapist does not disregard formal diagnoses but looks beyond them, at the individual in their context through an attachment lens*.

How does the attachment frame guide assessment? In terms of case formulation, the EFIT therapist attends mostly to underlying explanatory and

descriptive factors that inform the symptom picture. EFIT is fundamentally a non-pathologizing approach. Bowlby himself suggested that, in general, "Clinical conditions are best understood as disordered versions of what is otherwise a healthy response," (1980, p. 245). Withdrawal and immobilization can be a functional response to impossible or dangerous situations where vulnerability is overwhelming (Porges, 2011), such as finding oneself dependent on a dangerous and unpredictable attachment figure. Easily triggered anger and hypervigilance are likewise functional when the alternative appears to be that one is inevitably dismissed or deserted. Blocks to growth occur when such responses become generalized, global, automatic, and reflexive. The EFIT therapist is interested in how a particular client's natural propensity to grow and adapt has become constricted and iatrogenic.

Rather than focusing on more global constructs such as depression, the EFIT therapist focuses on the underlying structure of the client's lived emotional experience. Bowlby indicated that constructs such as depression could be defined more specifically in terms of key elements. He observed, for example, that depressed individuals commonly describe themselves and their lived experience in terms of four adjectives, namely lonely, unlovable, unwanted, and helpless (see also Johnson, 2019 for a more comprehensive review). David Barlow's unified protocol (UP) model for emotional disorders similarly looks beyond traditional diagnostic nomenclature and recognizes the overlap between various disorders such as anxiety and depression, as well as their common structure (Barlow et al., 2011). He suggests that anxiety and depression can be combined into one joint category, namely *negative emotional disorder*. He too identifies common elements of various disorders such as anxiety (e.g., hypervigilance, avoidant strategies, heightened sense of threat or danger) and depression (e.g., vigilance to failure, self-criticism, social withdrawal, sense of hopelessness, and loss of motivation). These core elements are also common to trauma- and stressor-related disorders, along with elements such as intrusive symptoms (e.g., flashbacks, nightmares, intrusive memories). All emotional disorders can be characterized by frequent and intense negative emotion. This emotion is also experienced with less coherence and clarity and seen as unacceptable to the client.

In general, a sense of the uncontrollability of life and vigilance for threat is a common core feature of an emotional disorder. In terms of coping, emotional disorders are also characterized by various forms of avoidance, both in terms of awareness and in terms of engagement in life experiences. From a process perspective, avoidance is the remedy that maintains the disorder in that it blocks further development and growth.

From a developmental theory perspective, disorders such as anxiety, depression, and trauma- and stressor-related disorders must be considered not only in light of the "symptom picture" but also in view of their origin

and developmental trajectory. With respect to trauma, for example, the EFIT therapist is interested in when the trauma occurred (at what age), how long it lasted, whether there was more than one traumatic event, and whether there was anyone to rely on. Also of paramount concern is how the individual coped. Considered on a continuum, the therapist assesses how that coping strategy might now be reflected in the client's current habitual affect regulation strategies as manifested in the form of either hyper arousal (e.g., anxious, jittery, fast-paced speech), hypo arousal (e.g., numbing, dissociation, shutting down) or some combination of both.

Also relevant to the therapist is the degree to which the client has some flexibility with such styles of coping under conditions of threat or stress. As alluded to above, secure attachment is associated with greater capacity for flexibility and adaptation, allowing the individual to live fully and to grow from new experiences. Attachment strategies characterized by anxiety, avoidance, or a mixed combination on the other hand, might be more or less restrictive depending on the client's capacity to adapt. As viewed on a continuum, clients' reactions might range from being highly automatic, rigid, and reflexive (akin to a "narrow window of tolerance") to more flexible and adaptive. In cases where healthy development was thwarted by trauma early on (e.g., chronic childhood abuse in the absence of any secure connection or support), more rigid and negative models of self and other would be anticipated, as well as more automatic and reflexive affect regulation strategies. Viewed through a compassionate, survival-focused attachment lens, the client's experience and behavior will ultimately always be revealed to be reasonable.

No matter what the presentation, the purported dysfunctionality or the nature or number of diagnoses, the therapist always actively searches for and articulates the client's *strengths*. In some cases, it is a huge testament to a client's courage just to have survived, struggled on, and sought out help. The therapist's non-pathologizing stance is often the first step in promoting clients' abilities to accept themselves and truly explore how they shape their world. As the therapist enters into the client's frame of reference, helping to clarify and focus on what is important to them, key concerns about self, relationships with others, and existential dilemmas naturally emerge.

To summarize, global constructs such as diagnosis and disorders provide us with an initial framework for understanding our clients. As we begin to delve deeper with a view to looking past such constructs and at their core elements and features (e.g., hypervigilance, sad mood, heightened anxiety, self-criticism, social withdrawal), we find clues as to what is most important to the EFIT therapist. That is, how do our clients view themselves and others? How do their strategies for coping with painful experiences prevent them from living fully? How rigid (or flexible) are these strategies? It is here that we focus our attention. More surface/secondary data are important but if we fail to focus

and look deeper through an attachment lens at clients' models of self and other and habitual ways of managing emotion, we will most certainly miss the mark. From an EFIT point of view, relying on traditional formal diagnostic categories does not provide a rich enough understanding of clients for case formulation and effective intervention and so constitutes a major rabbit hole!

We turn now to a guiding framework to help us tune in and stay attuned to our clients. This frame is applied in the initial assessment phase of Stage 1 and is held throughout the therapeutic process.

Tuning In with CARE – Context, Attachment, Relationship, Emotion

As clients begin to share their stories, and as the therapeutic process unfolds, the therapist "tunes into" and stays attuned to four main channels (easily recalled with the acronym, CARE). The first is *context*. Rather than being myopically focused on the problem as presented or some key aspect of the story, the therapist seeks to enter the phenomenological world of the client. As curious and open listeners, experiential therapists seek to immerse themselves in the contexts in which clients live and have lived. Attention is given to factors such as identity (e.g., race, ethnicity, spirituality, religion, gender, sexuality) and environment (e.g., socioeconomic, work/organizational, neighborhood), as well as experiences such as racism, colorism, sexism, and discrimination. The therapist is seeking a view of the client's landscape in its entirety. The goal is to understand how current and historic contextual factors have either restricted or facilitated growth.

Being open to this discovery process may be particularly crucial when clients come from different cultures or different economic, racial, and sexual backgrounds than the therapist. The EFIT therapist maintains a stance of cultural humility and basically undertakes to be a *permanent student in understanding each client's lived experience, in context*. As clients begin to share their narratives, the therapist seeks a broader and deeper understanding. "What was that experience like for you? What did it look like in your school? In your neighborhood?" Clients are the experts on their own experience and central to the art of the EFIT therapist is to become more and more able to sensitively attune to, hold, and capture that experience.

Good listening on the part of the therapist is not enough. Rather, in an experiential assessment, the therapist seeks full visceral and emotional engagement with the world of the client. As the therapist sees, hears, and feels what the client is seeing, hearing, and feeling while key memories and scenes are described, distance between therapist and client shrinks and understanding broadens.

The second channel is *attachment*. This channel taps into how individuals experience and view themselves and key others and how previous relational experiences manifest in their current interpersonal interactions, including

with the therapist. Taking an attachment history is not then simply a story about clients' most important relationships, it is a story about how they came to define themselves and their world. *The self is a process, constantly constructed in moments of connection and disconnection with others*. Irvin Yalom (1980) notes that the therapist must get to know the characters that live in a client's mind, that is, from an EFIT perspective, the characters who are instrumental in telling clients who they are.

The therapist takes notice of pivotal relational experiences that have shaped models of self and other, as well as habitual affect regulation strategies. The therapist also attends to possible current relationship resources (e.g., positive intimate relationship), as well as risk/vulnerability (e.g., longstanding and severe family history of depression) and resiliency factors (e.g., feeling of competence in specific areas).

More securely attached clients are more able to be specific and coherent, as well as more reflective, in assigning meaning to their experience. Anxiously attached clients become easily overwhelmed by emotion and present more extreme and fragmented narratives, while avoidant clients tend to skim the surface of experience, changing topics or deflecting questions and presenting as detached as they recount painful events without reflection or engagement. *How* an experience is encoded and presented is then often more telling than the *what* – the actual information given by the client. As highlighted previously, a focus on the depth of experiencing and the *granularity* of emotion helps to illuminate the client's habitual processing style.

The third channel, *relationship*, refers directly to the therapeutic alliance. Like other therapies, the therapeutic "relationship," the alliance, is a necessary but not sufficient condition for effective therapeutic outcome. As described in greater detail in Chapter 3, the alliance is given careful attention at the outset of therapy and is monitored throughout the therapeutic process, with attention paid also, as appropriate, to potential contextual differences between therapist and client. Difficulties with trust are anticipated with clients with histories of trauma, especially at the outset of therapy, and are addressed with careful attunement and with sensitivity. Throughout the process, attention is given to the therapeutic relationship/alliance and any concerns that may emerge are immediately attended to if and as appropriate.

The fourth channel and key, of course, to an experiential therapy, is *emotion*. The therapist attends to the way emotion is expressed (or not expressed, in the case of numbing or detachment), as well as the manner in which emotion is regulated (e.g., anxious, avoidant, or some combination of both). Clients may present as disengaged from their deeper internal experience – i.e., showing little to no facial expression, for instance, or alternatively taking a hurried approach to sharing their "stories," often in a disorganized manner and commonly with little to no emotional resonance.

The therapist attends to not only what the client says but how it is said. That is, the therapist focuses on both process and content. The way clients tell their stories and engage with others is at least as informative as the content of the interview itself (Main, Kaplan, & Cassidy, 1985). Specific process elements might include body language or facial cues, voice tone, as well as related shifts in such cues as the client talks about various content areas. For example, a tone of anger might be detected in the context of an event that likely engendered a sense of helplessness. As the therapist engages with the client's experience, the therapist tracks how the client expresses and regulates emotion. Core features of emotional disorders are noted. Attention is also given to "emotional handles;" that is, poignant words or phrases, images, key words, or metaphors that represent the client's inner felt experience. Such key words, images, and phrases can then be "bookmarked" with the understanding that they might later be used to open the door to core vulnerabilities.

Further with respect to the CARE model, it is important to highlight that these four key areas of focus are mutually informing. At any one time, at the outset of therapy in particular but also throughout the process, the therapist continually attends to and does not lose sight of any of these four critical dimensions of the client's experience. In the assessment phase, much like the optometrist uses a phoropter (fancy piece of equipment) during an eye exam, shifting between various combinations of lenses while collaborating with the patient to discern optimal sight, the therapist shifts between each of the CARE dimensions to ascertain the most clear, complete picture and *felt understanding of the experience* of the client. As the therapeutic process unfolds, the therapist moves fluidly between assessment and intervention and back again, continually assessing the pulse and confluence of these four perspectives, all the while gauging therapeutic interventions accordingly. For example, during periods of uncertainty in the alliance, the focus will be on this element. When a client's responses are notably overregulated when discussing a childhood memory, the attention of the therapist might turn to clarifying additional context for the experience unfolding in the session. Reflection and validation might then soothe the nervous system of the client and continue to propel the process forward. At times of high racial tension and stress in the workplace, for example, the therapist will shift focus to providing support in this arena. When the alliance is strong and solid and external stressors are low and support high, the therapist can then proceed to interventions aimed at joining the client in further discovering and exploring aspects of painful material.

With attention to assessment, in particular, and getting that initial picture, we now turn our attention to the "nuts and bolts" of the assessment interview. Specifically, a sample of some of the key questions/content areas to be covered within the CARE model is provided below (see also the

professional practice exercise at the end of this chapter for a conceptual summary). A case example is then given to illustrate both assessment and case conceptualization.

The "Nuts and Bolts" of the Assessment Interview

With the above guiding framework in mind, the therapist invites clients to share their stories. Much like setting foot on foreign territory for the first time or entering the home of a stranger, the therapist is cautious and respectful in extending this invitation. The therapist is, at first, a listener and an observer. Walking alongside clients as they share their stories, the therapist meets and gets to know significant others in clients' lives. Particularly noteworthy are key developmental transitions or significant life events and how they were navigated, emotionally and relationally. As well, recurrent emotionally laden themes are especially noted, such as isolation, betrayal, loss, or abandonment.

The therapist starts from a place of inquiry, not assumption. Initial assessment interview questions are open-ended and broad (e.g., "What was your childhood like?"). Inquiries become more specific as the client's narrative unfolds, and as the strength of the therapeutic alliance/relationship builds. Careful attunement guides the process. As therapist and client join in walking through the client's history, the stroll is paced and structured by the therapist and punctuated by various probes (e.g., "Who did you turn to? Did you share your feelings about that? How did that person respond?"). For some clients, those who have never told their story, or have many gaps in their memory given a significant and unresolved history of trauma, this part of the journey may be slow. In turn, the therapist may similarly need to slow the pace of assessment, allowing clients to maintain a safe distance as they discover and share their experience (e.g., reflecting client's words to create focus but minimizing questions and, especially, questions that might feel overly intrusive). Similarly, clients are given the freedom to speak from a comfortable vantage point (i.e., within their windows of tolerance and, once again, for some clients this might be from a place of detachment). At various points along the way, the therapist carefully tracks, reflects, and validates. As clients begin to feel "seen and heard," greater trust and safety is established, the working alliance/therapeutic relationship is strengthened and the overall story begins to take shape and become more coherent to client and therapist alike.

A sample of some of the core questions/content areas pertaining to (1) attachment, (2) relationship histories, and (3) potential vulnerability/risk and protective factors/strengths, is provided below. For a more complete summary of relevant assessment questions, readers are invited to consider some of the available EFIT trainings and resources (see www.iceeft.com). The templates below provide a basic guide and are not intended to be used in any kind of mechanical way. Once again, a curious and open listener, the therapist

loosely structures the interview while maintaining a genuine encounter and act of discovery with the client. In many cases, assessment, case formulation, and treatment planning might take more than a single 50-minute session. With other clients, the relevant information might be gathered more quickly, within one session, and the agenda for therapy also collaboratively established at the initial meeting. Some EFIT therapists will schedule longer sessions, especially in the assessment phase. Pacing will depend on clients' windows of tolerance, among other factors (e.g., practical issues, finances, childcare).

Core Assessment Questions

The simplest and most direct route to get to know clients is to ask evocative questions that encourage them to paint a picture of the people and experiences that have impacted them most. In some cases, the picture will have large gaps that will only be filled in the weeks to come. In other cases, a general picture will be provided early on, with details to follow in upcoming sessions. The therapist's stance of curiosity and openness will engage the client in this process of collaborative discovery.

(1) Attachment History

Attachment researchers have developed simple measures for assessing the core elements of attachment. Following their lead, you might begin your interview by asking general questions such as, "What was your childhood like? What did adolescence look like?" More specific questions about childhood might start like this, "When you look for an image of you as a child, what do you see? Help me to see what you see." Questions about primary caregivers or parents might go something like this, "What two words best describe your mother/your father/your care provider?" A key question from an attachment perspective, "Was anyone there for you?" might be translated and asked in one or more of the following ways, "Who held you when you cried? If you were sad or scared or upset as a child, who would you go to for comfort? What did that look like/feel like?"

Also important from a developmental attachment perspective are questions about key moments of transition such as family rupture due to divorce or loss or developmentally, with regard to identity or growth such as "coming out," becoming sober, withdrawal from drug abuse, and/or relationship dissolution. If the therapist follows the client chronologically, details will often be provided in the natural flow of the discussion. In other cases, the therapist might need to be more explicit. For example, "Are your parents still together?" If there has been loss, "Have you grieved?" and, if yes, "What did that look like? What did you do?" With respect to 'coming out' or 'getting clean and sober,' the therapist might ask, "What did that transition look like? How did key others respond? How did you cope and/or celebrate?"

Inquiries surrounding abuse, trauma, discrimination, and/or racism are also key and important aspects of the attachment interview. Given their potential sensitivity and especially for clients who might be sharing experiences for the first time, careful attunement is again important. For example, in response to queries about such experiences, the client might respond affirmatively and add that there is not yet the safety or comfort to provide additional details. In such situations, the therapist reflects and validates that this makes perfect sense in light of these earlier (and potentially ongoing) interpersonal experiences. Specific queries will be guided by the client's level of disclosure and *window of tolerance*. Questions might include, for example, some version of one or more of the following, "During such times, what did you do?" Again, the therapist follows the client into the experience. Further inquiry, including questions such as, "As you share about this, what is happening inside of you?" is gauged by attunement and with attention to the client's window of tolerance.

(2) Relationship History

Returning to a key attachment-related question, "ARE (Accessible, Responsive, Engaged) you there for me?" the answer is important from a developmental perspective and in the realm of adult relationships. From a meta-perspective, the EFIT therapist is concerned with clients' experiences of *secure base* relationships, the breadth and depth of support and whether key intimate relationships add to risk/vulnerability (if the relationship is insecure/distressed) or are a potential resource in the therapeutic process. Of particular import is whether the client has had key others to reach to and rely on and whether the client was able to take in/be nurtured by the love provided.

Considerations include, for example, whether the client has had any positive intimate relationships and if so, when? For how long? How did that relationship end (i.e., did the relationship and the separation provide opportunity for an experience of secure attachment and a healthy grieving process)? Also particularly relevant are inquiries regarding any history of *attachment injuries* and whether they were resolved (i.e., crises of trust such as infidelity or feelings of abandonment during key times of need, such as birth of a child, miscarriage, stillbirth or terminal illness of a family member). Also pertinent are non-intimate relationships (e.g., friendships) that also might be a source of support to clients as they endeavor to discover and process painful material.

(3) Vulnerability/Risk and Protective Factors/Strengths

Given what we know based on the research of David Barlow and others in terms of biological underpinnings and the overlap in the variables that are used to define diagnostic categories, it is also relevant to ask questions about the client's family and personal history of depression and/or anxiety, as well as

related questions about onset, time periods, chronicity, or recurrence, treatment trials, and outcomes. These same types of questions are relevant with respect to substance use/abuse. Other vulnerability factors might pertain to pain and/or medical issues. Related questions might look something like this, "You spoke about your mom spending lots of time in her room when you were little? Do you know, was she depressed? Was she ever treated for depression?" This question could then be followed with questions about personal history, "Have you ever struggled with periods of low/sad mood?" If yes, the therapist can then probe further with respect to timelines, symptom course, and severity. Follow-up questions aimed at more directly assessing risk and the client's capacity to cope might include questions such as, "During your teen years, when you were depressed, did you ever engage in any kinds of self-harm behaviors (e.g., cutting)?"

As a means of assessing potential resources or strengths, the question above regarding Mom's propensity to spend time in her room might instead be followed by a question such as, "When your mom was in her room for all those hours and your dad at work, what would you do?" Clients provide a variety of answers, of course, but in many cases will highlight various means of "escape" or coping, such as playing with toys, creating a make-believe life, writing, or drawing. Such strategies might still be a resource (e.g., writing) and might be used in the course of therapy. Other resiliency factors to listen for and inquire about include indications of positive model of self in specific areas (e.g., work, academics, sports, art), if not globally, as well as indications of hope and optimism. If sports were a refuge during adolescence, a follow-up question might be whether sports are still a refuge or, "What provides you with a refuge now?" A sense of belonging in affinity or community-based groups may be a resource for the client, as might be engagement in cultural, religious, or spiritual practices. If there are strong indications of a capacity to be resilient (i.e., to bounce back/regain emotional balance) during times of stress but the resource is unclear, a positive reflection can be affirming, followed by a question such as, "Where did you get your resilience?"

With the above in mind, we turn now to a case example. Provided below are a summary and excerpts of a 75-minute assessment interview conducted by the second author, Leanne Campbell. Excerpts are edited somewhat for clarity and brevity. The aim here is to illustrate some of the key premises and guiding principles as outlined above.

An Assessment Interview with Yezda

A mixed-race young woman in her early thirties, Yezda begins the interview by telling me that the past year has been marked by numerous changes (e.g., the expansion of her business, her fiancé's transfer to another city for work). As her story unfolds, she conveys to me that she is searching for a sense of

clarity and cultural identity as she is about to enter a marriage with a white male and is contemplating having her own children. She knows something about her parents' history, her father a war refugee from Iraq and her mother an immigrant from Argentina, but in various ways they both tried to hide their cultures in an effort to protect their children from discrimination.

Yezda tells me that she grew up with God and Allah in her home. Her mother was Catholic. Her father "still considers [them] Muslim," she says and adds, "I've never practiced the faith but it is like a cultural observing of faith." At this point in her life, she does not feel connected to any type of religion. Rather, she believes in energy and the "laws of attraction." This is the type of spirituality she intends to include at her upcoming wedding.

In describing her childhood, Yezda explains that she was a confidante to her mother and a caregiver to her two younger siblings during periods of parental conflict, including her father's violence toward her mother. Yezda's first memory, at about age four, is of her parents arguing, her mother crying and carrying Yezda downstairs, and then going back up only to be pushed back down the stairs by her father. Continuing to recite memories, some happy, Yezda recounts her father teaching her to roller blade and ride a bike. She also remembers their walks together and adds, "I remember he would cut a piece of fruit and have it with him on our walks and we would share that together." She recalls her father as affectionate. Yezda refers also to current and ongoing contact with her father, their weekly phone calls.

Memories of her mother, on the other hand, are less mixed and current contact with her has ceased. She describes her mother as controlling and physically abusive (her father did not abuse the children). Yezda then describes a poignant image of the night before Christmas. "This is probably one of the most vivid memories I have of her," she begins. Yezda was learning to read. Her mom was holding Yezda's sister. Every time Yezda made a mistake her mother hit Yezda. If her sister then cried, she would get hit also and be told to stop crying. "My mom told me that I was stupid and that the other kids would laugh at me if they knew I couldn't read and then she would make me start reading more … that's my earliest memory of that," she concludes, then reflects, "I don't remember at what point I knew it was wrong that she did it."

Adolescent years were marked by a period of being bullied and being "very shy and reserved." Although one of few minorities at her school in a "really white community," Yezda tells me that it was not so much because of the color of her skin that she was bullied. Rather, she attributed the bullying to the way her mom dressed her and the food she took to school. "She didn't let me conform." She was not allowed to shave her legs. As Yezda put it, "I was definitely an outsider, home was challenging, school was challenging." This is when she turned to dance as a refuge, but here too her efforts were thwarted by her mother. Determined to gain admission to a special school for dance,

Yezda recalls her mother driving her to the audition and then when Yezda was accepted, "making up excuses" as to why she could not attend ("It was too far to drive"). Unwilling to give up, Yezda continued to seek this goal, with the added goal of getting her driver's license. Again, however, her mother blocked her efforts and ambition.

As I listen to these early chapters of Yezda's story, I am struck by the lack of emotion or any notable shifts in her facial expression but also by the level of determination and clarity Yezda had as an adolescent, perhaps the same clarity and determination, I note, that she demonstrated at the outset of individual therapy when she so definitively outlined her goals. Reflecting back to the initial few minutes of this first interview, I recall that her dark eyes seemed to lock on mine, and now understand her need for vigilance. Throughout the interview thus far, her face remains mostly still, regardless of the topic area. Occasionally she smiles, a big white smile, and laughs quietly, almost politely. Her speech is quite formal. She is articulate. She is insightful. I also notice that as she speaks, she sits strong and tall, motionless, her back straight. (Perhaps, I wonder, a remnant of her years of dance but also likely another indication of an avoidance coping strategy?)

Further, with regard to her adolescence, Yezda shares that, "Back then [she] really struggled a lot, had so much insecurity and low confidence." She felt "awkward, like an imposter, and unworthy of friends." She did find a good friend and spent time at her friend's home. Gradually, Yezda started to try to remove herself from the grips of her family, her mom in particular.

Providing an example of her attempt to gain some autonomy, Yezda tells me that her mother would never let her cut her hair, not for any type of religious, spiritual, or cultural reasons but because her mother wanted Yezda to depend on her to care for her long hair. This was another way that her mother kept her close, she believes, to maintain control. The summer she turned 16 she got her hair cut short. She did not ask her mother. She told her! "That changed a lot of things." Her mother did not speak to her for the rest of the summer. Yezda got her first job and she got her driver's license. She was in her first serious relationship at about age 17 (he was 19 years old). He was kind and supportive. He would save his tips from his work at the coffee shop to take her away to new places for special events (e.g., a concert to see her favorite band at the time). It took Yezda a year to tell her mother about him and then when she did, her mother did not approve, claiming that he was "not good enough" for her daughter. This put a "strain on the relationship" and then she met her current partner, her fiancé. They have been together since that time.

Against this backdrop of what Yezda has told me about her history, I wonder *where she got her resilience*? Certainly, some clues point to her relationship with her father (though not consistently a safe base), while other hints suggest other social resources (e.g., her friend; her dance community, and presumably,

the regard of her instructors given her motivation and work ethic; and potentially her own sense of confidence and competence in this arena). Instead of inquiring about resilience more directly, I ask, with reference to various incidents above, "Yezda, what would you do in those moments as a little girl, do you remember?" She tells me that she would escape. She would take her younger siblings with her, into another room in the house. A loud TV was an effective distraction, "Or, if they knew what was happening, [she] would just try to console them." Other means of escape involved reading and writing. When she went to her friends' houses, she noticed that she felt more relaxed in their homes. Early on, she concluded, "Oh! there is a different way of living, I'm going to have that one day. I don't know what that looks like but … " She put up pictures in her room of universities she wanted to go to. She wanted more, and better for herself. Her mother also took her to therapy, starting at about age nine, but she was always too scared to talk about the abuse from her mom.

When asked what was different about her fiancé and what attracted her to him, Yezda describes an "electric current" that went through her when she met him. She then goes on to explain the contrast between his interest in her and the way others commonly treated her (and continue to treat her). Specifically, she described him as interested and curious about her. Rather than making assumptions about her given her appearance ("a lot of people think I am East Indian"), he explicitly asked her about her background and made an effort to know and correctly pronounce her full name. Her fiancé also has had a difficult past, she notes, marked by trauma and loss. This meant Yezda could share her history with him and he "wouldn't be scared."

Conversation surrounding her fiancé at this moment is more positive. I notice a shift in her affect. At this point, in an effort to explore further but also to draw her attention to the shift (to raise her awareness if and as needed), I take her back to the instance and ask her, "Are you aware of what you felt in that moment?" She tells me that she knew she was supposed to be with him, that she used to write these "letters to God" when she was little, asking for someone who would save her and understand her.

Given strong indications of personal and relational resources, her fiancé in particular, I now choreograph an encounter with her younger self as a means of gaining a clearer picture of Yezda's self-view, as well as her capacity to get closer to painful material and related emotions. Provided below is a snapshot of some of the dialogue that ensues.

I ask Yezda, "When you visualize yourself as a little girl, what comes up for you? What's the picture?" Yezda tells me that she sees herself in braids, she is "very skinny," probably about eight years old. She is wearing a baggy tracksuit. "Awkward … one of the tallest kids in my class … hunched over because I don't want to stand out … I don't want to be tall … quiet … shy … " I ask,

"Do you see her little face? Her eyes?" Yezda tells me she does and that, "She looks tired."

Therapist: Is she far away from you or can you get close to her? (Assess proximity to self, i.e., access to, acceptance of, and emotional connection with parts of self that endured traumatic experiences.)
Yezda: She's at arm's length to me.
Th: What do you feel in this moment?
Y: I feel like I just want to hug her. I just want to give her some affection that she's not feeling right now.
Th: Would she let you? (Assess capacity to take in love from another.)

Yezda affirmatively nods and I encourage her to express affection to her younger self.

Therapist: I love what you said about being able to transport yourself and that you can be so visual. I'm with you in this. Where is she? In your home or in the yard or … ? (Deepen experience and safety by entering the scene with the client. Let the client know you will be there too and inquire further about what is happening, where she is, what it looks and feels like.)

Yezda tells me that she is in the playground of her elementary school. She is by herself. She is alone.

Yezda: She's just watching. There's a baseball diamond that was behind the school and she's watching the other kids play.
Therapist: When you approach her, maybe take me with you, what does that look like when you approach her? (I am explicit in indicating that I will be there too, the support Yezda did not have as a little girl. She was alone.)
Y: I'm approaching her from behind. She's sitting by herself but she's trying to sit with another group of kids. She looks over at me. She's a bit nervous. I try to sit down next to her. She's curious. I want to put my arm around her… she leans in and takes a deep sigh and almost relaxes into me.
Th: (What am I thinking and feeling? I am impressed with the capacity of Yezda, the "wiser older adult self" to naturally respond to her younger self, to make contact with her, and I am equally impressed with this younger Yezda, with her capacity to take in the comfort and love of another. I also appreciate that they can see and know one another, that the distance between them is not so great that there is no capacity for eye contact or that the view of this younger self is not blurred or blank, as it sometimes is for clients with histories of trauma.) Yezda, that's so beautiful, that's good to stay with her, that's perfect, that's really nice. You can feel her, does she feel you?

Y: I think so, I can feel her little head in my side and I can feel that she just feels that she doesn't have to be tough. She doesn't have to be brave.
Th: (I reflect.) She doesn't have to be tough and she doesn't have to be alone, Yezda. (I highlight the relational aspect of this encounter.)
Y: Someone else can carry that for her.
Th: I don't know if she even needs to use words but if she could speak to you, do you know what she might say? (I provide the option of "no words" in this early stage; the goal here is an initial encounter, one that is within Yezda's *window of tolerance*, and that allows for a direct assessment of proximity to self, degree of trust between younger and older Yezda, and, more generally, level of trauma impact.)
Y: She would say that she is lonely and tired and just sad and doesn't know why.

Following this, Yezda moves into the here-and-now, "That comes up a lot for me, those feelings lately, and I don't quite get sad, I get angry … the person who was supposed to be there for me wasn't."

As Yezda describes her sensitivity to criticism in her relationship with her fiancé or not being seen, heard, or understood, I reflect my understanding in the context of her history and reference, in particular, her experience of reading a book the day before Christmas.

Therapist: Help me understand and connect all of this or try to make sense of it together. What I hear you say is that if your fiancé is at all critical, the impact of his words is amplified given your history and then you get angry, and then what do you do, Yezda? (What is her prototypical response? Her reflexive strategy? Her action tendency?)
Yezda: I shut down.
Th: You shut down. You go to another place again. Is that what you did as a little girl? (Begin to explicitly link her current responses to the way she coped as a child, when she was alone and helpless; what would she do?)

Yezda now links her childhood experiences with her current responses but also notes that she and her fiancé are both more aware than they were in earlier years in their relationship. They are continuing to grow together.

As the interview continues, Yezda tells me that though she has engaged in therapy at various times over the years, she has never been formally diagnosed and she herself has never been suicidal. Drugs and/or alcohol have never been a big part of her life. Themes of nightmares vary but generally involve her mother dying. Her mother attempted suicide early in her parents' marriage. In addition to being vigilant for danger as a child, Yezda was vigilant for loss, often lying awake, listening to hear if her mom was taking pills at night.

As we move toward closure, Yezda tells me that she really tries to forget about her younger self and her childhood. I again reflect that this was adaptive in those circumstances and add a reflective summary that validates this tendency in the context of her family history. As Yezda acknowledges the accuracy of this summary, she adds that, as a child, she was always trying not to feel and was always fantasizing about being someone else. She does not know who she was. She does not know who she is.

The Attachment Frame to Case Formulation

Guided by the framework as outlined above, I note that Yezda's narrative is relatively coherent. I am struck by and impressed with her resilience, her many strengths, and by the determination she clearly had as an adolescent and as a young woman. I also note, however, that her family history is marked by significant trauma and abuse, including witnessing parental violence, as well as verbal, physical, and emotional abuse at the hands of her mother. All of this occurred against a backdrop of social isolation and lack of belonging in her school and broader, "mostly white community." This was the case throughout her childhood and beyond, and was compounded by a period of bullying in her late childhood/adolescent years. The echoes of her past continue to reverberate in the foreground. Contact with her family remains ongoing but with extended periods of estrangement from her mother. Also noteworthy are indications of various core elements of emotional disorders such as vigilance for threat, nightmares, emotional detachment, and numbing.

Tracing her developmental history, I note that Yezda shares a number of key pivotal moments (e.g., memories of parental conflict, learning to read with her mother on the eve of Christmas) that will potentially offer a doorway to her inner experience and to the associated pain that she now holds at a safe distance. Also noteworthy are indications of resilience. That is, a demonstrated capacity to assert herself during adolescence following a period of bullying, to find refuge in dance and to begin to date and assert her autonomy in other ways (e.g., through securing a job and getting her driver's license). Important also, and a likely resource as Yezda moves forward in the therapeutic process, is the safe haven her fiancé provides.

Themes of loss also mark her history, loss of aspects of self, and cultural identity in particular. Poignant images and phrases capture and provide context for Yezda's various descriptors of her self-view. She indicates that she does not know herself. She reports that she has endeavored to distance herself from her younger years and her associated history. As she begins to look back at her younger self, various *emotional handles* are offered, "Lonely, tired and just sad."

Given her many strengths and stable external resources (e.g., her relationship with her fiancé, work, finances), an encounter with her younger self was choreographed in this initial session as a means of gauging her capacity (i.e.,

flexibility of her attachment strategy), her self-view, and her ability to connect with and accept herself. In some cases involving chronic childhood trauma, for example, when the only means of survival is significant dissociation and numbing, individuals at the outset of treatment will often report being unable to see a younger self or will view the younger self with disdain (a reflection of unresolved shame). Yezda's capacity to see and have an encounter with her younger self is promising, as is her younger self's capacity to accept the love and support "older, wiser Yezda" was able to provide. Yezda's commentary regarding her relationship with her fiancé and some positive aspects of her relationship with her father also are positive signs from an attachment perspective. Other positive factors include the sense of competence she felt as a dancer in her youth and the sense of competence she now feels in her career as a business owner and leader.

Viewed through the lens of attachment, the EFIT therapist now has an initial picture and a view of health to move toward. The therapist will accompany Yezda through some of the doorways this initial assessment has revealed (i.e., pivotal moments such as parental conflict). As Yezda allows herself to feel some of the pain that was intolerable to feel at those times, her capacity to tolerate such emotions will expand. Similarly, engaged encounters with her younger self will lead to greater self-coherence and integration, as well as increased capacity to assert her needs in key relationships. Increased capacity to accept and be nurtured by the love of key others (e.g., her fiancé) will lead to stronger therapeutic momentum and a broader platform for growth. As Yezda gains greater self-coherence and integration in her key relationships, so too will her cultural identity become clearer, along with related choices about how she might wish to raise her children and offer them the type of clarity she now is seeking.

Yezda is an excellent candidate for EFIT. Her goals are clear and manageable and she has the personal and social resources to manage the therapeutic process. What if the assessment process reveals otherwise or the client's goals for therapy seem better suited to another modality? Prior to concluding this chapter, we offer a few related comments below.

Contraindications, Goal Setting, and Treatment Planning

A key assessment goal includes establishing the capacity of the client to safely engage in EFIT. In some cases, the assessment process will reveal that EFIT is unsuitable for the client (e.g., for individuals exhibiting psychotic features or antisocial personality characteristics). At other times, it might be necessary to refer the client for additional services either prior to or while engaging in a course of EFIT (e.g., home supports, substance abuse treatment, psychiatric consultation to consider medication).

In addition to guiding such clinical decisions, the assessment process guides therapeutic pacing. There are times, for example, when a slower pace will be necessary, with clients who are highly avoidant or intellectual or who

present with signs of dissociation. Once again, careful attunement guides the process and this initial picture provides the therapist with a sense of what to anticipate with respect to pacing and expected outcomes.

That said, the formulation of the key problem to be addressed in therapy is a collaborative effort, not one imposed on the client. One client may come just to see if it is even possible to talk to a mental health professional about her life; another may bring a more extensive agenda for negotiating a life transition without succumbing to debilitating anxiety. The more explicit, concrete, and realistic the articulation of the goals of therapy, the better. If the goals are incongruent with the goals of EFIT, then the therapist says so. For example, the therapist might suggest to the military veteran that, given his focused discussion on his relationship in these initial sessions and not the impacts of war trauma, he consider a course of couple therapy, either concurrent to or prior to engaging in EFIT.

To summarize, assessment in EFIT is a process of collaborative discovery that begins with an exploration of each of the rings of a concentric circle comprising the individual, the family, the community, and the broader context (e.g., sociocultural system). Recognizing that there is no line between assessment and treatment, the therapist uses this initial discovery process as a first step to tuning in and finding focus. As the therapeutic process unfolds, the initial picture becomes more detailed. Individual's realities and potentials become clearer. As fresh possibilities emerge, the initial chart is revised and refined and, in many cases, expected outcomes shift and expand. The seeds to growth are discovered and sown and therapeutic momentum takes hold.

Play and Practice

For You Professionally

Think about one of your recent cases. As you review your client's overall narrative and key scenes and transitions in your mind, what stands out for you? What aspects of your client's history are noteworthy? The CARE model handout provided below is intended as a guide.

Context

Experiential therapist seeks to enter the phenomenological world of the client. Therapist immerses self in contexts in which clients live and have lived, with attention to:

- Identity (e.g., race, ethnic, spiritual, religious, gender, sexuality).
- Environmental factors (e.g., socioeconomic, work/organizational, neighborhood).
- Experiences (e.g., racism, colorism, discrimination, sexism).

_____
_____
_____
_____
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_____

Attachment
Therapist explores attachment and relationship history, with attention to:

- Pivotal experiences/key moments that have shaped models of self and other.
- Coherence of narrative.
- Current relationship resources; potential intergenerational or transgenerational impacts; risk/vulnerability and resiliency factors.

_____
_____
_____
_____
_____
_____

Relationship/Therapeutic Alliance
Therapist as a "temporary attachment figure" establishes a "secure base" characterized by ARE at the outset of therapy.

- Therapist monitors the therapeutic alliance throughout the process of therapy.
- Therapist attunes to potential ruptures; contextual factors, including key differences.
- Therapist joins with the client in discovering and exploring painful material.

_____
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_____

Emotion
Therapist attends to expression of emotion, affect regulation strategies and capacity (e.g., "window of tolerance"), with attention to:

- Core features of "emotional disorders" (e.g., self-criticism, numbing, detachment, nightmares, flashbacks, hypervigilance, heightened anxiety).
- Process elements (e.g., body language, facial cues; automaticity and/or rigidity of strategy); capacity (on a continuum from wide to narrow); "emotional handles" (e.g., poignant words, images, phrases).

_____
_____
_____
_____
_____
_____

For You Personally

Reflecting upon your own developmental narrative, identify three key events/transitions/defining moments that have been instrumental in shaping your models of self and other. Has one or more of these key events blocked you at times, either in your personal life or as a therapist? If yes, as you reflect on this, how might you consider removing this barrier? What will you do?

BOX 7.1

Tuning In and Staying Attuned with CARE

Context

What was it like for you to be Catholic in your Jewish school?

Attachment

Can you give me two words that capture your relationship with your mother?

Relationship/Therapeutic Alliance

What is it like for you when I ask personal questions?

Emotion

How do you deal with it … when this emotion "hijacks" you?

8

How Does the Therapist Shape Stabilization in Stage 1 of EFIT?

Soundbite Answer to Question
As the first step toward a felt sense of secure attachment with self and other, stabilization refers to the capacity to begin to encounter and engage with emotion in new ways. Much like learning to ride a bicycle or dance the Tango, initial trials feel shaky and contrived and are often short-lived. As clients become more comfortable tuning into and staying present with deeper emotion, their capacity to maintain emotional balance during times of stress, overwhelm, and even trauma exposure becomes greater. Habitual and reflexive coping strategies give way to increased flexibility and adaptation. As affect regulation capacity expands, models of self and other also become less rigid and more accessible, and any loss of emotional balance is regained with increased confidence and with greater ease and fluidity. In short, "stabilization" is characterized by increased emotional balance, symptom reduction and increased confidence in the self and the therapeutic process.

Earlier chapters focused on the key EFIT interventions. The next three chapters (Chapters 8 through 10) focus on how these interventions are used to move clients through the three-stage process. Now grounded in the key elements of Stage 1, safe haven alliance, assessment, and case formulation (Chapters 3 and 7), we elaborate further on this stage in this chapter. The following two chapters focus on Stages 2 and 3, Restructuring Attachment

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(Self and System) and Consolidation, respectively. Each of the three chapters includes a case example for illustrative purposes.

Central to the Stage 1 process at the outset is an understanding of how clients prime and maintain their symptoms (e.g., depression, anxiety, traumatic stress) and how these recurring patterns shape their inner emotional worlds. The therapist clarifies processes of emotion regulation (most simply, noting how clients turn emotion up high, turn it down, or try to turn it off) and the meaning making that arises in this process. Second, the therapist outlines with clients the habitual patterns of engagement in interpersonal relationships that are shaped by the action tendencies inherent in their emotions (most simply, noting how clients turn toward, away, or against others). The therapist listens to content issues and the narrative of the client's life but sorts continually for these process variables – patterns in the inner ring of emotional processing and the outer ring of interpersonal responses.

Also central to Stage 1 is a discovery of the pivotal experiences that have shaped models of self and other and their prototypical emotional responses and that, now, are barriers to personal growth and interpersonal connection. As these blocks are identified and processed, clients gain increased awareness of and access to previously disavowed aspects of themselves and their emotional experiences.

As a means of removing barriers and providing clients with increased access to and flexibility with habitual responses, the therapist seeks to move emotion into granularity. That is, vague or disowned responses are made explicit, specific, and concrete. This may be a simple process of focused reflection and evocative questioning with some clients, or a much more elaborate structured assembly of emotion with others. *We can think about this process in terms of the E for emotion: We evoke, engage, explore and expand, elucidate, and actively encounter emotion.*

As emotional experience begins to evolve, new action tendencies and new meanings emerge which the therapist validates, heightens, and turns into enacted responses in imaginary encounters with key figures in the client's life, parts of self or the therapist. The choice of such figures is informed by the assessment process and by the overarching and key goal of therapy; that is, a felt sense of secure connection with self and other. Guided by the Tango, these encounters are then processed (Move 4) and the overall five-move sequence is integrated, consolidated, and celebrated (Move 5 of the Tango). Over time, as the process takes hold, clients then begin to take such experiences outside the therapeutic context to their key relationships. As clients become more balanced emotionally, that is, less reactive or numbed out and more aware of and accepting of their emotions, especially fears, vulnerabilities, and longings, they also become more likely to reflect on them and, over time, will begin to directly express their needs to key others.

The following case example (based on a series of three sessions provided by the second author) provides an illustration of how the initial assessment informs and focuses the Stage 1 process and how the Tango is used to propel the process forward. First, an introduction to Chris will be provided through a summary of the assessment interview. Next, based on this information, we consider how best to move forward. That is, we consider possible entry points or doorways to scenes, events, or pivotal experiences likely to have an emotional charge. Excerpts of a transcript of the third session with Chris illustrate various interventions and demonstrate also how to work with emotion. Once again, excerpts are edited somewhat for clarity and brevity. Final comments highlight, in particular, the active and key role of the therapist in Stage 1.

An Assessment Interview with Chris – Tango Move 1 in Stage 1 of EFIT

After a brief introduction, I ask Chris what his childhood was like. He tells me he was born overseas, to British citizens and that his family moved to a major city in central Canada when he was seven years old. His father is now deceased and his mother lives in a care home nearby. His younger sister lives in the US and is a source of stress given her interpersonal and other problems. His older sister, on the other hand, is a key source of support and an ally in caring for their mother.

Growing up, they lived in an affluent community and were raised against the backdrop of the Christian faith but did not actively practice or attend church. Rather, in his words, his father proclaimed early on that Sundays would be family days, dedicated to discovering their local community and spending time together, a practice Chris continues to adopt with his own teenage son. Affection from his parents was limited but he always felt loved and was consistently supported. It was only when his father was dying that Chris and his father used the words, "I love you," as his father drifted away.

Up until this point, I note, Chris's tone has been matter-of-fact, his voice clear and booming and the narrative of his history coherent and systematically outlined. When he speaks about his father, however, his facial expression shifts slightly. He does not overtly cry but he does convey a sense of endearment. After rapidly blinking his eyes a few times, he continues. He tells me about the positive impact his father has had on him, the wisdom he imparted and how much he misses him but is grateful for their years together. He believes he has grieved this loss.

"Were there any incidents of abuse, trauma, or loss?" I ask, and it is here that Chris tells me that as a mid-adolescent, his parents moved him to a school in a more affluent neighborhood with the explicit aim of introducing him to "connections" for later in life. His father's intentions failed. With a

tone of stoicism and some agitation in his voice, he tells me that for a stretch of about 18 months, he was severely bullied (physically and emotionally) by a group of boys several times weekly and that some of his key male friends also were bullied. Over time, he prepared to fight and continued to do so until, one day, he finally "had it." He went home. He was exasperated and overwhelmed. That day, he cried and told his mother for the first time that he was being bullied. The next day plans were underway to move to a new school. He moved within the week. Shortly after, his friends also moved to the same school. The transition was positive. He successfully graduated and then pursued various post-secondary studies.

Early adulthood was characterized by some stops and starts with regard to his education and his career but, by his late twenties, he was on track, married, with lots of friends and a satisfying career. His marriage ended after two years, however, due to his wife's infidelity. In his words, though initially devastated, friends and family "rallied around him," he grieved, moved on, and remarried about ten years later. (Guided by attachment, a developmental theory and theory of personality, and by the framework provided in Chapter 7, I am attentive to various developmental transitions and pivotal experiences that have shaped Chris's self-view and his capacity to reach for and rely on others. Based on his account, it would seem that he was able to rely on others during a time of loss.)

Now living on the west coast of Canada in a small community, he is surrounded by friends, happy in his career and financially secure. For about the past six years, however, his marital relationship has been strained. As I inquire further about this, Chris tells me that his wife has an eye disease that deteriorated significantly about six years prior to our first appointment, leaving her and the family to quickly adapt to new circumstances. Specifically in her case, she was forced to stop driving, resign from her job, and re-educate and establish herself in a new career. She has been attending counseling and has adapted. Chris, on the other hand, tells me he is lagging behind. He is frustrated with her lack of competence and with her lack of autonomy. He is overwhelmed with work and does not have time to "be a taxi. This is not what I signed up for." The future looks bleak. He had anticipated traveling the world together. He had expected her income to be higher in these earning years. He cannot understand why it is such a big issue to walk "two minutes" to the grocery store. "Can't she figure it out?" he ponders, his tone sharp and his voice loud and exasperated. "Why can't she just figure it out? I don't want to be a babysitter!" He then weaves a tale or two into the conversation, punctuated with wit but with an undertone of helplessness and disdain, providing examples of her inability to complete a task in a timely manner or manage a minor problem with the lawnmower, evidence of her incompetence and his plight. He is "on his own."

At various times of disappointment with her lack of ability, he "loses it." He lashes out. He says mean things and then there is a period of about three days of silence. They have been to couple therapy. It helped but he still feels tense and agitated and he thinks seriously about ending the relationship. As I explore this further, he talks about the "90% of the time when it is positive." They laugh together. She is "emotionally intelligent." He adds here that he is inferior to her in this regard. She is kind and compassionate and well suited to working in the capacity she loves at an animal refuge center. She is beautiful. They are dedicated to and love their teenage son and they really love each other. "I need to make this right," he says. "I need to fix it. She is done with couple therapy. She wants me to fix myself. She wants me to deal with my anger." (As I listen to Chris, I am reminded that vulnerability is often replaced by reactive, more surface anger. This cuts him off from his own experience and from others and adds to his sense of helplessness.)

Drinking or drugs are not an issue. Chris has never been diagnosed with any type of psychological disorder. There are no indications of any type of risk of harm to self or others. His goals are clear. He wants to improve his relationship with his wife and he wants to be a better father to his son.

Viewed through the lens of attachment, I strive to make sense of Chris's response to his wife's failing eyesight, his reliance on anger under conditions of stress and overwhelm and his propensity to push his wife away during times of need rather than responding to her. I recognize, also, how easy it would be to get caught in content, to go down that *rabbit hole* in various ways, either through focusing on his many harsh statements toward his wife and her disability and thereby likely evoking guilt or shame, or by trying to shift his perspective by illuminating the many positive aspects of his life that he has highlighted. His wit and humor and his engaging interpersonal style are also likely to derail me if I follow his lead in that way, another *rabbit hole*. I stay focused. I think about what could be blocking him from showing compassion to the person he tells me he loves. I am aware that an excellent EFT couple therapist was unable to break through this barrier. What is the problem here?

Various possibilities come to mind. Has he grieved his father? The loss of his first marriage? Has he addressed the impacts of bullying during that key developmental period? What happened on the day they discovered his wife's eyesight was significantly failing? Was there some type of "attachment injury" (i.e., a moment of crisis in the relationship, when one or both partners has the experience of, "You were not there for me, never will I trust again,") either then or at some other time in the relationship? I am confident that the EFT couple therapist would have explored that possibility but perhaps Chris was unable to access his own sense of disappointment and loss at that time. Clearly, based on the narrative he has provided, they have been unable to share in the grief of this loss.

Still through the lens of attachment, I consider what we know about the impacts of trauma based on the growing body of research and clinical literature. Chris tells me that when he finally told his mother about the bullying, she was supportive and advocated for him. She was accessible, responsive, and engaged during a time of need at a key developmental period in the shaping of models of self and other. Her response was positive. On the other hand, 18 months of bullying is significant during that phase of development and she was unable to support him for a period of months, primarily, it would seem, because he did not tell and, presumably, did not show any easily visible signs of distress.

Noteworthy also, on the positive side, are various indications of resilience (e.g., recovery from job loss and various vocational disappointments), as well as personal (e.g., positive self-view as a problem-solver, a key and valued trait in his work) and other resources (e.g., social support, including a stable, albeit currently strained, marital relationship, healthy and thriving son, financial security, safe community). Favorable as well are no warnings of any contraindications, risks, or vulnerability factors (e.g., substance abuse, psychotic features, severe and recurrent depression) that might need to be considered in moving forward in Stage 1 of EFIT.

Guided by the EFT model and its theoretical underpinnings and with the help of the key macro-intervention, the Tango, I first reflect with Chris the manner in which he constructs his inner/emotional world (*within*) and how that impacts his relationships (*between*) with key others (Move 1 of the Tango). Chris tells me he has a hard time accessing himself emotionally, that he never has been able to, that he is a "fixer" and a "problem-solver." In his words, he, "runs to solution … fails to go inward … very unfamiliar ground." He also highlights that his inability to "keep up with his wife emotionally" is a barrier to closeness for them and that his anger also tends to push her away, at times for days, as noted above.

To summarize, rather than engage with frightening, alien, and unacceptable emotion during moments of vulnerability, Chris moves to problem-solving and solution. Focused on logic, analysis, and self-sufficiency, he cannot count on others and instead alienates others. As the weight of his allostatic load increases, he becomes increasingly overwhelmed. Any slight change in plan or unpredictable event is met with anger and agitation, leaving those closest to him and in the best position to provide support fleeing and retreating. Alone again to contend with the daily and major stressors of life, his assumptions are confirmed. He cannot count on others to "measure up" to his expectations.

As we move to crystallize his experience in this initial phase of Stage 1, to affect assembly (Part 1 of Move 2 of the Tango), various triggers/cues are identified (e.g., when his wife asks for help, when she needs a driver). His initial perception is, "She's not measuring up … I can't do all this … I can't keep

up." The basic threat/danger pertains to loss, of business, of self, of additional aspects of his wife, but this is initially unclear and implicit. When I ask him to focus on his body, "What is happening for you now as you share this? Where do you feel this?" Chris describes feelings of fear and panic. He also references a pit in his stomach. As the meaning is explored, Chris first responds, "I can't be everything to everybody, how can I make it work?" and again exclaims in an angry tone, "I don't want to be a babysitter!" Viewed through an attachment lens, I note this emotional handle ("I don't want to be a babysitter!") and the attachment significance here ("I can't count on anybody, I am alone") and later provide a reflective summary, shown below, that illuminates this for Chris. When triggered in this way, Chris's typical response is to get frustrated and irritated and, he estimates, he "lashes out" about six times yearly; mostly, he gets frustrated and then shuts down. In response, his wife conveys a sense of incompetence and a fear of losing him. She thinks and reflects aloud, "You won't stick around as I continue to lose my sight." She then retreats into silence for days. They lose each other. They are both alone.

As I prepare for the third session with Chris, I consider my overall goals based on the available information. These are identified as follows:

- Help him gain access to self/his inner world so that he can be guided by it, build capacity to share it more openly and fully with key others, and be challenged to take in love from others in new ways (become more ARE/Accessible, Responsive, Engaged with SELF and OTHERS).
- Help him further develop compassion for self and others.
- Help him gain more emotional balance (less reflexive shut down/anger).
    - Anticipate that as this process evolves, it also might put him in contact with sense of loss/grief.
    - He and his wife's capacity to share and deal with the loss of her sight together will strengthen their bond and provide them both with a stronger platform from which to continue to grow and thrive.
    - As he grieves loss in one area, this may put him in contact with and give him opportunity to grieve/resolve other losses (as necessary).

Possible entry points (i.e., key pivotal moments or doorways to deeper emotion) are identified as some type of encounter with his younger self during the period of bullying; the scene/day he/they were told his wife's sight was now significantly compromised and would continue to deteriorate; or a recent example of being triggered and confronted with his current experience of loss (of aspects of his wife and their previously anticipated future together).

How best to start and focus a session in Stage 1? Speaking generally here, it is prudent to check in with clients to ensure that no new external stressors have emerged or that symptoms were not significantly aggravated by the

therapy process such that slowing the pace might be necessary. Once safety and capacity are established, a reflection/summary of some key aspects of the previous session might be highlighted with the intent of continued focus. Alternatively, in response to an inquiry about how the week has been, the client might cite an incident involving a trigger and reflexive reaction. The affect assembly formulation could then be summarized in the context of this incident and used as a starting point to focus the session. Various aspects of the client's narrative might be alternatively reviewed, highlighting in particular key pivotal moments and emotional handles, with the overarching goal of using this summary and the elements of RISSSSC to access more primary/deeper emotion.

In this third session with Chris, the ability to move forward established, I begin with a summary of what happens when he gets triggered (e.g., his wife asks him for a ride), how he responds and what happens interpersonally, in his key relationship.

Chris: I get angry and there's resentment too. I feel put upon and you know this is going to happen a lot. What bothers me is I'm sick of going to that place because it's unsupportive of my wife. Why am I going there? It's driving me crazy.

I hear this as a will to change and continue to focus the session. Chris continues, "When I'm under stress, I'm not present for my family, that's the bottom line." I then ask, "When you're under stress, are you present for you?" "Definitely not," Chris replies, "I'm just in survival mode."

When asked about a time when he had been 'present' for himself, Chris tells me about his experience of being bullied. He was confronted daily by two or three older boys.

Chris: I'd get the first shot in, then I'd get pummeled. That is what I knew to survive. I could trust myself to get in that fight and not be afraid. I was not going to be afraid of those guys. That's my inner strength. I think this was a positive.

In his words, he had no other options. He did not feel supported by school personnel. This was in the early 1970s, "Before the pink t-shirt stuff and all that awareness about bullying," he pronounces.

As I hear this account of Chris's experience, I begin to understand the possible origins of his reflexive propensity to express anger during times of stress, overwhelm or vulnerability. I silently note this and then ask what would happen when he went home. He tells me he would go to his room. He did not tell anybody what was happening at school. He simply carried on with his day, as though nothing happened.

As Chris provides additional details regarding the city he lived in, his neighborhood, and the school environment, I get a more complete picture of the context of his narrative and he moves deeper into the experience. Facilitating further discovery and exploration, I ask Chris whether he would ever talk about these experiences with his friends who also were being bullied. He answers, "No" and explains that they would all move on, ride their bikes, play touch football, "sporty things. We would just bury it," he said, "All of us would just bury it." He says he kept thinking, "Oh it's going to get better tomorrow," and recalls that he believed it would, "Until it was the worst one."

In describing the "worst one," Chris then goes on to explain that he was about 14 years old. He was in the changing room. *Chris:*

> I went to my locker to get my clothes and there were no clothes. I had nothing except my underwear. I had to figure it out, okay, now what do I do? I don't know how I got out of it. I don't know what I did.

The doorway now opened, the aim is to help Chris feel what he was unable to feel, what was intolerable to feel at the time of this incident, and to accompany him as he begins to experience these unfamiliar feelings of vulnerability. First, I help Chris make contact with his younger self. I tell him I will be there too.

Therapist: What do you see Chris, when you see him? What do you see?
Chris: I see somebody who's a bit lost, confused. I just want to lash out, I want to do some damage here. I'm just very angry, that kid's angry.
Th: Can you see his eyes?
C: They're like lasers. They're not crying eyes, they're fighting eyes.
Th: Are you able to stay with him for a minute? (He nods affirmatively.) What do you feel in your body Chris as you stay there with him, in that room, in that space? (I am again using the body as a gateway to emotion.)

Now, moving further into Move 3 of the Tango, Chris expresses a need to help that younger self and then moves into analysis. I reflect and validate that Chris is "putting it all together" but recognize also that to follow him here would be a rabbit hole, taking us into an intellectual explanation before he has had a *felt experience*. I invite him to stay with that younger person who was all alone.

Therapist: That's good Chris, you're putting it all together, that's right, so let's just stay here with that poor teen that was all alone. And Chris, the purpose of this is not to dredge up all of this awful pain and this difficult period but to work through it in a way that gives you agency, agency that you didn't have as that 14-year-old-kid in that change room … so awful and not right, you're right … you're right! (I provide a rationale for what

I am doing. Transparency provides agency. I also use my voice to reflect and validate Chris's anger. The hope is that if the anger is validated, if Chris is heard and seen in this way, it might allow him to stay still with his younger teenage self and begin to allow some of the other deeper, more vulnerable feelings to emerge.)

I then ask Chris where he is in proximity to that teen. "So, Chris, where are you, as the adult, the older, wiser support to this young man, the support that he didn't have, are you in that room?"

Chris again moves to anger and indicates that he would, "Shake the tree of bureaucracy, blast the principal, the guidance counselor, the teacher, he would hold them all accountable, the whole group of them." The same "rabbit hole" emerges. I invite Chris to, "Stay with his younger self in this other way, to help him, to be with him in his pain." Initially, Chris can only feel and express his anger and vengeance. He says, "I'm not going to take it. I'm going to do something about it." As he continues to stay close to his experience, to make sense of his inner world, I note key words/emotional handles, *lost*, *powerless*.

Chris begins to link these earlier experiences with his current circumstances.

Chris: I try to have power and control in my life as much as I can. I have my own company. I don't like to delegate. I don't trust others to do it as well as I will. I think my frustration comes from having no power and control over my wife's loss of vision.

Again, I reflect and acknowledge his capacity to see the parallels between this earlier key experience and his current circumstances and then redirect him to the young teen in the change room.

Therapist: We could stay there and this time he actually doesn't have to be alone, this time we could be there with him and maybe it would allow him to feel some of the other things, allow you to feel some of the other things that one would feel in those moments. From there, maybe it gets easier to delegate, to count on others and to be there for others and them for you?

He concurs.

Reflection and validation are again used to focus the session,

Therapist: Because what I hear happened, and it makes perfect sense Chris, that's what any kid would do, that's what any of us would do – that's what we do when we feel powerless and when we're alone and vulnerable. The last thing we're going to do is sit in that pain but then it gets all locked away and somehow we lose some part of that experience.

I then again return to Move 3 of the Tango and invite Chris to glance at that young teen. Chris describes his look as one of despair. As the interactional sequence between the younger and older selves unfolds and Chris stays present in the despair, new discoveries are made.

Therapist: Stay there Chris, stay really still with him, right there, in that moment, in his despair, in his eyes. What happens inside of you Chris, what happens in your body?

Chris: Just help, I need help. (Chris naturally occupies the body of the young teen and feels the associated sense of vulnerability and powerlessness/helplessness. This is positive.)

Th: Yeah, that's what he'd say, that's good Chris, stay with him. I need help, can you say that again? (Give young Chris the opportunity to have a voice, the voice that was silenced and/or ignored in earlier times.)

C: I need help!

Th: That's good Chris, let yourself feel that. You're there with him now, it's going to be okay, let him say it again, to speak again, "I need help."

C: I do need help. I need a lot of help.

Th: That's good Chris. Let yourself feel that. Where do you feel that in your body, in that younger boy's body, what do you feel in your body as you stay in his body? (Again, the goal here is to help him feel what was unsafe/intolerable to feel at the time of the event.)

C: I just feel invisible.

Th: Good for you, Chris. You are able to stay there. "I feel invisible," is that in your gut, Chris? Or your chest? Where does that sit? I feel invisible. (I want to keep Chris "out of his head" and in his body, in the experience, as I continue to endeavor to help him deepen the experience.)

C: It's here. (He points.) You know, solar plexus kind of thing.

Th: Yes, so focus on that Chris and let it grow and develop and really make space for it, the space that you couldn't have made at that time, of course you wouldn't, it wouldn't have been safe to, but now you can. If you make space for it, what happens as you allow that to grow and build? Breathe and let yourself feel whatever you feel, it's okay to do that now, to feel what you couldn't have felt back then.

At this point, Chris moves to reassurance. He wants to tell his younger self that it will be okay, he will get through it. Again, I refocus the session to ensure that shifts occur, not at the level of intellect but, instead, at an experiential level.

Therapist: Chris can we just stay there for another minute? You're doing amazing. It's so beautiful. Just stay with him. I hear you, that you want to reassure him. As you breathe through it, you can show him that you're

okay, it's going to be okay. Let's just stay with him for a second, for a minute, with that young boy.

Chris: I feel invisible, I'm alone, nobody's listening, nobody cares.

Th: (Here I distill the vulnerability he does not let himself feel.) What does that young teen want to say to you Chris, that older, wiser you? You're there with him, what would he say to you, in this moment, could he speak to you? Will he?

C: Thanks for saving me, man, thanks for being there.

Th: Yes, that's it, isn't it? Thanks for being there, thanks for being there with me, thanks for not leaving me alone. That's so nice, what do you say back to him?

C: Sorry.

Th: Keep talking to him Chris, that's nice.

C: Ask for help! (I nod and agree.) Ask for help!

Th: It's okay to ask for help.

C: That's coming through, ask for help, soon, don't wait.

Th: Yes, that's what you say to him, what do you see? (Move 4, process the encounter and assess the impact, was he able to take it in?)

C: Yes, that's what I say to the young boy.

Th: And what do you see in his eyes, in his face? Help me to see what you see, what do you see? (Continue to focus on Move 4, continue to focus and assess the impact of the encounter.)

C: Oh, I just feel unburdened, if you ask for help, you feel unburdened, you don't feel alone. (Therapist smiles and nods.) Share the pain! Share! (The tone of exasperation intensifies.)

Th: Does he feel visible? Does he see that you see him? (A reference to his earlier statement that he was invisible, that "he didn't matter," that he was "alone" and a direct inquiry as to whether this has shifted. If yes, it is important to draw attention here given the attachment significance of this shift.)

C: Oh yeah, there's somebody there, there's somebody there to help.

Th: Chris, what are you drawn to do when you see his face, his eyes?

C: Just march him out of the school.

Th: What else might you do? What else are you drawn to do?

C: Hug him.

Th: Let yourself do that Chris, just there in that scene, are you able to do that? Hold him and hug him and be there for him.

Chris then explains that he feels lighter and more optimistic. The tightness in his belly and chest is gone. As the experience takes hold, the attachment significance is reinforced as Chris repeats to his younger self, "I'm there. I'm

absolutely there," and then adds, "I want to be there for the kid and I want to be there for me, now."

At this point, Chris begins to link his current propensity to look ahead to plan, predict, and problem-solve, to these earlier experiences. He reminds himself to be present, to stay present with his family, and to stop rushing to solution. As he continues to process, he acknowledges a lack of predictability surrounding his wife and her vision. Again, rather than following Chris in this direction, I acknowledge this uncertainty and then refocus. It is important to help Chris integrate and consolidate what happened in the session (Move 5 of the Tango).

Therapist: I hear you. Let's slow everything down. You tell me if I got this right. So the thing that happened is that you beautifully took the risk of going back into that scene in the locker room with that younger you, humiliated and alone, vulnerable and invisible, and the initial perception that you had of that young person, that young you, was anger in his eyes. Of course, he's not going to share his pain. Of course, he's not going to reveal that to anybody because nobody's listening, nobody's there. *It's so not right, you're right about all of that*. (Here I carry his tone of anger as a means of validating it, then switch the tone of my voice and load it with RISSSSC.) But the thing that happened is that when you slowed everything down and tapped into his body, that's when he was able to share his pain and his vulnerability and his feeling alone and invisible. And then he wasn't alone. You were there alongside him. You were able to help him and he actually took in your love and care and felt seen and heard and known and understood. And there was a sense of relief that came. Let's just stay there and freeze for a moment. Chris, right there, right now, what do you feel, now in this moment? (Given the numerous potential detours and exits, I need to be clear, specific, and directive.)

Chris: Safe. No worries, somebody's looking out for me.

Th: Okay, good, and are you together? Do you feel like you're in his body? (Chris nods.) Okay, good, good, what are you drawn to do as you're in his body, Chris, or to say?

C: Let's have fun, let's just get on with life, let's go. (Another attempt to rush ahead, another *rabbit hole*. Rather than follow Chris, I continue to reflect and summarize.)

Th: You were breathing and you were there, and then the thing that happened, Chris, I think, is that you shot ahead to problem-solving and solution, into your future, but that's the struggle I think, isn't it? It's hard to be there for you, to stay still with you and then you lose yourself. You're there for everybody else but it builds up and you develop resentment and feel alone again. This is good, Chris. As you really stay in this

moment, what is the word you'd use to describe your bodily sensations, your feelings?

C: I think when I race ahead, I get uptight again.

Th: Yes and if you stay really still, what do you feel?

C: Well, if I can visualize myself as my future self, with that boy, when everything was cool, like I had back-up, the older self, that's a great place to be.

Th: Chris, that's beautiful, that's brilliant. That's exactly what you can do. In those moments, just every once in a while, you can just glance at him, glance at you, and remind yourself to be present and still, and then you have you. You have this internal compass and you're not racing to wherever you're racing.

C: Ahh, it's a touchstone. (I nod and reflect, "A touchstone.") Clever, so that'll be a safe place for me to go when I'm overwhelmed maybe.

Th: Exactly, Chris, and the more that you can embody that and use that feeling, that experience, that knowing as a touchstone, the easier it will be to stay still with you and be there with those you love and take in the love they wish to give because it's much easier to do that when you're more still and breathing and not running to the next whatever it is.

C: Interesting, that's cool. I like it.

As Chris prepares to leave the session, he tells me he has a tool, a "touchstone." Indeed, he does. A glance back at that scene, the locker room and the associated *felt experience* of the encounter with his younger self is a helpful reminder to tune into (rather than away from) his inner emotional world and an opportunity to use this internal compass to guide him and his interactions with others. Although I might not use the word "tool" in this context, and the overall goal in EFIT is not necessarily to help clients develop skills or acquire tools, I am appreciative that this terminology fits well with Chris's natural propensity to be analytical. I accept his frame for integrating and building on this corrective emotional experience.

It is also important to highlight that there were several occasions during this approximately 60-minute session where I had to block exits and prevent Chris from moving away from his felt experience toward his intellect, to his usual way of coping with distress (with anger) or from going down some other *rabbit hole* that would have taken us in the wrong direction. This is typical, particularly in the early phase of Stage 1 and especially when working with clients who tend to be intellectual or avoidant or with any form of trauma. Over the course of therapy, as Chris and other clients gain increased awareness and begin to let go of their habitual strategies for coping, the focus of the

Tango shifts from affect assembly to further deepening and the need to block exits or prevent escapes down *rabbit holes* diminishes in frequency. Working models of self and other are more open to revision and the client's increased capacity to move with and through emotion (effective affect regulation) affords opportunity for deeper levels of engagement and discovery. By the end of Stage 1, with various barriers unblocked, emotional balance improved, and symptoms reduced, the path is paved for the significant, deep, and sustainable change events characteristic of Stage 2.

Stay tuned, you are about to witness the opportunity of this pivotal stage, central to creating sustainable change and fully unleashing the potential for growth!

Play and Practice

For You Professionally

Think about a recent client that is in the early phases of Stage 1 of the therapeutic process. Using the guide below, identify the key elements (trigger/cue, basic perception, body response, meaning, action tendency). If you were to provide a process summary/reflection to the client, what might you say? Write out what you would say to the client in the blank below.

Trigger

What is the scene/cue/situation that gives rise to the strong feeling? What was the trigger?

Basic Perception

What is the client's basic/immediate/initial reaction? It is typically associated with an undercurrent of threat and danger and is unclear and implicit.

Body Response

In exploring body response, the EFT therapist maintains a stance of *soft*, *slow*, *simple*, and *specific* and a position of curiosity. (e.g., what's in your body right now? What is happening for you now as you share this? Where do you feel this?)

Meaning

The EFT therapist seeks to provide clients with a more cogent sense of their experience. (e.g., what do you say to yourself? What does this mean? How do you hear/experience this? What is the attachment significance?)

Action Tendency
The EFT therapist helps clients to become more aware of their reflexive, automatic, and inflexible responses under conditions of perceived threat or danger. (e.g., what do you do? What happens next? Do you run? Shut down? Numb out? Lash out? Cling?)

For You Personally
Think about your own prototypical attachment strategy, as well as your own key relationships. During times of stress or overwhelm, what are you prone to do? And how does that impact your key relationships? That is, if you think about Moves 1 and 2 of the Tango, how do you make sense of the way you organize your inner emotional world and how does that play out in your most important relationships? Are there specific triggers that you might also need to be aware of and attend to in the context of your work as a therapist? (e.g., How might you respond to a client's anger?) If there are triggers, what might you do to ensure they do not pose a barrier in the therapeutic process?

BOX 8.1

Toward the end of Stage 1, the following can be anticipated:

- Increased awareness of patterns of emotional responses to stress (i.e., action tendencies), as well as interactions with key others.
- Improved emotional balance/wider window of tolerance (more flexibility, less numbing/reactivity, moving into and through emotion).
- A reduction in symptoms (e.g., less anxiety, depression, anger).
- A more coherent narrative.
- Increased awareness (e.g., of fears, longings, vulnerabilities).
- More access to key elements of models of self and other.
- Movement toward self-acceptance.
- Improved capacity to be ARE with self and others.

BOX 8.2

As the therapist moves emotion into granularity, vague/disowned responses are made explicit, specific and concrete. We can think about this process in terms of the E for emotion:

Evoke
Engage
Explore
Expand
Elucidate
Encounter emotion, actively and deliberately!

9

How Does the Therapist Restructure Self and System in Stage 2 of EFIT?

Soundbite Answer to Question
The experiential concept of changing into more of what one is, rather than trying harder to be what one is not, is relevant here. As clients deeply engage in, claim, and congruently express previously unformulated or avoided experience in the presence of a trusted other, this expands the sense of self and the person's repertoire of interactional responses. Core definitions of self and other become available and open to modification. Intrapsychic and interpersonal self and system shift into a new integration. In this integration, core emotions are fully experienced and reprocessed and the client moves into what Carl Rogers coined "existential living." In EFIT terms, the client literally becomes FIT, not only to manage their inner and interpersonal world but to expand and grow these worlds into a full rich life.

The essential elements of the restructuring stage involve taking clients into deeper levels of engagement and for longer periods. With symptoms reduced, more emotional balance (and capacity, i.e., a wider window of tolerance), and more trust in the therapist and the therapeutic process, clients are now well prepared for the risk therapists will invite them to take. It also is at this point that clients will naturally reveal new aspects of their narrative or will share key aspects of their story in new ways (e.g., with more emotional engagement and more detail). Previously disavowed aspects of self and experience become

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more accessible. Fundamental definitions of self and other are now available and more open to modification. Core experiences of sadness and loss, shame, and fear are more fully engaged with. As themes and triggers central to the definition of self and other are now more fully explored and deepened, encounters with inner emotions and representations of others become more intense and take on a more existential tone. Deep feelings of attachment longing, abandonment, and rejection emerge, as well as fears of catastrophic isolation and emptiness.

It is here that clients will be taken to the edge of their now widened window of tolerance and be asked to face questions surrounding our shared humanity: will I ever trust again? Will I allow my partner to see me and know me as I come to know myself? Am I enough? Am I worthy of, entitled to, love? Will I allow myself to love and be loved and face the fear of loss, abandonment, or rejection? If I am not bad, does that mean my parents/caregivers/key others who have been instrumental in shaping me are bad? And, if yes, what does that mean about my ability to predict and control my destiny? Does my life have meaning and do I have the freedom and competence to run my life?

These questions are not explicitly posed or confronted. Most typically, they are not even in conscious awareness but rather in the undercurrent of deep experience. This all sounds very profound and meaningful but how does the therapist get the client to this place? Building on the framework provided in earlier chapters, Chapter 4 in particular, the role of the therapist is to trust, expand, and follow the path of emotion and support the client in doing the same. Working at the edge of the client's window of tolerance, the therapist guides and accompanies the client to deeper levels of experience (Level 4 and beyond, as described in Chapter 4). With careful attunement, the therapist keeps the client at the growing edge of experience, moving between containing emotion (through interventions such as reflection and validation) and heightening emotion (using conjecture and repetition, evoking images and emotional handles/key phrases), and at times, a proxy voice (speaking as the client in the client's voice).

As clients move into deeper levels of engagement, they become absorbed, enlivened, and moved by the experience, in a state of flow as described by Csikszentmihalyi (1990), as when one is caught in playing a piece of music or dancing and where the process seems to take over and shape the dancer. Knowing that the therapist, the process consultant, and temporary attachment figure are there in the background, much like the diver has a line to the surface, clients are able to immerse themselves fully in this new and deeper level of discovery.

Herein lies the creative mystery of psychotherapy. Neither client nor therapist is aware of what is to be discovered. What is clear to the experienced therapist, however, is that, at a minimum, increased clarity will emerge as clients begin to more explicitly and directly enter into, embody, and face the

core vulnerabilities and dilemmas that have imprisoned them. Although, at this point, both client and therapist share trust in the process, even now this is more the case for the therapist than the client. The therapist must be willing and able to use this trust to leverage the therapeutic relationship to lead and hold the client in this deeper place, this foreign territory. As Gendlin (1981) and others have noted, it is in this state of *absorption* that new and emotionally grounded understandings emerge and substantive felt shifts occur. The therapist directs and supports this process, refocusing the client in the face of detours, such as tangential memories or intellectual discussions.

Clients' engagement with themselves and key aspects of their narratives, revisited at deep levels of experiencing, give way to powerful corrective emotional experiences that similarly lead to potent and lasting change. These experiences involve clients moving into and through the emotion associated with key events that have shaped them, in the company of a trusted other (or others, e.g., the therapist and an older, wiser self). It is here that attachment needs and fears can be encountered and owned in the present and in a visceral way. Critical incidents, pivotal events, and traumatic experiences may be revisited and ultimately mastered from a position of efficacy rather than helplessness. In this state, vulnerability is embraced and owned in a manner that leaves the client feeling more whole and balanced and, ironically, more powerful. The therapist helps the client distill and synthesize the new experience effectively, as well as encapsulate the new sense of self and other this experience offers. Clients find themselves more empowered in terms of defining their own experience and in imaginal interactions with attachment figures.

In the context of such experiences, the above questions confronted, clients can then find new dimensions in themselves and in their encounters with others in ways that are reciprocally influential and continually evolving. Fresh imagined encounters with others shape a different emerging sense of self and vice versa. This evolving process is synthesized by client and therapist into a more coherent and constructive whole. Key aspects of the client's narrative are similarly integrated in new ways. Returning to Chris (introduced in Chapter 8), for example, as he moved forward through Stage 2, his wife asked him, "What happened in therapy?" She described him as more compassionate, patient, and vulnerable, and more likely to reach to her in times of need. In turn, she felt more confident in their relationship and in her competence, in spite of her failing eyesight.

Indeed, as this natural process of growth continues to gain momentum, key change events begin to take hold outside the therapy sessions. Now absorbed in a new dance, the dancer begins to lead and follow significant others into deeper and more secure levels of engagement, again, in ways that are reciprocally influential and in a process that fosters ongoing growth. Clients are not

just less symptomatic, they are balanced. They are tuned into their vulnerabilities and needs, and they are empowered to assert those needs directly! They are able to love and be loved! The hallmark of secure attachment now at the forefront, the template has been set for ongoing and healthy development and increased resilience in the face of the harshness and challenge that life can, at times, bring.

The process of Stage 2 now introduced, let's return to the second author's work with Sandy, the client in the clinical example in Chapter 3. First, building on the introduction to Sandy that has been provided, a cursory overview of the Stage 1 process will be given, along with a closer look at one of the sessions. Next, the Stage 2 process will be reviewed with excerpts of transcript provided and with accompanying commentary highlighting key interventions, level of experiencing, and noteworthy shifts. Excerpts are edited somewhat for brevity and clarity. Final comments pertaining to the EFT roadmap will help therapists discern their location and continue to chart the course toward secure attachment.

An Overview and Glance at the Stage 1 Process

Reflecting on that initial session with Sandy through the lens of attachment and the CARE framework, prominent features include strong indications of suicidal ideation and associated risk, as well as an apparently rigid and negative model of self. Indications of childhood trauma compounded by various other traumatic experiences in later childhood, adolescence, and in her adult life, provide clues to the likely origins of her insecure attachment style. Also informative from a developmental perspective are indications of a generally tumultuous relationship history up until the time she met her "perfect" partner. Though together for over a decade and similarly well-resourced with respect to neighborhood and community, social, and financial status, these are luxuries Sandy is unable to enjoy. She feels undeserving and unable to live fully in the present context. Relationships feel shallow and superficial. Emotionally, she feels out of control. Angry outbursts are frequent and damaging and are often followed by periods of significant and debilitating depression.

More specific details (e.g., indications of resilience, various process elements) pertaining to the CARE model were highlighted in Chapter 3 and are, for the most part, not repeated here. Instead, we provide a brief summary of the roadmap, tailored specifically to this client. Looking, then, past the various elements of emotional disorders characteristic of Sandy's presentation (i.e., vigilance, self-criticism, nightmares, agitation and irritability, low/sad mood), we focus on what is central to attachment – models of self and other and affect regulation strategy and capacity. Given strong indications of self-loathing and associated suicidal ideation and risk, as well as limited capacity to manage more vulnerable emotions, the first step in the process was to help

Sandy develop some self-compassion, the well-established antidote to shame (e.g., Gilbert et al., 2010, Gilbert 2011; Kaufman, 1992).

In light of Sandy's narrative, as well as her response to the encounter in the initial session, in the sessions that followed (an additional five sessions, provided over an approximately two-month period), the overarching goal was to maintain and augment contact with her younger self and thereby bolster self-resources. The assumption here is that if we can begin to contextualize and "tame" shame (i.e., turn the volume down) in Stage 1, Sandy's access to her vulnerability will increase and her ability to be softer and more compassionate with her family will follow. Such shifts will lead to a reduction in symptoms – more emotional balance. As Sandy moves toward the end of Stage 1, stabilization will provide the platform to more directly work with and resolve shame in Stage 2 and support the continued expansion of self. With this immediate goal in mind, efforts were made to prime and promote self-compassion, both through helping Sandy to make sense of her current way of being and relating in the context of her history, and through choreographed encounters with her younger self. For illustrative purposes, excerpts of a transcript and summary comments from Session 4 follow.

Early in this fourth session, Sandy proclaims that she has suffered a setback, that she was foolish to hope and that there really is "no point." Describing her anger as a light switch, she then continues.

Sandy: It feels like everyone around me is intentionally pushing my buttons. I just feel so out of control. I get so hurtful. What am I doing to my children? What am I doing to my husband, to the safest most precious relationship I've ever had? It's just not fair to send them through this spin cycle, so that's when I think about leaving, for them, because it doesn't feel like there will ever be a time that I could manage it.

Nothing feels "real." It is "all surface." She feels "wrecked." She views her children's love for her as by default. In her words, "The kids don't really love me, they just think they do." If she were gone, then the children might have the opportunity to learn about "real love and not just default love." Everything feels hopeless and insignificant. She cannot see a way out.

Guided by Move 1 of the Tango and with the use of micro-interventions such as tracking, reflecting, and validation, efforts are made to contextualize the adaptive strategies she has developed. Specifically, it makes exquisite sense that in the face of isolation, Sandy developed a way to survive, to retreat, and to be self-sufficient, to endeavor to outwit her opponents, to anticipate what was expected and to focus on getting things "right." Her model of self now cloaked in shame and her vigilance for danger now on hyper alert, any hint of being disapproved of, devalued, dismissed, or criticized results in sharp and

reflexive anger. Her family then retreats and so does Sandy. She feels "broken" and "trapped." Her behavior confirms her self-view and her belief about her worth to her family. Indeed, she proclaims, "They would be better off without me."

Moving further into the session and some of those childhood experiences that shaped her, efforts are again made to make contact with her younger self. Sandy describes her childhood home, specifically her bedroom. I follow her there. As she makes contact with her younger self, around the age she was at the time of the bullying, Sandy is fearful that others are going to attack and reject her. Her feeling inside is worry. Guided by Move 2 and focusing at a bodily level, the immediate intent is to get more specific and precise. What does this mean? What is she drawn to do? As she sits with the tightness in her chest, Sandy identifies a feeling of anger. When asked what the anger would say in that moment, Sandy replies, her tone impatient and cold, "Just leave me alone. Get lost! Just, violent, frustrated anger."

More fully entering the bedroom scene, I continue to probe for additional details, asking, for example, "What is on the walls? What does the bedspread look like?" with the explicit aim of deepening experience and with the ultimate goal of giving this younger Sandy an opportunity to be seen and heard, by me but, more importantly, by her older, wiser self.

Sandy: I don't think the blankets are on the bed. I think they're pushed off in a mess. We're sitting on the bed with our feet up and our knees up, leaning against the wall.

Therapist: Sandy, how might you impact young Sandy? In your body, as you see her, what are you drawn to do?

S: Just sit there. With her. Don't try and convince her of anything.

Th: Just sit beside her. That's nice. That's good. That's a good thing to do. And as you glance at her and feel her, even from a distance, what's happening inside your body?

S: I don't like being ignored. (I nod as an acknowledgment that this is difficult.) She's ignoring me. She's very spiteful. She's just turned her back on me, literally.

Th: And as you stay really still with her … I get it … there's a part of you that feels frustrated and rejected but there's some other part of you that has compassion and empathy and understanding, at least in the sense that you actually know what's going on inside of her, which is why she wants you to stay. But she, for her own reasons, can't and won't say that. I guess maybe it would hurt too much, if you then left, she would be so vulnerable. So you are just staying really still with her, right there beside her. Even though she can't communicate that to you directly, you can feel it because you can feel her little body. And now as you sit super still …

S: Just feels like… unbelievable that … someone so young would have to feel things so heavy … it's not fair. (Starts to sob.)

Th: Yes, that's right, Sandy, it's good to let yourself cry. Yes, let her sob. That's the best thing to do, you're absolutely right. Let yourself sob. It's good, from your chest and the tension and that feeling in your throat. Let yourself cry and release it. That's good. Are you okay to keep staying here? (She indicates that she is.) Sandy, what happens now as you breathe?

S: It's easier, not so tight.

Th: It's easier. Are we still there, in the room, on the bed, with her? (She indicates that she is.) Now what's happening for her? What do you see and feel?

S: I don't know how to describe it, she's so hesitant to soften.

Th: To be impacted by your presence, yes? We're going to need to be patient. If we keep breathing, Sandy, what's going on now? (Notice that as Sandy begins to feel what she was unable to feel in those earlier times, I encourage her to express those emotions. I also continually reference myself as there as well, highlighting that she is not alone.)

S: We're just sitting and it feels to both of us like it's not permanent … when I get up and leave, she'll be alone again.

Th: Right. Yes. Sandy, in your gut, if your gut could speak to her, right here, right now, in that bedroom, what would your gut want to say to her? We actually, I think we understand it … young Sandy's not going to talk … it's too scary to talk … it would hurt way too much to speak and then to be alone again, right? I think that's what's going on for her. So, if your gut could speak to her, what would it say?

S: Everything seems so flimsy … like nothing would …

Th: Well we won't expect her to give us anything back because that's just not how it's going to work with her, right? Especially with somebody like her … who's been so hurt … and felt so alone … and feels so trapped … so we won't. But I hear what you're saying as well, that it's hard to find the right words to land on her in any way that might have an impact … So, if we stay out of our brains and just be in our guts with her, on the bed, in the room with the wood door, if your gut could speak to her, what would it say? (Notice that I highlight the details in the room again and reference her body/gut to encourage her to stay in the experience and out of her intellect.)

S: I would want her to know that I've been there and I understand. I want to tell her that it gets better … but I'm not going to lie to her.

Th: What would your gut say to her, about your commitment to her? If your gut could speak … because that's the only part you really have control of, right? You can't control the kids at school or what's happening on the other side of the door.

S: Right … I don't think anything matters either.

Knowing what she knows, that young Sandy has a lot of painful events still to come in her life, older Sandy is unwilling to deceptively reassure her in some sugar-coated way that everything is going to be fine. What she can provide, however, is company on the journey. She can be the ally and resource she did not have at the time of these earlier traumatic events. In processing this interaction then, in Move 4 of the Tango, the focus is on the potentially soothing impact on young Sandy, who remains withdrawn and apprehensive, that may come from older Sandy's compassion, honesty, empathy, and sincere wish to join and stay with young Sandy on this painful journey. They can do this together. This time, she does not have to be alone. They do not have to be alone. (In addition to this more immediate goal, relevant also here is the desired outcome for more self-acceptance, cohesion, and integration in the future. I recognize that these are the initial steps.)

Therapist: Sandy, do you have a sense of what young Sandy felt as you quietly sat beside her?

Sandy: She didn't want me there … Says, "Get lost …"

Th: Did she feel your presence and comfort? (Sandy acknowledges that she did.) Yes, okay, so there was a part of her that was taking it in and another part of her that wanted to push you away? (She nods.) Yes, so with that understanding, Sandy, what feels right to say to her, from your gut? I guess you could share that understanding, maybe, or just be still with it, I'm not sure.

S: I feel like everything I say will just be into thin air, like, why bother, she's not going to believe it anyway. She's fluctuating between loneliness, her normal feeling, and now something else. But she's not used to this new feeling so she doesn't feel like she's supposed to want me to be there or enjoy it at all. (This is key. Once again, assessment and intervention merge. This is a good sign. Young Sandy is impacted by this bid for connection. I am also aware, however, of Sandy's struggle.)

Th: (Using proxy voice, moving between older and younger Sandy.) Tell me if I get this right, Sandy. The thing I hear you saying or reflecting to young Sandy would be some version of, "I hear you and see you and feel you, that it's been a lonely journey and even when you thought and believed that things might be different, they weren't different. And your only recourse has been to be alone, to curl your little self up in this room, on the other side of the door, and listen to what's happening outside it but really struggle hard not to be affected by it and not to let anybody

in, and well, not to have hope, not to believe." I now turn my focus to younger Sandy and speak for her.

Therapist: And I think what I hear that younger you say is some version of, "When you sat alongside me, this older, wiser, more experienced part of me, there's some part of me that's impacted by your compassion and clarity, and wants to be warmed by that but it's been a long road, a long journey alone. So there's another big part of me that feels angry and frustrated and wants to just push you, like I push everybody else. But I actually didn't do that. I turned away but I didn't push you and I'm not going to push you but I'm also not going to let you in fully because that's way too scary. Because then, if I am alone again, that will be devastating, that will hurt more than anything." So what would reassure her, Sandy? I think the only reassurance would be to know that … maybe you'll come and go. And maybe there'll be times when you have your attention on her and bring her into the room but you're not going to leave her. Do you feel like you could assure her of that? You've got lots going on because now you have your own family and various other commitments. You are going to come in and out of her life and bring her into the room in small and big ways but it won't be an ever-presence because you're not going to be able to promise that. Does that all feel right? What does that feel like for you? (I am again guided by attachment science and by the EFT roadmap. As I begin to prime a felt sense of secure attachment, the goal is not an "ever physical presence" just as it is not the case with parenting or in adult love relationships. Rather, the goal is a "felt sense of security," a knowing that, "If I call on you, you will be there.")

Sandy: It feels honest and manageable.

As I move toward closure in this fourth session and adult Sandy continues to sit in contact with young Sandy, I integrate and consolidate what has just occurred in a way that engenders hope and that helps order and give Sandy's experience more coherence (Move 5 of the Tango).

Sandy: Young Sandy is not near the end of it … there's no light at the end of the tunnel for her. She still has some horrible things to go through. (I nod in agreement.) And I can't reassure her that she's any better on the other side of it.

Therapist: Yes, that's right, we are not going to be able to change … her … your history … but we can change the impact, not completely and not perfectly, and not in a way that you never get triggered or never get impacted

or old wounds don't get touched by certain events that remind you of past events, not even consciously but probably more often unconsciously and automatically. But the more that we can embrace young Sandy and help her to know that she doesn't have to be alone in the world, the more that you connect with her and the more that she develops trust and belief and hope, the more that she has a representation of you in her little tiny body, the more that you don't actually have to be there. She can call upon a representation of you. She can call upon that experience of you sitting beside her on the bed. (Here again I call upon attachment science and what we know about secure attachment to guide my reflection.)

S: That's good.

Th: Yeah … because that's how it is for us, right? You don't always have your husband beside you … and I know that's not been perfect either and there's some scars to work through there … but in a real time of need, do you feel like you could call upon a representation of him to support you? (Sandy nods.) Perfect. And your babies, your kids, could they do that with each of you? (Again, she nods in agreement.) That's our goal, that's what we wish for and strive for, not to be ever-present physically but emotionally. (Again, Sandy nods.) She's not trusting yet but your honesty will help her to build trust.

Over the course of these first six sessions, Sandy was able to gain access to those younger parts of herself and to the vulnerability associated with those earlier experiences. As she gained greater compassion for herself and the distance between her past and present narrowed with increased contact (through Move 3 of the Tango in each of the sessions), so too did her capacity to trust and to manage difficult emotions. At one point, she disclosed that her husband had commented and expressed gratitude for the important work she was doing and the notable advances she was making. Gains were similarly noteworthy in various areas based on Trauma Symptom Inventory findings (TSI-2, Briere, 2011), including, for example, in the areas of anger, depression, intimacy, and suicidality, and with regard to affect regulation capacity, identity/self-knowledge, coherence, and self-direction. At the outset of treatment, symptoms were notable in each of these areas, especially suicidal ideation (nearing the top of the scale at the outset of treatment) and by the end of the six sessions, only the self-related/self-resources scores (self-knowledge and self-direction) were above the normal limit range. In summary, Sandy is more self-aware and compassionate, and more likely to be guided by herself than by others. Her window of tolerance has widened and her capacity to love and be loved broadened. At this point in the process, we would consider Sandy part way through Stage 1. Given increased self-resources, flexibility, and capacity, as well as the now more likely possibility that Sandy could use her partner as a resource in the therapeutic process, ongoing individual

therapy might be recommended or some combination of individual and couple therapy. In either case, the available data are suggestive of momentum and a template for growth. With the overall goal of self-coherence and integration and companion targets of increased trust and affect regulation capacity, the EFT approach and associated attachment framework provide the map to the safe haven that will become her more permanent home in Stage 2 and the platform for similarly secure base parenting.

Sandy's Progression from Stage 1 into Stage 2

The boundary between Stages 1 and 2 is not thick and black but rather ombre, in shades of grey. Although the therapist will continually assess progress and look for markers or signs of stabilization, such as those cited above (i.e., reduced symptoms, indications of gains generalizing to relationships with key others, more emotional balance, a greater sense of confidence and competence), key to crossing that boundary is both the readiness of the client and the willingness of both client and therapist. To cite the well-known adage, "You can't cross the sea without having the courage to lose sight of the shore," both client and therapist need this courage. The shore should represent stabilization and the springboard for secure attachment. That is, as the therapist continually evaluates while intervening and assesses for client indicators of stabilization, the therapist attends to the shoreline (i.e., the client's context outside of therapy, for example, external stressors and/or resources), as well as client readiness to enter into what is required in Stage 2.

Clients cross the threshold into Stage 2, not as the traveler with the map (the therapist holds the map), but instead, as the passenger with a voice. Referencing the old adage and the diver analogy above, some clients will leave the shore, move into deeper levels of experiencing (4–5), then return to shore or to the surface for a period, then go back again. For other clients, once they leave the shoreline and move into deeper levels of experiencing, they become absorbed and though there may be breaths of air taken, they remain in "the zone" or to use Csikszentmihalyi's term, in a "state of flow" for extended periods. In other words, as described in greater detail in Chapter 11, these significant and meaningful Stage 2 change events might be incremental and cumulative, a combination of small and large shifts, or a more organic process might ensue as clients are held and guided as they move into deeper and deeper levels of experiencing (Level 4 and well beyond). As always, it is incumbent upon the therapist to continually assess and determine what is possible, both from the vantage point of the client's personal resources, as well as the "shoreline" (i.e., external resources and/or stressors). Excerpts of transcript and commentary of a Stage 2 session with Sandy follows.

Following the six sessions described above, Sandy invited her partner Jake to join us. Given that EFT is a multi-modality approach (see also, Johnson,

2019), I was able to oblige and seamlessly integrate the two modalities. In the couple sessions provided, therapy focused on integrating and consolidating the gains that had been made in the individual therapy sessions and further bolstering the relationship as a resource for Sandy. After a break of a few months, Sandy then returned to individual therapy. The seeds of growth sown, there were no concerns about losing momentum. To the contrary, I assumed that she would continue to grow from the lovely "shoreline" (i.e., increasingly stable base) she had built with partner Jake and from the progress she had made in earlier individual therapy sessions. About 30 minutes into what was now the 10th individual psychotherapy session, Sandy reported that she had been experiencing intrusive memories.

Sandy: I've been thinking a lot about … not thinking about … well a mixture of replaying and thinking about … what happens … happened when I would go over to my neighbor's house … (As I nod in acknowledgment, Sandy continues.) When it's happening, I don't have any emotion around it, it's just sort of like another thought that's coming and going but I have noticed the frequency has increased … (I again nod.) There just seems to be one instance that pops up … as opposed to replaying scenes and if I really think about it, I'd have to really go deep to pull details from other scenes which I don't really want to do.

Therapist: Are you comfortable to share the scene? You don't have to share it in detail or just even maybe share … how old you are in this picture? How old is she? (Here I am assessing readiness, I am tentative. If Sandy is ready, I intend to focus on one memory in an effort to focus the session and with the understanding that all of the memories/traumatic events do not need to be addressed. These memories/traumatic events tend to share common themes, e.g., betrayal and/or powerlessness, which will be addressed.)

S: I guess, probably nine or ten. It's logic bringing me to that place, that age you know, intellectual thought, not memory but I'm sure it was somewhere around there.

Th: Okay, I see what you mean, do you see her little face?

S: No, when I picture it, I'm in her body.

Th: Okay Sandy, that's excellent, are you able to stay there? (This is a good sign, a sign of readiness and an indication of increased integration, and certainly a wider window of tolerance.) That's good, Sandy. Sandy, stay with it. I'll stay too. (Again, I make it explicit that this time she will not be alone, I will be there too.)

S: I don't remember why we were in the garage, the detached garage. It was summertime. It was hot in there, like a garage gets you know? (I nod in acknowledgment.) It had one of those grimy aluminum single-paned

sliding windows … with all the dead flies in the sill … (I nod.) And the sun was coming in and Tom had a work bench along that wall … the door was only a few feet behind me and it was open … he's just sitting on a stool … (Sandy now starts to cry.)

Th: That's good Sandy. Let yourself cry. (I am saying, "Let yourself feel what you were unable to feel at the time of the incident/s.") Do you see his face? With a look of disgust, Sandy replies, "He's just so ugly and fat. He was fat. He had this gross pudgy freckly face, orange hair and stupid gross orange eyelashes … " (The level of detail provided is likely both an indicator of her coping response as a child, to look outside and pull away from her internal experience, and now also a positive indicator of her capacity to revisit this scene in detail in a manner that will foster deeper experiencing.)

I reflect, "You can see him," and Sandy continues.

Sandy: You could smell his musty basement, the books smelled like that, and he said, "You know you owe me something." I knew what he meant but I didn't acknowledge it. I didn't want to do it.

Therapist: Yeah of course, Sandy, of course.

S: And then he kinda joked, you know, "C'mon, just come over here … oh c'mon … c'mon be nice … " (Sandy's tone and facial expression convey disgust.)

Th: That's good, Sandy, let yourself feel how that poor little girl was feeling. It is good to let yourself feel that now, Sandy, good. (Tracking process and noting that Sandy is vacillating between moving toward and away from the edge of her window of tolerance, I intervene to hold Sandy there and deepen the experience to between Levels 3 and 4.)

S: I did feel like I owed him.

Th: Yes, I hear you. I get it.

S: Maybe that's why I didn't tell anybody, cause I thought he was right, you know?

Th: (I nod.) Are you still in her body Sandy? (Sandy indicates that she is not.) What are you feeling now in your body? (Track process.)

S: Just holding my breath.

Th: I hear you. I understand … yeah … do you still see her, Sandy? Is she nearby, that 9-year-old?

S: I can see her standing there. I'm at the doorway.

Th: Right, okay Sandy, that's good, that's perfect. Sandy are you able to … you don't have to say anything out loud but can you speak to her? (I want older Sandy to make it explicit to young Sandy that she is there with her.)

S: What do you say? (I hear this as helplessness, the same helplessness she felt as a little girl. She is focused on what is to come next, not on her capacity to now provide support.)

Th: If you imagine that you are there and I'm there right behind you, are you able to get in touch with what she might say to you? (I make it explicit that I am there too.)
S: She wouldn't say anything, just like back then, you know? (I nod.)
Th: She'd be silent … (Pause.) And scared, of course.
S: I can feel how embarrassed she is, not just because of what he wants her to do. She doesn't really understand why but she knows it's not good. It's confusing. She knows she's not supposed to do it but she doesn't understand why and so she's embarrassed to tell anybody.
Th: Of course, Sandy, of course, and of course we can't control all this but we can be with her now and that's what's so powerful about your amazing capacity to go back into these moments … are you able to quietly share with her … and what I mean by that is … this is just between the two of you … and I'm here too … he's actually not going to hear it … this is what I'm getting at … what would you say to her? (Make explicit the therapeutic goal. The key here is accompanying that younger Sandy; weave this into a reflection, let her know that I understand that she cannot control the outcome and that she does not have to confront the perpetrator. Again, I also make explicit that I am in the scene.)
S: This isn't your fault. (Earlier Sandy referred to embarrassment, a close relative of shame. Here she directly and naturally takes an important step toward resolving shame. Hearing this and the importance of these words, I have her repeat them.)
Th: That's good Sandy. Good, tell her again, that's good. (Given Sandy's strength and clarity, there is no need for me to intervene, only to support her. Saying, "It's not your fault," will be much more powerful coming from older Sandy than from a therapist.)
S: It's not your fault. This is something that's being done to you.
Th: Yes, Sandy … exactly …
S: You're not doing anything …
Th: Just an innocent beautiful little girl that should've never been in that situation.
S: It's okay not to know what to do.
Th: Yes, it's okay.

Continuing to track and reflect the process, I note that she is letting older Sandy hold her in this moment. I reflect that this is what she needs and that this is what she didn't have as a little girl. I encourage her to continue.

Therapist: That's perfect Sandy, that's good.
Sandy: I just want to leave. I want to leave the garage, just take her, we're going away, we're leaving the garage! (Sandy is empowered and assertive/Level 4–5 on the Experiencing Scale.)
Th: Where is she now, Sandy? She's still letting you hold her?

S: Yeah, we walked away with my arm around her. We walked right onto the road that goes past the house. (I nod.)
Th: That's nice, that's good.

At this point, Sandy turns her attention to her children and what she would do if anyone ever did anything like this to them. I tell her we will come back to this and redirect her focus to her younger self.

Therapist: Sandy, let's just stay with her for another minute or two or as much as you can. Is she letting you hold her? You're walking together and you've got your arm around her shoulder … is she able to glance at you or not so much? (Again, I provide details in an effort to hold Sandy in the experience.)

Sandy now shares a tender image of the two of them walking down the dirt road. It is summer and the road is dry. Clouds of dust follow. They are walking from the garage to her family home. They are not talking, just walking.

Sandy: My dog is there. (Another resource.)
Therapist: What does the dog do? (I can count on this answer and want to make explicit that she has another resource in her family pet.)
S: She's running to us on the road, up the driveway. It is a really short driveway; the house is right there.

To hold Sandy in her experience, at Level 4–5 on the Experiencing Scale, I invite her to stay, I paint the scene to hold and deepen the experience and draw attention to the support she now has.

Therapist: The dog's coming … are you able to be in her little body for a second and tell me what she feels, in this moment, your hand on her shoulder and the dog's coming toward her? What happens in her little body?
Sandy: She likes the sight of the dog coming, you know … with his smiley face … and she lets go of me, moves away from me to crouch down and pet the dog, my childhood dog, her childhood dog.

Sandy then shares a tale about her dog, her protector. I listen and acknowledge that dogs are loyal, at times confidantes, and certainly protectors. I then attempt to hold Sandy in the experience and carry it forward. As the process continues to unfold, vacillating between Levels 4 and 5 on the Experiencing Scale, younger and older Sandy proceed up the stairs of the childhood home. They sit together, the sun shining above them. Younger Sandy feels protected but the garage is not very far away.

Sandy: She feels like she deserved it because she went back after the first time.

Therapist: Sandy, are you able to talk to her about that? She doesn't have to say anything … I understand why she's too scared to say anything … you have her attention … If your body could speak to her, what would it say? (Initially, older Sandy is looking for the right answer. Again, I want to keep her out of her intellect and I want to promote more compassion and understanding, with the goal of further resolving the shame and expanding her sense of self.)

S: It was okay to want to borrow a book and you don't have to pay for it, in any way. I'm sorry that you don't have anyone else to ask to borrow a book from. You didn't ask for it. I wish that they could see you the way that I see you.

Th: Sandy, tell her more about what you see.

S: You're so awesome. You're so fun.

Th: That's good, Sandy, keep telling her. (I want to keep the exchange going, model of self is open to revision.)

S: You think about things the way that nobody else does, that's why they don't understand. You're just so cool the way you think about things. I know that about you, they're missing out when they don't give you a chance, they're missing out on you. I know it seems like it's gonna be a long time but people who really take the time to get to know you are gonna love you. Please don't give up, please don't. (These last words are poignant. I feel them in my own stomach as they take me back to our initial session and to the risk for suicide that was present at that time.)

In response to Sandy's comment, "I wish I could change it," I reply, "You're changing it now." I then assess whether young Sandy is able to take it in. She is. She is leaning into older Sandy. She can feel older Sandy's chin on her head.

The session continues, with another significant shift in and expression of emotion, at deeper levels of experiencing (first at Level 5, then at Levels 6 and 6–7 on the Experiencing Scale). Specifically, as Sandy again revisits the scene and begins to feel, I say, "Let yourself feel it now to move through it and beyond it" (i.e., effective affect regulation). As Sandy allows herself to feel deeply, she describes, "Feeling sick … nausea … a sludgy texture like clay that you can't rinse off the bottom of a bottle, it's sticking to you and greasy, you can't wipe it." As I hold and support Sandy in this experience, I encourage her to keep breathing, to, "Feel that, to be liberated from that, to stay in [her] body as much as [she] can and be liberated from that." I again let her know I am there, "I will breathe too." Sandy first expresses anger and then sobs. She then tries to make sense of all this. "What if somebody did it to him?" she wonders, then adds, "There is no sense." I nod in agreement and then check in, "Where is she? Where are the two of you?" (I track process and continue to hold her in the experience.) They are on the steps. Following a felt shift,

there is relief. It is a hot summer day, "And you can just see everything." I probe further.

Therapist: What does she see?

Sandy: The grass is drying up. We have acres of it so we don't water it. Right on the other side of that is the road, and if you stood on it, you'd never see the end in either direction but you can see where it turns and goes up … right now she wants to go ride her bike or something, she's like, "Let's go do something."

Sandy then adds, "You go be a kid, I'll hold these heavy feelings for a while."

In closing the session, a summary/reflection is provided.

Therapist: Did you see what just happened, what you did? As you bravely shared with me about that scene, you very naturally and beautifully arrived at the door for her and that's a key difference. This time she wasn't alone. In fact, you spontaneously took her with you and as you both walked down the road, the dry dirt kicking up behind and creating little clouds of dust, she could feel your arm around her little shoulders and was comforted when you were greeted by your family dog. As you then sat together on the stairs of your home, what emerged next was more of the experience of being in those moments in that garage, the flies in the sill, the heat, the smell, all of that came back, and, this time, you allowed yourself to bravely sit in it and feel it, even the awful sick nausea that, of course, anybody would want to run away from. This time you stayed with it in a way that would be healing and this is what we're trying to do, is allow her, allow you to feel it and to be liberated from it. With a return to the stairs, there was a lighter feeling, somehow the sun was a little brighter and the details of the grass and the road, all those elements that could be seen through the eyes of this beautiful little girl are captured as she shares her experience with you. And then for a moment, or at least in that moment, an experience of just wanting to be a little girl and ride her bike emerges, and you said, "I can hold your pain … I can actually hold this for you … you can be a little girl and I'm here. I'm here with you. I see you and I know you and I understand you and I can see what you see." That's perfect.

Sandy: Feels different today, than other times when I go to her sitting on the bed, you know? Like something tangible… I don't want to say changed but … I've only ever just been with her where she is, you know? But taking her away with me feels different… now we're out of there, this is not okay, we're out!

With a look of ease, Sandy ends with, "Thank you."

Concluding Comments and Reflections

Here we have the privilege of witnessing the beautiful work of Sandy and her transformation from risk to resilience. Previously rigid and restricted views of self and other become more open to modification and begin to shift and expand through Stage 1 as younger Sandy feels seen, heard, and understood and is able to take in the care and love that older, wiser Sandy is able to provide. This relationship is not "surface." There is no sugar-coating of the messages. As older Sandy consistently offers support and becomes acquainted with and begins to share her view of her younger self in Stage 1, with increased trust, coherence, and integration, the foundation is laid for the key messaging that was provided in Stage 2, "It's not your fault!" Engaging in deeper and deeper levels of experiencing as the Stage 2 session unfolds, Sandy demonstrates effective affect regulation, "A process of moving with and through an emotion, rather than reactively intensifying or suppressing it, and then being able to use this emotion to give direction to one's life" (Johnson, 2019, p. 11). Sandy goes into the core vulnerability (i.e., helplessness, powerlessness) and deals with it differently, in a way that leaves her balanced, coherent, integrated. Now empowered and her sense of self expanding, she spontaneously leaves the garage and takes her younger self with her. As she continues to move through the deep emotion associated with this traumatic event (representative of many and characterized by violation and dismissal), she is able to liberate herself. A felt shift occurs. The landscape also changes and is now colored by the wonderment and innocence of childhood.

In the sessions that followed, the interchange between older and younger Sandy continued. Sandy spoke of ready access to one another. Choreographed encounters revealed younger Sandy's position, "I did not deserve that. I deserve to be loved and cared for, that wasn't about me." Older Sandy elaborated, "She feels the absence of harm, she does not feel danger, she feels unencumbered, lighter, easier, more playful." On the other hand, at individual therapy session 13, older Sandy was still struggling to take in the love and care others were attempting to provide, including her partner and her younger self.

In an effort to anchor ourselves in the process of change, we can refer to the many EFT sessions that have been coded over the past three decades. Based on these numerous studies and with reference to Sandy above, it would appear that she is struggling most with taking in comfort and care from others but has found greater ease with engaging with vulnerabilities and needs, asserting her needs coherently and directly and giving attuned support to others. (See also, Johnson, 2019, for a review of the key elements of change, p. 33).

We will return to Sandy in the next chapter when we discuss Stage 3 – Consolidation. For now, let's talk about how the Stage 1 and 2 processes might look with different types of clients, with different presenting problems. The

client struggling with anxiety, for example, might first gain emotional balance through various encounters with feared events or people and then move to Stage 2 change through encounters at deeper levels with aspects of self and/or key others in scenes representative of pivotal events. The client gripped by and stuck in unresolved grief might first find stability and emotional balance through encounters associated with the lost loved one, and then seek lasting and sustainable change through deep encounters with aspects of self. The police officer with 20 years of service might begin the process of stabilization through processing the traumatic work-related event that prompted the initiation of therapy. Once through the stabilization phase, this same officer might then engage in deep encounters with significant others, including spiritual others, as a part of the Stage 2 process.

In all cases, the guiding principles remain the same. A thorough assessment helps the therapist chart and pace the course of therapy and careful attunement and on-target interventions propel the process forward. On the shoulders of attachment science and, now, years of research in EFT for couples in particular, attention to the indicators of stabilization and to the key elements associated with Stage 2 change help the therapist navigate through the course of therapy and monitor progress along the way. The overall roadmap is clear, as is the desired outcome, a felt sense of security, in self and in relationships.

Play and Practice

For You Professionally

A common concern in working with trauma, in particular, is how best to gauge the client's window of tolerance and to ensure that clients are working at their leading edge of growth (neither over- or under-shooting the window and overwhelming the client or restricting growth, respectively). With the consent of one of your clients, videotape your session, then watch it with reference to this key consideration and with regard to the Experiencing Scale. Note where you might have encouraged the client to stay longer in the experience and when you might have used interventions such as reflection and validation to titrate the process.

For You Personally

With respect to the above exercise, if you notice a tendency to undershoot your interventions or get derailed by the process in other ways (e.g., go down *rabbit holes*), reflect upon your own blocks, based on either your personal history or your professional experiences. For example, are you fearful of retraumatizing the client? Do you have a difficult time with strong emotion, making it difficult to be present and encourage deeper engagement with your clients? Or perhaps you notice yourself pushing your clients beyond capacity. Once

you have identified any challenges, how might you address them (e.g., peer consultation, supervision, additional training)?

BOX 9.1

What Happens In Stage 2 of EFIT?

- Client moves into deeper levels of experience for longer periods.
- Clients engage core emotions – enter an absorbed flow state – awareness shifts.
- Pivotal conceptions of self and other arise – become fluid and changeable.
- Clients move through key moments – achieve state of closure, coherence, competence.

10

How Does the Therapist Guide Consolidation In Stage 3 of EFIT?

Soundbite Answer to Question

As clients move through the process of therapy, their stories and identities change. The narratives that shaped their views of themselves and others in their world take on a new valence. The role of the therapist in this third and final stage of EFIT is to collaborate with clients in making explicit these pivotal shifts in the main character, the self, and in patterns of relating. Confident that clients' felt sense of security will continue to evolve, the therapist also guides clients in continuing to shape this new narrative beyond the therapeutic process.

This chapter describes the termination phase of EFIT. Now nearing the end of their journey together, the therapist guides the client in consolidating and integrating the therapeutic gains that have been made. The growth process now well underway, the key role of the therapist is to shine a spotlight on the gains that have been made. Any changes in emotion regulation, cognitive meaning frames, behavioral responses like avoidance, and levels and forms of interpersonal engagement are made vivid. The therapist collaborates with the client in articulating an overview of the client's therapeutic journey and present reality relative to the clinical issues presented in initial sessions. This narrative is compared with the story shared at the outset of therapy. The differentiation of past ways of interacting and their emotional underpinnings are underscored.

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In constructing this story, the therapist again maintains a stance of curiosity. Questions are guided by the unique characteristics of various clients and their respective journeys. With the implicit aim of assessing how and if the narrative has shifted or expanded, the therapist might ask, "When you look in the rearview mirror, what do you see? Help me to see what you see." With the same goal in mind, pivotal change events might also be referenced, "When you return to that event (i.e., a key representative scene that was instrumental in shaping models of self and other and that was addressed in therapy), what do you feel now?" Move 3 encounters may be choreographed to make vivid shifts in patterns of relating with aspects of self or key attachment figures over the course of therapy. Significant others, as available, may also be called upon to provide their perspectives. For example, the therapist might ask the adolescent client, "If your mom was here with us, what would she say? Has she noticed any changes?" Or adult clients might be asked one or more of the following questions: what might your best friend say about what is the same and what is different since you started therapy? If your partner were here, what would she say about your relationship now compared with when you started therapy? Relative to the outset of therapy, do you notice any changes in the way your children relate to you? In short, clients are encouraged to articulate a new narrative with the aim of highlighting any differences in the coherence of the narrative, as well as shifts representative of model of self and other revision and affect regulation capacity.

With this central goal in mind, to construct an overview of the therapy process, we turn again to the second author's work with Sandy. First, a summary of a consolidation session is provided. Concluding comments and reflections follow.

Following the series of sessions referenced in the previous chapter, Sandy again completed the Trauma Symptom Inventory (TSI-2; Briere, 2011). Compared with the previous administration, the measure revealed an additional reduction in symptoms, as well as positive shifts in the key areas of attachment. At that time, only one self-related subscale (that pertaining to identity/self-awareness, knowledge, and coherence) was elevated, marginally above the normal limit cut-off. That same fall, Sandy participated in a live session as part of an online training with a large international group. Excerpts from the related transcript (edited somewhat for clarity and brevity) and summary comments are provided below.

At the outset of the session, Sandy begins with an account of her earlier experiences of therapy and her initial expectations of the current therapeutic process.

Sandy: I feel like I've had so many lows over the years. I was very skeptical because I felt like I had tried so many things. I never felt like I had

anything tangible that I could take with me. Although it felt really good to talk to someone with an open ear and an open heart, it would finish when the time finished and then I would leave, and then I would get upset or sad or whatever. And then I would come back and feel good for that hour or whatever it was. I had become really good at learning what people wanted. (I nod in acknowledgment.) I had told the story so many times, to no avail. It was very flat and just something that you do or that you say and nothing's ever going to come of it anyways so what does it matter? When it was recommended that I see you, I thought, "Oh, here we go again," but it wasn't like that. I didn't know what to expect. That was unnerving for me because I feel like I always know what people want and how to give it to them. This keeps me safe and feeling in control. When we started, you would say, "Can you picture yourself … " and I thought, "What does that have to do with anything?"

Therapist: It's good, I love that you're telling me. Yes, you just tell us. This is great, tell me. (I appreciate and want to encourage Sandy's honesty and authenticity, a new way of relating relative to the outset of therapy.)

S: I wasn't all on board. I thought, "Oh gosh, here we go, okay whatever." But the more we met, some of the things you said really mattered. At one point, I was walking by myself and pictured that girl who was sitting on the bed and wouldn't even look at me (her younger self, as referred to in the previous chapter). I thought, "Oh, okay, maybe I could just hold her hand right now, and just let her know that if we're walking down the street, she's safe, and if we're at home, she's safe, and even if we're not together, she's still safe" … and that started infiltrating regularly. Even then, though, there were still some pretty incredible lows.

Th: Sandy, that's brilliant and what strikes me about what you're saying is that it doesn't stay within the session. You keep working and growing and moving in the right direction. So dedicated, that's a big part of it, Sandy. I did hear your skepticism, of course, but you stayed the course. You are staying the course. It's beautiful.

S: I think I stayed the course because it was so different. I don't know how but I felt like it was working. I didn't know what you wanted from me so all I had left, the only option, was to be authentic. I could go back in my memory and I could see that little girl and I was really sad that she didn't want to see me. (I nod.) She didn't trust me, she was like, "Get lost! You're just another one … " And then we grew together. You helped us and guided us along the way and opened up the doors that we could walk through together. That was just really, really different and meaningful and long-lasting. And I can find her now, in a walk or a meditation or a moment of high emotions, anger, or frustration … and it's having a drip-down effect, to my husband, my sister, my mom … and onto my children. I had a little bracelet made, this little tiny silver

one, it says, "There is time." (I note here that Sandy is referring to one of the contentious issues she cited at the outset of therapy, being on time. Here I want to shine a spotlight on new solutions to old problems.)

Th: Oh, Sandy! That's fantastic, that's brilliant! I think I understand but please share.

S: Well, being a black-and-white thinker, time is the thing … there is not time for this! You need to get yourself together! You need to organize your life! You need to just make this happen! And I put that on the people around me, my kids. My daughter has told me a million different ways, usually with tears, that this doesn't work for her but I didn't know how else to be. In my personal growth with you, I find time for softness. There's time between the thing that happens and the reaction. I used to think that they happened at the same time but I've been able to cultivate that time and wow, things get a lot smoother. (As Sandy shares this, I note that this is in stark contrast to the picture she gave at the outset of therapy. The time lag between trigger and response is much longer. She has more flexibility. The response is no longer automatic and reflexive or characterized by either lashing out or shutting down.)

Th: Well, that is brilliant. So, can I see if I can capture this? It'll help us. Let's think about this together. What I heard you say in our work together is that you were feeling skeptical and hopeless. And in your family, you would get triggered when your children didn't listen to you or when you felt dismissed by your partner. When we went into some of those scenes, it became clear that you had those same experiences of feeling dismissed or unimportant as a little girl. Rather than reaching out to others, you learned to cope in other ways. Your automatic reflexive tendency was to either lash out, get angry, or shut down, and then your family would scramble, you'd feel terrible and you'd find yourself thinking, "What's the point?" Now I hear you saying that there is time between you getting triggered and responding. Can you help me understand how you do that? How do you slow everything down? What do you do? (My intent here is to summarize and consolidate therapeutic gains and make explicit her sense of agency.)

Sandy explains that being interrupted leaves her feeling unimportant. She has learned to pause and attend to her children, to look into their eyes, just as she did with her younger self. She also now touches her daughter. "That's how she feels that connection and love."

I then move to Sandy's partner and ask her about their interactions.

Therapist: As you're more attuned with you, are you more able to reach to him in direct ways, when you feel dismissed or when you feel your needs are not heard? (Again, attachment science and the EFT model guide me.

We have found it is crucial in key change events for clients to be able to assert their needs coherently and directly.)

To this Sandy explains that it is not always easy and not always smooth and fluid but they are working on it together. Her partner now has more compassion and they are better at communicating at deeper levels.

Sandy: Yeah, he hears me for sure and he doesn't have to agree and that's okay.

Therapist: My sense is he sees you because you allow yourself to be seen. (I want to underline and make vivid the risks Sandy has taken in her most important relationship. As she has more access to herself, her emotions can help guide her needs and preferences and she can more deliberately and directly express and assert those needs and preferences.) The more that you do that, Sandy, the more that you'll continue to grow, both personally and with him. It's strengthening your bond.

S: I'm feeling safer to disagree with him now. He was upset with some actions I took. I said, "Okay, I see why you think that but I don't agree." I was just calm and quiet, which is not my style, I've never been able to do that before, just let it go. There was no animosity. I felt empowered. On another occasion, I was having a bad day and was able to share that with my family. My husband came to my room and said, "I sent everybody else away, we're just going to hangout." I said, "What?! You want to hang out with me like this?" And he did. (Sandy is providing various indications of more authentic responding and of a felt sense of security in a key attachment relationship. This is a key desired outcome of EFIT.)

Th: Sandy, that's so beautiful, a poignant example of you revealing yourself to people you love and that love you back and when you do, they can really be there for you in a way that you didn't have as a younger person.

S: I've been telling myself for years that people don't want to see you this way, they don't want a broken you. They want who they think you are because you've been showing them that. It's a hard learning curve to undo.

Sandy then refers to the way she conditioned herself and adds, "I had so much support from you. I can trust and believe what you say – your words of encouragement." Sandy then highlights that this was not initially the case. There were times when she felt, "I'm at ground zero, I'm back *before* square one!" I nod in agreement.

Sandy: I wasn't really that far back. I was just caught in a cycle.

Therapist: That's right, that's so good Sandy. And when I ask you to look in the rearview mirror, I guess what I remember is that scene on the porch. I wonder, when you sit with me now, in this moment in time, when you look back and see where you are now, what do you see and feel? And maybe, what do you see in your future?

S: So first of all, looking back I don't really want to put any labels on anything but I know that I've grown enough that I'm probably not going to end up in those places anymore. If I end up there every now and then, it certainly won't last as long as it used to. Before, it would last weeks and weeks, unbearable weeks where I couldn't get up, I couldn't do anything. That seems really far in the past now. Looking forward, I find myself contemplating my personal wants with more seriousness than I used to but I still have self-doubt. When I think about a new line of work that might involve sharing my story or helping others, what pops into my mind is, "Who do you think you are? Why would anyone want to listen to what you say?" That's hard to overcome.

Th: What might you say to that younger you, as you sit on the porch with the sun beaming? What would your honest answer from your body, from your gut, say? What would it say about risking, and doing and being something new? (Here again I paint the scene with detail and with a RISSSSC voice to encourage Sandy to speak from a deeper place, not from her intellect.)

S: You're right, not everyone is going to get it, or appreciate what I do, but how are you going to feel if you don't do it?

Th: (I now provide a general summary/reflection.) That's great, I hear you. You are remembering just how hopeless you felt but now you have a different perspective. The more you share those difficult times and experiences with others in direct ways, the easier it is for them to respond and the more you feel valued and visible to the people you love most. And as you look into the future, you think about taking more risks and revealing yourself and your talents in different ways. (Sandy nods.) It is true that there will be dark spaces, that's a part of being human and it's a part of your vulnerability. When we think about personal growth, we don't expect that people will never have bad days. Just as you have been doing, our hope is that people will be able to regain their balance and reach to others in a way that doesn't leave them feeling alone. (Sandy nods in acknowledgement.) This is all great Sandy. I heard what you said at the beginning of this, that you had told your story many times. If you were to share your story now, would it be the same? And if not, what would it be? (I explicitly want to know if her narrative will contain new understandings and show more coherence and less self-blame.)

S: Oh gosh, well the first thing that pops into my mind is that it feels like there's an ending, there was never an ending before. All those times that I would say the same things over and over, about my past experiences, with nice cadence, and in chronological order …

Th: Sandy, what does that mean, an ending? Help me understand.

S: I was looking for an ending when I would seek professional help. Looking back now, that's what I wanted, an end to this story. Now if I were to tell it, I could say, "And this is when it stopped, this was the turning point."

Th: What was the turning point?

S: When we were in the garage and I decided enough was enough. I said, "You're not staying here!" I went in and I took her hand and we left before anything happened. I was mad, mad that someone would do that to someone I love. (I smile in acknowledgment and celebration of this shift.) I never got mad before, I just felt responsible and guilty, like it was something I should have been able to control or prevent. I think about all the choices I made in my life as a young person based on that thought process, thinking I wasn't really a worthwhile person. Now there is an end. I'm not holding onto anger. I was angry at the right person. (I again acknowledge and celebrate this important shift.) I don't have to hold onto it because it doesn't matter to me anymore. What matters is … it just feels so good to close my eyes and look at myself and to feel connected again.

Th: Sandy, that's beautiful, can we do that? When you close your eyes and I can close mine too, tell me what you see. (I am explicitly and deliberately further assessing her current model of self. Is it positive? Integrated? Coherent? Having her articulate her self-view also will consolidate the positive gains.)

S: Well, I always go back to the steps because it's easy … the sun is on us, it's a warm day … the lumber on the steps that we're sitting on is worn smooth from all the feet and it's warm. (I quietly acknowledge her description and the exquisite detail she provides.) I can turn my head and look at my young self and understand why she feels all that, how hard it is at school and at home and she believes me, that I really get it, and then she puts her head here. (She motions to her chest.) I have my arm around her, put my head on her head, and there's a comfortable kind of … warmth … safety … We don't have to be alone anymore. (Sandy is giving me various indications of a felt sense of security in self, a key desired outcome in EFIT.)

Th: That's so beautiful, Sandy, that's so amazing. Now Sandy if we just stay really still here in that feeling and I can feel and hear what you're saying. I love your words about the lumber and the sun and now when you look in the mirror, Sandy, what do you see? What do you see when you see you? (Continue to consolidate and integrate gains with respect to model of self, in particular.)

S: I see the toll it's taken but I see someone that I like, that I like to spend time with. I no longer have to worry about hurting myself or saying mean things to myself.

Th: Sandy, that's so nice, that's so beautiful. And what do you like about you? Can you tell her? You? (Asking Sandy to articulate her self-view with specificity will solidify the therapeutic gains that have been made.)

S: She's really smart and funny … (I nod in acknowledgment.) For years she has been reading people for self-preservation but now she can do it for

empathy and compassion instead. Even if her life comes to an end and there isn't some big flag somewhere with her name on it, she will have impacted enough people for other people to notice. She will have especially impacted those she loves most.

Th: That's so beautiful, Sandy, that's right. That's good, Sandy, and do you breathe and take it all in? (As we clarify and consolidate, we continue to move the process forward, to deepen the gains that have been made.)

S: It's not easy.

Th: I know, I hear you, it's okay, take your time and really sit with it, Sandy. This is so good. Take all of that in.

Building on Sandy's comments regarding her impact on those close to her, I provide a summary of the impact on her family. As I next move to close this live session and thank her for joining our community of learners, Sandy expresses gratitude.

Sandy: I just wish that there was something that meant more than, "Thank you." I never thought, never dared to think, that anything that I would do would have a positive impact on anyone. I was here to just not screw up my kids, to get through life, to put nice throw cushions on the couch and that was it, that was going to be my contribution because I wasn't worth anything else. Every time you or someone tells me that they appreciate what they see and it was just really who I was, the gross, dirty, messy stuff, and someone said, "Thank you for that," I don't think I'll ever understand that. I tried everything and this is the only thing that worked for me. (Sandy is tearful as she shares this.)

Referencing the therapeutic alliance and the power of attachment, Sandy then adds, "Even when we're not together, when sessions aren't as regular as they were, you're still there and when you say, 'You've come a long way, this isn't ground zero again. I believe that now.'" I then offer a summary with the aim of instilling continued optimism and the expectation of ongoing growth.

Sandy then references other allies in the process, her partner, and some admired authors. In this context, her eyes light up as she tentatively shares a new insight, a testament to ongoing growth!

Sandy: I think it's because of this … I just had a realization … you know, my husband and I have been together a long time and I love him like I've never loved anyone in my whole entire life, and he tells me all the time that he loves me but I never believe it. (I nod in acknowledgment.) I never really believe it but that's changing, even now, and I haven't told him that. Maybe I should tell him that? (Sandy's eyes are lively and her smile infectious.)

Therapist: That's perfect! Yes, that's good! I hope you will find space to share that with him.

As we then move to closing the session, Sandy indicates that she will.

Coincidentally, as I was finishing the last chapters of this book, Sandy contacted me to let me know that she was embarking upon a new career! Although some self-doubt still lingers, she described feeling more confident and competent. She described family relationships as positive. Overall, the sentiment was one of hope – that her future would shine as brightly as the sun did that day on the porch.

Concluding Comments and Reflections

As illuminated with Sandy above, this new narrative provides a sense of closure, reinforces the changes that have been made and acts as a positive reference point for the future. As therapist and client identify and celebrate various markers of success, the therapist also highlights the client's increased sense of agency. New solutions for old problems based on revised working models and a new ability to use emotion to pinpoint, elucidate, and assert needs and preferences are highlighted. References to the future and new growth-producing paths are made explicit. Goals and aspirations are made intentional.

As client and therapist prepare to part ways, it is with the understanding that the therapist, the supportive surrogate attachment figure, can be let go of but also held in mind. It is with the understanding that the client can now approach decisions about the future with increased confidence. Significant others can be relied upon in new ways based on clients' new responses.

In this final stage, the client leaves therapy not only non-distressed but also with a new felt sense of security in self and in others. On this platform of felt security, clients are in a solid position to be resilient in the face of stress and to manage the ebbs and flows that a rich life naturally engenders. At the end of EFIT, the goal is for the client to know that vulnerability can be managed and that self-actualization is an alive possibility for them.

Play and Practice

For You Professionally

If you have been reading this book in chronological order, you too are nearing the end of this aspect of your professional journey. Some of you might have joined us familiar with EFT, whereas others might be new to this model of working with clients. Regardless of where you are in your own journeys of professional development, we welcome and invite you to consider how *you* and your work have changed as a result of reading this book.

We would like you to consider the following:

Has reading this book and the clients' narratives within it shifted your view of humanity? Your understanding of emotional disorders/distress?

Has your view of change in therapy shifted? Has the way you relate to clients changed?

Are you more comfortable working with and trusting the power of emotion as a key change agent? Has your window of tolerance for difficult affect expanded and changed?

Take a few minutes to answer these questions. Perhaps you want to speak to a trusted other about your goals and aspirations or seek guidance and consultation. The more FIT for life we are the better we can guide our clients toward this same goal!

For You Personally

Participants in our trainings regularly write to us about the ways they have been personally moved and transformed by the live sessions they have viewed, or by the model more generally. Has reading this book and our clients' stories had an impact on you? Consider the following questions:

Referring back to your responses to the exercise in Chapter 7 of this book, has your personal narrative shifted as a function of reading this book?

How has reading this book and reflecting more deliberately on your own personal story shaped you, and how have your most important relationships been impacted?

If you identified any key blocks or barriers, have you been able to address and/or remove them? Again, journaling your response will be useful, and sharing this with another, trusted other, will continue to propel you forward as it has our clients.

BOX 10.1

The Consolidation of a Secure Base: A Summary of the Session

- Changes are distilled, highlighted, celebrated.
- Shifts in client's narrative are illuminated.
- New solutions to old problems are identified.
- Shifts in model of self are exemplified, consolidated, integrated.
- New modes of engagement with key others are consolidated.
- New action tendencies and increased flexibility are made vivid.
- Relapse (or symptom aggravation) is predicted and prepared for.
- Client is invited into vision of future, goals, aspirations.

11

What Do Key Change Events Look Like in EFIT?

Soundbite Answer to Question

Whether it appears in tiny steps in a session or as a key Stage 2 identifiable change event, significant change involves transforming frightening, alien, and unacceptable emotion into new manageable, normalized, and owned experience that prime specific new responses and offer a compass in life. As emotion changes, associated cognitive frames that define a sense of self and other also shift. The self becomes defined as more competent, worthy, and whole, and so moves from helplessness to agency.

We can also look at a quote from the book *Attachment Theory in Practice* (p. 29) that states in change events, "The therapist is not a composer writing a musical score for the client to lessen symptoms of discordance but rather a conductor who knows that a full vibrant song is already waiting to emerge. He or she simply guides and moves with the client to uncover it … the secure base cultivates growth and aliveness."

A change event is about going to the leading edge of known experience and then taking a vault into growth.

In EFIT, the therapist's goal is to shape significant moments of change in every session, but these shifts may be small and cumulative or they may be

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events (usually in Stage 2) where small shifts come together to form significant new dramas that take people to the heart of their vulnerabilities and existential choices. As stated previously, these new dramas or change events are characterized by a deepening of emotional engagement (to Level 4 and beyond on the Experiencing Scale) and exploration and new encounters with core parts of self or key attachment figures with whom the self was or is presently defined. They have a sense of completion – of moving into and through core pain and fear into a new sense of balance and agency. So Louise, who comes to therapy to address her reluctance to enter into engaged intimacy with friends or lovers, is able in a key session in Stage 2 of EFIT to really immerse herself in her grief at her mother's and first partner's rejection of her and the fear and rage that fuels her "never again" stance in relationships. She is able to accept her helplessness in these primary relationships and embrace the fear of unworthiness hidden behind this emotion. She is then able to find her balance and see, in a visceral way, how her fears have kept her isolated and insecure. She emerges from this process as a more whole and flexible person who can trust her own experience, name her needs and chart a new course for herself in relationships.

These change events predict a successful outcome in the EFT model and changes, such as more secure attachment for clients, at the end of therapy and at follow-up. The theory of change has been validated in numerous studies. Empirical data supports the premises of the model and the assumptions of foundational figures such as Bowlby and Rogers. One of the key *rabbit holes* in the field of psychotherapy is mistaking theoretical premises for actual change factors. For example, changing "dysfunctional thoughts" has been found to be associated with negative outcome in CBT (Castonguay et al., 1996) rather than success in treating depression.

A key change event was presented with the first author's trauma client, Henny, in Chapter 1. Once we are clear as therapists where we are headed and the changes that make a difference for our clients, it is easier to define and hold to our course in particular sessions and keep in mind the key topics, issues, and processes that need to be addressed. Once you know where you are going, you can find your direction and chart your course.

Change Events Up Close

We can now look at three Stage 2 change events in more detail with Henny, who you met in Chapter 1. As suggested by both the theory and the research on EFT, we can expect to see deeper levels of experiencing, more complex engagement with core emotions, especially fears and longings, struggles with core existential dilemmas, and more acceptance and compassion for the self as well as new kinds of engagement with key others.

A few sessions into Stage 2 – Restructuring, we have a session where Henny begins with core sadness over her just-ended marriage and we discuss

difficult issues around this, such as her children being angry at her for deciding the marriage was over. As always, the chaos of the present and all its hurts and choices and the trauma of the past, spin off and into each other, as, nearly at the end of the session, she moves back into her traumatic past.

Henny: I just feel like I'm always on a battle ground. At work I was superfunctional but then I would just go home and be ruined. Just nothing is ever easy, like it is for normal people. So – it brings that bitterness we talked about last time …

Therapist: Yes. Your life has been so hard. And as I remember then you say to yourself, "I should be like the others." You mean the ones whose nervous system hasn't been revved up by living with constant terror and danger all through their childhood? You have to battle to keep your balance – keep the ghosts of the past from invading your life and then you say, "This is a war that I can't win, just like my childhood," and can become demoralized – and the terror gets more and you feel more on the outside – the one who doesn't get what others get. Is that it? (She nods.) So hard. So hard. (Tango Move 1 – pinpointing the cycle of emotion regulation that is self-maintaining.)

H: Well – it's not like I was in a concentration camp or anything – some folks had it worse! (She begins to cry.)

Th: Aha … I can't imagine what it was like being in a concentration camp – but I also can't imagine going through your childhood and fighting to survive the way you did and making it through! You could never sleep in safety, your reality was totally denied, threat was everywhere – even threats of death. Your father basically told you, "I can do anything I like with you," so at times, you just had to go catatonic. Most of us could not have survived the fire you walked through. And I get that there is a bitterness there – you are entitled to rage and sadness – to what you call "moral outrage." Where is the bitterness right now – when does it come up the most? (Validation.)

H: I would babysit and those kids would have music lessons and ballet class – and I just … I bought my kid this violin you know – and my husband left his car unlocked and it got stolen – and now she says she doesn't want to play anymore anyway.

Th: Yeah, you have always had incredible dreams for your kids – and have fought for that, showing such strength but somehow there have been blocks always in your adult life and you were fighting alone it seems. (She cries.) I think I hear you saying that others seem to get their dreams. Your dream of a happy marriage disappeared – of your kid playing violin – of safety to sleep in as a child – you fought for that but … there is bitterness. You said it was the girls who were loved and safe who won

the competitions in gymnastics, even though you were so good – cause you would have flashbacks during the competitions … Where is the bitterness in your body right now? (Tango Move 2 – Affect Assembly.)

H: It's like … I am clenching my jaw and … it's like … it's pointless to keep fighting. (Long silence … Weeping.) I'll never be good enough. Maybe not smart enough … It's like I am broken. ("Broken" and "bitter" are emerging as key emotional handles.)

Th: (Slow and low.) Hum, broken. That is what you called little Henny when you were remembering your dad assaulting you and mocking you for hoping for his attention – his love. He told you, "No one cares, no one will believe you … you are helpless." And you have said about your husband, "How can he care so little for me, say such terrible things to me?" How come everything has to be so very hard – such a struggle for survival, hum? It all leaves you feeling bitter and broken. It feels pointless this fight. (She nods and weeps.) Am I getting it? (She nods. Focused reflection – distillation – ordering.)

H: Yes. Yes. And I am still alone. Haven't found a person who can turn and give me this love … I don't have the energy for the fight anymore … even when I fought my dad it was a war that I couldn't win as a kid. Always there was dread. I'd sleep ready to fend off blows. No wonder I'd wake up in panic as an adult. Not so much now but …

Th: Yes. And little Henny did fight him, didn't she! She was such a brave little one, even though she was all alone. Can you remember those times? You told me about one time when you woke up with him on top of you and you arched back and kicked him. (She smiles.) Do you remember what you said to him? (Therapist is thinking that one antidote to the helplessness of the battle may be the fact that she fought bravely and, in some ways, she did "win" – survive. The key is to hold and titrate pain, as well as evoke and explore it.)

H: Yes. (Smiles again.) He said, "How dare you kick me. I could kill you." And I said, "I don't care, cause I will go to heaven and you will go to hell." (She sits straighter and squares her shoulders.)

Th: Yesssssssss! Brilliant. Gutsy. Amazing. And so awful that you had to do that. You are smiling – remembering your gutsiness?

H: Yes. (She sits up and her voice gets stronger.) He decided that my sister should have a room by herself – and I knew why. So I went and got her and brought her into my room and we pushed and pushed and got the dresser in front of the door to keep him out. He was in a rage – banging on the door and shouting. I heard my mom say, "They are doing this cause they are scared of you." We stayed in there all night and we peed into cans that we kept the crayons in.

Th: How are you feeling as you say this, Henny?

H: (She beams at the therapist.) Victorious!!! (She laughs but then her face crumples and she tears up.) But I was always afraid – he'd make me pay.

Th: Yes – you couldn't win the war but you never surrendered, did you! And you were the only one who confronted him – also a number of times as a teenager. (She nods.) So you somehow kept some part of you out of his reach – intact. Even though it all left you with so much sadness and fear. You found a way to bring little Henny through it. (Reframe, validate, order her experience in a way that supports a competent sense of self.)

H: Yes. On my birthday, the other day it was kind of sad but I thought at least I have ME! (She moves from beaming to tearing up as a natural flow now.)

Th: YES. Moments of sadness and bitterness at all you went through – but victories too. And now? Is there victory happening?

H: Oh yes – I feel like I am coming alive. Taking my life back.

Th: You are indeed. At times you had to go numb – what you call "catatonic" and other times you ran, escaped, just as you have at the times when you left your husband and literally moved to another city. But you also turned and fought, even as a small child, and you took stands with your abuser and you went out into the world and leapt into the air in that gym – you found a way to express the strength that is Henny. (Ordering story of affect regulation into a coherent story with positive meaning. Also normalizing fight, flight, and freeze – she needed all to survive.) And it is outrageous that you had to fight for your life all alone – there has been no sanctuary for you in your life. That tastes bitter? Is that bitter, angry or … ?

H: Not really. Sad, sad. Always struggling. I get tired.

Th: Yes. Fighting for your life. Can you close your eyes … (She does.) And see the Henny, so small and so scared and so alone, who still found the courage to tell your dad when he threatened your life, "I don't care – I am going to heaven." Can you see her face? (She nods.) Can you feel your body response as you look at her? (She nods.) What would you like to say to her? (Evocative questions and Tango Move 3.)

H: I don't know. She knows she will pay for that.

Th: She is afraid … (Henny nods.) But she takes a stand anyway. If you, the adult Henny, is standing beside her, how could you help her? Because she IS in a concentration camp, isn't she – she is always in terror for her life? She says, "I am going somewhere – whatever you do," doesn't she? Sad, tired, afraid, but … Tell her what you see.

H: (Very softly.) You can have victories – moments. And you will go on … you will have to fight … but you can … you will make it out … (She opens her eyes and looks at the therapist.)

Th: (Softly.) You can … You can find that balance beam – find your balance – leap into the air. Even though it means a struggle and it is exhausting.

You are so brave and creative, Henny – you can do so much! How do you feel as I say that? (Tango Move 4 – integrate the struggles/defeats and the heroic victories – accept both realities.)

H: Good. Good. But … sad … No one did anything to help us. (She weeps.)

Th: Yes. (Long pause, softly and slowly.) And we speak a lot about that deep, deep sadness. A sadness that is like the sea – a wrong that is unspeakable – what you and your sister went through was unspeakably wrong, unfair, outrageous, criminal. (She weeps. Long pause.) You grieve for all that you went through but you don't let that sadness define you – define who you are and how you live now. (Long pause.) But at times, all we can do is cry, yes? For all the terror and pain … (She nods.) I am crying with you – for all that you went through. You were so alone and so vulnerable and so hurt. (Therapist and client cry. Move 5 of the Tango.)

What stood out for the therapist in this session was the following:

- The way Henny is able to move flexibly and easily between smiling and reflection and weeping. There is a focus and a flow to her experiencing and she is able to stay engaged with the process and with her own pain but not be overwhelmed by it.
- At one point, she touches on a sense of inadequacy but is able to hold the terrible struggle and vulnerability and the sense of victory and strength.
- She still finds staying with Move 3 hard and can only stay in these dramas for a short time. However, she has always reported to me that she takes in the messages in them and they help her feel more grounded in herself.

As usual, the therapist follows and leads, holds, and evokes core vulnerabilities. Always the therapist is aware of the client's active process of defining the self. Validation is a core part of Tango Move 5 but it is also a constant micro-intervention that supports Henny's positive sense of self.

In terms of the general process of change, some clients can go into one key core emotion and productively stay there for a whole session in Stage 2 of EFIT. Others such as Henny, even in Stage 2, touch, feel, process, and then move out of core emotions. At this point, when Henny feels core sadness, she does open to it and show it intensely in the moment. The therapist respects each client's rhythm and style.

Excerpt from a Second Stage 2 Session with Henny

The session opens with Henny talking about how going back to work is stressful after a break and how she is always vigilant and adapting to the world around her, just as with her father. As a child she had to keep changing her strategy to handle his different moods, which was "exhausting." As noted above, she is

now open and seems to dive right into emotional themes, rather than, as she did in Stage 1, needing a very long warm-up before she could do this. She notes how, when people around her seem inconsistent, she finds herself on edge and wants to withdraw – to be alone. She talked about this in relation to her husband, both in the past and now. Recently, he would be relatively pleasant on a family outing and then revert to cruel blaming statements that devastated her. Her mind then told her that being alone was the only safe way to be but this was also painful. The essential existential dilemma emerges: let people in and they can devastate you – keep them out and the loneliness will devastate you.

Henny: Maybe what he said … wasn't so bad really … he wasn't like my dad. (Weeps.)

Therapist: Yes. That was your benchmark, wasn't it? The terror of your dad. But my sense is that right now you feel the loss of all you could have had and worked for so hard with your husband, the sadness, and that sense of aloneness. (She nods and cries harder.) Being with him hurt and being without him and alone hurts. (Reflection of core affect – echoes of Move 1 of Tango – focus on present process.)

H: (Weeps.) It's impossible to imagine a relationship where I don't get anxious. Maybe I make it too difficult to be with me … He says it's impossible to love me – too hard – that I created a hell for him.

Th: Ah-ha. Yes. (Softly. Long pause.) There was no sanctuary with him, was there? And you needed that. (She nods.) And now he blames you for calling a halt. And that hurts, hurts. After all the times you tried – using all the strategies you could lay your hands on – to keep your family well and together. But he says, "It's all your fault that you are alone." And you wonder … ? He triggers all your fears. How does your body feel right now, Henny? (Affect assembly. The word "sanctuary" is an emotional handle.)

H: Pressure in my head and neck – depressing. I went out canoeing with friends on the weekend and it was good and then I went and picked up the kids and he was so cold. Like I meant nothing to him at all. (Weeps.)

Th: (Very softly and slowly.) Yes – that is so, so hard. And, as when you were small – as you have said before, "It's like no one sees me – no one cares for me – it's like I am nothing." This is such a wound, isn't it? You kept bravely coping – in your childhood and with your husband but … (Reflection of the key theme of invisibility and insignificance.)

H: (Very softly.) I was always alone with him, really. Now at least, I am not always afraid of what will happen next …

Th: Yeah – it's bitter … (Emotional handle.) To feel so alone and afraid – safety has always been out of reach. But you tried so hard with him … (From this point Henny is in the flow of her emotional reality – the therapist is

just a support and guide to keep her focused. The process of exploration, distillation, and integration has its own organic momentum.)

H: I loved him so much. So hard to see him in his addictions – so sick. But … (Closes her eyes.) "I cannot be around you – I can't."

Th: Yes, yes … tell him, Henny, "I tried so hard to be with you … for so long – I loved you … "

H: (Weeps – long silence. She nods.) I tried. I tried. "And you are cruel." (Lots of long pauses here.) "All the things I did, again and again, to make stability – safety – to have everyone feel nurtured – and you … just did the opposite – drinking and driving with the kids … losing our house to gambling … lying and flirting … I had to fight against it all… and you just got worse and worse. Drugs. Drinking. I had to choose … to get help … to escape." (Weeping.)

Th: Yes … "I had to fight for my life and for my kids – find safety. I couldn't let you …"

H: "Destroy the life of us all – stay in all the uncertainty and chaos – had to fight. It was either keep trying to change you – stay silent, be invisible or … (Weeps. Now her voice gets louder and she sits up and squares her shoulders.) I was in DANGER.

Th: Yes, danger. Danger. Can you tell him again, "We couldn't take the chaos – I was – we were alone, in the danger. I couldn't let you destroy us so I had to choose." Can you tell him again, Henny? (She does this, basically, in these very words and very convincingly.)

H: (Calmer now.) It wasn't just my PTSD – the chaos went over the top. It was real.

Th: It was real. You took a stand and refused to pretend – to be blind. But the choice was so, so hard. Took such bravery, such courage! How do you feel as you say this? (Tango Move 4 – refusing to be "blind" in the face of the denial of her felt reality is a core theme and identity issue.)

H: (She smiles.) Tired. (She yawns.) Calm. (Dries her eyes.)

Th: Yes. You took a stand – just like with your dad. You spoke what was true. You said, "You can't treat me like I am nothing – I won't let you."

H: Yes. (She closes her eyes again and speaks to her husband.) "I should thank you – thank you for teaching me to value me – put me first." (Big sighs.) "I was alone anyway – I was."

Th: Yes – and it hurts – it's hard. "But I am finding my safety – taking a stand for me. It's scary – to believe in me – to decide to go for safety – what I need … to hope I can find that … " (Proxy voice used.)

H: (Smiles at me and nods.) Oh yes! Oh yes!

Th: But you are doing it – fighting – for life – to be alive. Not to live in constant danger. You are a brave and splendid fighter, Henny! (Move 5.) Can you take that in? (She beams at me.)

Here the process that Henny goes through shows all the signs of a Stage 2 change event. Paralleling the session outlined above:

- She is fully engaged and absorbed in the emotional process, the flow of the session. She can take the therapist's guidance and, also, shape her own way forward. She can use the connection with the therapist as a secure base from which to explore vulnerability.
- She is at the leading edge of her experience – exploring and going deeper – honing and distilling her evolving reality.
- She can stay present and be hurting but not be overwhelmed. She has the balance to stay with difficult feelings, moving in and out of them fluidly.
- Her emotions are evolving and rich – core emotions – grief and sadness, fear and shame, or fears about the nature of self emerge and interweave. She moves into the heart of her pain, distils it, and moves through it.
- She faces key existential fears: the fear of aloneness; the fear of deficiency or unworthiness in the self; and the terror of making choices that define her reality in the face of denial and dismissal.

Basic frames about the nature of self and other and the entitlement to love and care emerge and are available for revision. She can integrate that in one moment she can own being broken and bitter and then, also own being brilliant and brave. A more integrated, multifaceted, complex, and coherent self is emerging.

Third Excerpt from a Stage 2 Session with Henny

The session begins with a familiar trigger – Henny's now-separated husband coming to pick up the kids and telling her again that the family breakup is all her fault. She begins by discussing how she knows this is not true now and that it does not overwhelm her. I hear this and I also know that, most often, her grief and anger at her husband's responses trigger and tie into her past traumas and her struggle about her identity and self-worth. We also revisit again (as in almost every session) how her experiences as a gymnast have been a source of resilience that have grounded her all through her life and helped her feel her body, even though she had to "zone out so much at home." I frame these experiences as her "life-raft" and she agrees that it was in the gym that she first "saw" her marriage and asked herself, "What am I doing here?"

Therapist: So can we go back here. You are saying that you are now able to calm yourself and regain your balance when he says these blaming things to you and you implied that this is also true with flashbacks of your childhood. You can feel in control in your body?

Henny: Yeah, definitely. This time of year, winter, is the hardest for me cause that is when the major assaults happened. We were outside lots in the summer but in winter, especially around holidays, it was bad. I wouldn't really remember the really horrible parts before, they were all fragmented. But now they are pretty complete stories. That is a huge difference.

Th: It all hangs together now – kind of ordered … coherent? Maybe more manageable even?

H: Yeah. Oh yeah. It used to be like movies flashing, phew, phew, phew, image, image, image, and my brain would be like, then this, then that. But when I closed my eyes this week, I immediately went to a kind of, "How could you?" moment. My mom knew what was going on. Like when my dad molested one of our family friend's kid and her dad came round and punched my dad out. Called Dad a sick bastard. And Mom was there. And when we came home from church and walked in on my dad molesting my sister … my mom just turned around and walked out right away! Then anger comes.

Th: Yeah. Is that anger part of the bitterness we talk about here? We talk lots about "broken" but also "bitter." (Emotional handles.) You talk of looking around at others who had such safe lives and you being in a war you could never win – being all by yourself in that war. The grief and huge sadness that is there, but now, also the anger. The "nobody did anything" protest. And Mom was there. (Very slowly.) Your mom knew what a predator you were facing and she left you to fight that war all by yourself. She was not a mom to you, was she? No protection – no sanctuary. This hits me in the gut when you talk about it. You deserved her protection. What happens to you as I say this?

H: Hum … (She goes still and quiet.) It sounds crazy but she was pretty much invisible! I guess, I realized very early that she wasn't able to do anything. I was on my own! But back then, I never felt any profound resentment for her or anything.

Th: She was invisible – not there. You were so small, so helpless, and on your own! But back then anger wasn't relevant somehow? Wasn't even a possibility?

H: Hum – maybe I should be angry for a while? I don't really have extreme emotions. (This surprises the therapist who has seen her in extreme fear and extreme sadness.) I guess I was never allowed to feel anything as a kid. If I cried when I was abused, I was punished even more. There was no way I would have been able to get angry! (Therapist is aware that she somehow wants Henny to get angry BUT that is not the point. Maybe Henny does not need to hang out there – the client is the expert on their

healing process. In Stage 2, anger, if primary not reactive, often gives way to huge grief.)

Th: Yeah – I get that. That was way too dangerous. Although you did fight your dad – the time you kicked him when you woke up and he was molesting you. But you paid dearly. He knocked you unconscious. (She nods in agreement.) You weren't allowed to be sad either – to express yourself. But you do express that here. But I think you are saying, "If I had let myself feel and stay in anger, I would have been killed." (Therapist uses proxy voice, Henny nods.) So now, in this place of more balance, what do you feel for you mom? Can you go inside – let that come up?

H: Pity. Pity. Feel so sorry for her sitting all alone in that house with him. My sister doesn't have any contact with them. He has kind of destroyed her. All her family has passed on now …

Th: So, can you help me, is it that you gave up on her? The main feeling is that you feel sad for her – and for you – grief that you were so alone and now pity for her? (She nods.) Hum … (Long pause.) How does your body feel when you say that, right now?

H: Tense. Closed in. Remember that I did try to confront her in my twenties when my memories started up – but she maintained the same story. She said, "That would never happen." I guess, if I was angry at her now, I would say, "How could you just walk out – the things you saw happen?"

Th: Okay. So let's do it right here. Can you relax in your chair? Close your eyes now. (She does this.) Your mom made herself invisible but can you see her? See what she looks like, her face? (Henny nods.) See what she might look like when you say to me, "My body feels tense – closed. I would have died if I had really let myself feel anger – so it's hard." (She nods.) The moment when you confront her with your pain – your aloneness – his crimes. And this time you say, "How could you – how could you?" Can you see her? (Henny seems to freeze up.) Can you take a breath, Henny, deep breath with me? Aha … (She does. Very softly, repeating.) "How could you mom?" What would you say now?

H: (Very quietly.) How could you pretend that he wasn't hurting us – how could you just walk away?

Th: Yeah, "You knew, you knew what he was doing, you saw our terror and pain."

H: (Now sobbing uncontrollably, very garbled voice.) "You sometimes said stuff to him to protect children outside our family – told him, 'Don't do anything now,' to not be embarrassed. Maybe not have your husband go to jail." (Long pause, sudden calmness.) She says she had no choice. (She goes reflective and opens her eyes and comments.) She says her own dad was an alcoholic and she thought my dad was better. Of course, he wasn't! Maybe she was molested … maybe this was normal to her!

Th: Hum … It is very hard to get angry at her, isn't it? (Henny nods.) Can you close your eyes again? (She does.) What happens to you when she says, "I had no choice?" Are you generous with her now, feeling pity or … ? What happens to you in your body when she says, "I had no choice?"

H: (Opens her eyes.) I hear her. I am glad I have the choice now. Not sure what the supports were for women in those days. We have come a long way and … (This feels like an exit.)

Th: Ah-ha. Hum. I would like you to stay in the conversation with your mom. (Refocus.) You seem to be telling her that you are trying to understand her. (Hennie nods.) Yes. You have made the opposite choice. You did even when you were so small and helpless. You took on protecting your sister even when you were so small and so scared. And now you are being understanding with your mom. What do you want to tell her now?

H: (Suddenly weeping profoundly but clear strong voice.) I chose to fight. I chose to fight. I chose to protect … (Therapist murmurs, "Yes, you were so brave.") I chose to escape. (Stronger voice, sitting up.) I made a choice not to be blind – blind in my own marriage and to move to create safety for my kids …

Th: Ah-ha – yes. (Softly.) That so touches me when you say that, Henny. Amazes me – makes me cry. You made the choice not to turn a blind eye – not to be blind. You made a choice in your marriage AND you made a choice when you were so little – to fight, protect, escape. You went and got your sister when you knew he was going for her. Your mom pretended – pretended it wasn't happening – left you standing alone against the monster. And some part of you is angry at her and some part of you pities her? (She nods.) Even when you were little, you were stronger in some way – had more courage than she did.

H: YES. YES. The police constable told me that what she had admitted to was the story of my dad beating me with a belt and how she covered up the bruises with make-up so I could go to gymnastics. She could have been in denial about it all.

Th: What is happening now, as we are talking about this?

H: I was just wondering what it was like after I did talk to the police, after my youngest was born and they went to the house to interview them all. I just couldn't press charges. The police wanted me to. That was 13 years ago and some of those memories are only coming out clear right now. In that first police interview, I was a total basket case – rambling, rambling, trigger, trigger – rambling craziness.

Th: Oh – overwhelming and chaotic, maybe, but there was nothing crazy about it, was there? It was heroic – a heroic and terrifying thing to do. To refuse to deny and choose to look, to see, to struggle. (Reflect, validate, heighten.) As you say here, "I am not going to be blind." As you said in the first

session with me, "I want my life back and I want to be alive not numb," do you remember? (She nods. Long pause.) So now when you hear your mom saying, "I had no choice, I couldn't try to protect you," you feel … ?

H: I don't know. Some anger but mostly sadness, but, but… (Long pause.) I am glad… I am glad that I have a choice now! Women have come a long way … (Exit again.)

Th: Yes. Let's stay in the conversation with her just a moment longer, shall we? (She nods.) You told her you feel pity – you try to understand her – you gave up on her – you have sadness, some anger. Can you tell her, "I was small and alone and helpless and you offered no sanctuary. You saw our pain – wounds … " (Henny is not responding, not with me, so I turn to her power to choose – her source of strength.) "But I chose – I chose to fight for my life – I had a choice – I have a choice now ... "

H: (Closes her eyes and sits up, speaking assertively and clearly.) I chose to fight Mom – I chose to protect – I chose to escape. YES. YES. (She opens her eyes and looks at the therapist.) I did that! (The therapist sees that she moves into assertive self-confirmation, which is the place that the exploration of primary anger naturally moves clients into so this suggests she does not need to explore anger and staying with her primary sadness is positive.)

Th: Yes, indeed you did, Henny. You did. It touches me so much – how much courage you had. Yes, you did. You paid the price for fighting for your life. It was terrible and terrifying – but you chose!! Do you have any more to tell your mom right now?

H: (Her face now lights up with a smile and she closes her eyes.) "You will never be at peace, Mom, until you can be honest about what happened – you live a life of lies. You are still in hell. I got to choose." Heh … (She glances down.) Here is my fluffy kitty – he has come to calm me down. (She laughs.)

Th: Yes – this kind of work is so hard isn't it. Our pets do comfort – accepting that comfort is part of you creating sanctuary, isn't it? There was no sanctuary with your mom. She was caught up in her secrecy, all her avoiding ... so she acted like all the pain didn't matter …

H: YES. That's right! And THAT is crazy. She is captive – thinks she can't do without my dad. I think she had very, very severe depression. I remember her sleeping all the time. Her life had no joy. Only once I remember my dad being violent with her, hitting her, and I called the police. I dialed 911.

Th: YOU were the protector, even as a child! You even tried to protect her! Like the dream you told me about when we first met – of swimming out in the ocean and desperately trying to hold everyone else up! And there

is incredible sadness in that but also strength! You bravely fought a war even when you couldn't win it.

H: Yes. Just like with my husband. I believed all his lies for so long. But I stood up to him and he freaked, balked. It's ludicrous that he tells me it's all my fault – all his gambling and drinking and it's ME that should be ashamed!! Fuck off. Maybe it's okay to be a bit bitter!!!! Embrace it! (Laughs.)

Th: Hum – your anger at him got you out of the numbness and the deadness, got you into fighting to be alive.

H: Maybe it's not bitter at all. (Long pause.) Hum … maybe it's about holding people accountable!! I need to do that. No one did that when I was a kid. Even the neighbor who came and punched my dad for hurting his kid – he knew what my dad was doing to us but he didn't do more! (Moving through core emotion naturally moves us into being able to touch and own and assert our deepest needs – what we need to be healthy and strong and to grow.)

Th: Yeah. You need to hold people accountable for the damage, the pain – your dad, your Mom, your husband. I can imagine them all in a line and you telling them, "I hold you accountable!" Can you do that? (Brief Move 3 of Tango.)

H: (Clear with a strong presence.) Yes. YES. "Don't tell me I have no right to be angry," like … when Tom comes over for the kids. "Don't tell me that if I am angry, I am bad or crazy. I am human and emotional is all! I get to raise my voice!"

Th: Yes – can you say that again? Let's really taste this – savor it. "I get to raise my voice – say my truth and hold you accountable!" (Henny giggles.) "I will say my truth and hold you accountable."

H: Yes –Yes. (Huge smile.) Heh, my cat is purring loudly now! My therapy cat!

The session time is now up and the therapist summarizes the key process of this session including core emotions and most important shifts.

Henny's inner world and her encounters with others are becoming more grounded in her core experience which she now trusts and acknowledges. She can still be overwhelmed for a short time but she bounces into a resilience stance. This process seemed to the therapist to reflect the statement that, "Working with emotion is an organic process in which technique can be held to a minimum and the innate power of emotion itself can be used to take a client to another universe" (*Attachment Theory in Practice*, p. 47). This is what EFT therapists call biologically prepared learning. To move the client thus, emotion has to be fully engaged with, concrete, granular, and able to be integrated.

It is also worth noting, here, the core aspect of the systemic view of change outlined by Bertalanffy (1968). Significant change events do not change first-order variables – the many single and often peripheral variables in a relational or individual system. They change the key organizing elements and their relationship to each other in both individual processes and key interactional dances that make up a person's life. They transform the structure of both within and between. In Stage 2 of EFIT, Henny moves from an emotional roller coaster to becoming much more open, centered, calm, and confident. Her sense of self as a mature, empowered trauma survivor who can define and trust her own reality has grown. More than this, she is reaching for her goal of engaged flexible aliveness in every session.

A Summary of Stage 3 – Consolidation with Henny

Since we do not look at Stage 3 with Henny, it is useful to simply summarize how she reported seeing herself and her life a few sessions later in the consolidation stage of EFIT.

In a key session where we talk about the symptoms and concerns she came into therapy with, she confides that she has come to see how "crazy" her family of origin was and has moved to a place where she is content to be distant and separate from them. She tells me that, "In the past three months, it seems like huge changes have happened." She reports that she no longer has the bad dreams she used to have and for the first time in her memory, she has not had a panic attack for months. "My slate is cleared enough that I can actually think ahead – to a future," she announces with conviction.

She continues with a short story of how she had begun to lose her balance when her soon-to-be ex-husband had come round and began to tell her what a bad and crazy person she was but found she could, "Recover quickly and make my own decisions." She also talked about being able to rest and sleep and not finding herself going into long moments or hours of shut down and numbing. She is able to talk about these things in an integrated way, putting them in specific contexts and elaborating on them and then, drawing conclusions about herself. Her manner of speaking is calm and smooth with an easy flow between more emotional and more reflective moments. Henny tells me that, "To not feel perpetually overwhelmed is just incredible," and this allows her to plan for the ways she wants to run her life and redo her house. She proudly shares that she has just cut a large amount of firewood and fixed her oven herself. All through the session, I mostly follow and reflect and heighten her struggle and her successes, and validate her while asking questions about her symptoms and achievements.

We talk of her work life and she shares, emotionally, how she now works with a young boy who has just experienced the traumatic death of his father and how she sees her younger self in him. She sees him in the gym, "Moving, moving, and working off his fear and his desperation," and knows she can help

him. We celebrate how she has taken her life back from her childhood trauma and her abusive marriage and the challenge involved in leaving this marriage. We naturally go back to her resilience image of her as a young child on the balance beam and stay there for a while talking of her astounding courage on that beam and how this sense of control over her body and her will saved her life. I ask her where that ability to trust herself on the beam has taken her and she smiles at me. "Into a quiet confidence," she says quietly. "Not having to remind myself all the time that I wasn't really so broken – I was capable. I didn't have to go into this roller coaster of dread and despair that was always waiting around the corner for me." She elaborates and says, "I see that my life was insanity. It was not me! People couldn't handle my emotions. This was true even with the professionals I went to. The basic message was to be stoic."

The session ends with her recounting a fight with her husband about parenting and him berating her. She is able to quietly tell him, "It's okay. You see me as a terrible person, I guess. But I have got this. I can take care of our daughter and I have to go now." At the end of the session, I noted what a privilege it was to work with her and how her courage inspired me. We both seemed to share a sense of elation.

Henny was seen for approximately 40 sessions over a period of about 14 months. About 10 of those 40 sessions took place in the initial phase of Stage 1. This was unusual but this client needed a number of sessions to begin to feel at all safe and to be able to stay focused in session. Henny then moved forward through Stage 1 in another 12 sessions and into Stage 2, which was completed in another 13 sessions. The remaining 4 to 5 sessions were aimed at consolidation, Stage 3 of EFIT. Each client will have their own timeline for going through the different stages. Consistent with observations of change described above, the reduction of symptoms, and expanded sense of self and agency were reflected in Henny's post therapy TSI-2 (Briere, 2011) scores. In particular, the most problematic high-scoring symptoms dropped dramatically. For example, her dissociation score was reduced over the course of therapy from the high clinically elevated range to only just above the normal cut-off. Self- and relational-orientated scores also improved substantively, indicating greater coherence and self-awareness and self-directedness.

Henny read the chapters where her therapy was described in this book. She commented that they made her cry and that she felt very honored and respected.

Play and Practice

For You Personally

Can you find a personal change event in your own life that changed or expanded your sense of who you are and increased your emotional balance?

On reflection, what do you think the key elements were in the experience that really made a difference?

How might a therapist have set up these key elements in a series of sessions?

For You Professionally

Choose at least one of the excerpts above and read through it carefully.

See if you can find as many of the elements of heightening that deepen the client's engagement in the change process as defined in Chapter 6, as you can. These are: the repetition of key emotions and emotional handles, especially core emotions such as fear, sadness, and shame; the use of evocative images and metaphors; a persistent focus and the blocking of exits; additions to client processing in the form of interpretations; the use of proxy voice in reflection; and the use of the elements of RISSSSC.

Also find a place in any one of the transcripts where you would have naturally intervened in a different way or in a different direction. Outline how the process of change might have evolved from there.

Consider ways in which this Stage 2 process might have been focused differently if the client's main issue had been clinical depression.

BOX 11.1

When Preparing for a Stage 2 Session with Significant Change Events, Remind Yourself of the Following:

- Treatment goals client expressed in Stage 1.
- Client's strengths/resources – specific resilience images.
- Primary emotional handles already distilled.
- Core emotions that recur and how they are handled now.
- Key struggles around model of self/model of other.
- The central conflict in the client's existential reality.

Think forward – what specific new responses would your client optimally construct at the end of Stage 2? (For example, the therapist hoped Henny would confront her husband's characterological blame with healthy assertion.) Imagine.

12
EPILOGUE

This book is a primer designed to acquaint you with the basic EFIT model. As we stated in the introduction, the goal is to help you begin your EFIT journey to full confidence and a sense of competence that grounds you in every session, no matter what kind of client you encounter.

We hope that this text has enabled you to begin to integrate the wisdom of three different bodies of knowledge: attachment science; humanistic experiential therapy, with its focus on the primacy of emotion and attuned collaboration with clients; and practice and research in the general EFT model as applied to distressed couples over the last 30 years. The latter has shown us how to swiftly and accurately translate attachment science and experiential interventions into key moments of change that do much more than modify individual symptoms and relational distress; they reliably transform both models of self and other and, at the same time, significantly shift relationship structures. These change events transform both dancer and dance. They change the key organizing variables of individual identity and interactional pattern.

EFT and EFIT explicitly honor the core aspects of the above bodies of wisdom. We can outline the ways that are most apparent:

- As an experiential therapist, the EFIT clinician constantly tracks and actively expands the client's emotional processing – this is the main

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theme in the music of every EFIT session. Experiential learning is prized above imparting information or insight and coaching purely cognitive learning. As other authors suggest (e.g., Damascio, 1999; Stern, 2004), the primary way the self is known is through direct lived experience. This is the ground from which the ongoing sense of self is created and continually defined. Corrective emotional experience – a new felt reality – is the key to significant, lasting change in psychotherapy.

- The experiential EFIT therapist constantly seeks connection with every client, joining clients where they are with deep compassion in order to lead them forward. This connection is authentic – person to person, human to human – and extends beyond a more traditional, purely formal, and removed professional role.
- As an attachment-oriented therapist, the therapist places prime importance on a felt sense of secure connection with self and other (these are two sides of the same coin) and the strengths this offers, or conversely, on the lack of secure connection and the iatrogenic patterns of engagement with self and other that this fosters. Emotional isolation primes helplessness, while rejection and abandonment rob us of the resources we need to thrive and grow as human beings. EFIT is a relational therapy in perspective and intervention.
- As an attachment-orientated therapist, the clinician acts as a surrogate attachment figure and is guided by an organic developmental view of change. The therapist has a map to inner needs, misery, and motivation, and to the key aspects of relationships to guide him/her into attunement and give direction to therapy. The goal of therapy is to develop the self of the client as fully as is possible at the time of therapy. The model of health offered by attachment science offers us a destination.
- As a clinician benefiting from the three modality EFT model and all its outcome and process of change research, the EFIT therapist has a practical, accessible, and systematic set of interventions to orchestrate transformation. The coding of specific change events and their accurate prediction of positive outcomes across time has validated the EFT and EFIT understanding of dysfunction and how to address it. It is clear from this research (Greenman & Johnson 2013; Greenman, Johnson, & Wiebe, 2017) and other studies (Castonguay et al., 1996; Elliot, Watson et al., 2004) that the deepening and integration of emotional experience is the key to change, together with an accepting and affiliative connection with core aspects of self and with others.
- The body of intervention mentioned above is also accessible and user-friendly, having been systematically taught in more than 40 nations and cultures across the world for many years and reliably replicated again and again in research studies with different kinds of therapists with differing

levels of expertise. This is of crucial importance given that psychotherapy has a tendency to promote obtuse and/or complicated models that can be difficult to learn and faithfully replicate.

EFIT is based on a clear and massively researched understanding of human beings and how they function, humanistic values, and the honoring of our emotional and relational selves, as well as a clear tested body of intervention.

In the end, however, the passion you will typically encounter in the proponents of this model is perhaps due to the magic of how the above perspectives and interventions come together to, as one client stated, "Sing to my heart and soul." Commentators of the therapy field note that fewer people seem to be willing to seek out therapy and many have little confidence in its effectiveness (Miller, 2017), perhaps due to an apparent focus on data collection and intellectual surface elements, rather than on reaching and responding to the heart of our client's suffering. Therapy may then be scientific but unable to "enchant." It does seem to be true that professional training often focuses more and more on the learning of techniques and formulas and can miss the mark in terms of enchanting – that is, fully engaging clients and even therapists. As noted in this volume, therapists in our trainings report being not only moved by the power of the model but experiencing it as fostering significant personal growth in them as people.

It appears that EFIT possesses this ability to fully engage, even enchant, perhaps because of the precision with which we have learned – with the help of Bowlby and Rogers and thousands of distressed clients – to attune to and go to the core of the dilemma called being human, longing for certainty and significance but feeling small and fragile in an uncertain and often brutal world. The meta-goal is to constantly educate in the largest sense of that word (the word 'educare' means to lead out), both ourselves as professionals and our clients in how to be fully alive and fully human. It is always surprising and enthralling to discover the order in experience and ways of embracing the vulnerabilities that we all share, and this has the potential to leave both the therapist and the client more fulfilled.

It is also important to note that EFIT shares certain techniques with other experiential models of therapy, such as IFS (Internal Family Systems), AEDP (Accelerated Experiential Dynamic Psychotherapy), and the Process Experiential approach, often called Emotion-Focused model (PE/ET). All, for example, use the basic Gestalt technique of rendering inner dialogues and conflicts explicit by turning them into dramatic dialogues with parts of self and other people in session. All espouse the use of focused empathy and respectful collaboration with clients. In all, the process of unblocking key emotions and emotional experience is seen as a key factor in change. EFIT seems to be parsimonious, accessible, organic in its growth processes, on target in practice, and

to have a solid empirical base. We believe that EFIT operationalizes the experiential approach to therapy with maximum effectiveness and incisiveness. We also believe that the deep commitment to the attachment science framework offers therapists a direct path into advanced accurate empathy and connection with their clients. There is a structure to emotion, to the ongoing construction of self and to key dances with others; once we grasp this structure, hidden patterns and realities become clear and so able to be modified.

Being an EFIT Therapist

We hope as a result of reading this book you have a felt sense and a cognitive understanding of how the EFIT client moves from distress and dysfunction to stability and health. We hope you also have a sense of what goes through the mind of the EFIT therapist. It may be useful to briefly share and summarize here what the authors' anchoring cognitive and emotional processes are as they implement EFIT. In a given session, we find ourselves asking the questions listed below:

- What would be happening for me – in my reality – for me to be saying the things my client is saying and taking the position he or she takes toward themselves and others? This is a stance of open curiosity. Where is the logic and sense in seeming dead-end positions and choices the client is making? If I can't see this, I must look harder. So I must look past Carl's very objectionable accusations toward his wife and see that he is desperately testing her, asking her to prove he is wrong, precisely because he is confronted, at this particular time, by how much he needs her and how deeply terrifying it is to need. So instead of, "Carl, I am not sure it is helping to repeat these accusations again and again and discount your wife's assurances," I can say,

  > Carl, I see how tormented you are by the fear that your wife betrayed you all those years ago. The awareness of danger is so high right now. It is like you are desperately asking her to prove that there is one person in the world you can count on – that you are not alone, alone. So you push and push. Is this right?

- What is blocking this person from moving toward growth? What stops the client from taking in success or the therapist's affirming words, from reaching for others and from effectively mobilizing in the face of fear and challenge? What keeps clients caught on a wheel of distress, tied into reactive ineffective coping which then cues more distress? How do their blocks and stuck places make sense – arise out of natural protective maneuvers?
- How far do I invite this client to reach right now? How much do I focus on holding and regulating or even structuring a resilience image/drama/

story or gently set up steps toward the leading edge of their experience? If they are in contact with that edge and risk, how long do I ask them to stay there? I need to monitor and also check in and ask them. Part of why emotion has not been fully recognized and honored in therapy is that the balance between evoking and regulating has not been attended to, so, how do I, as the therapist, keep this balance? Am I afraid of asking the client to risk and reach? If so, what am I afraid will happen? A trust in the attachment framework as a model for the therapeutic relationship and as a way of understanding human vulnerability and its antidotes help the therapist with any anxiety he or she may have as to the so-called potentially destructive or disorganizing power of emotion.

- What is my central goal with this client and what does this client want and need? Am I moving forward or am I stagnating? Am I keeping sessions chatty or calm while avoiding change and challenge? Am I focused and on track with this client? Am I using the Tango to maximum advantage?
- How is this client with me? Are they open, responsive, and engaged to the maximum they can manage right now? If not, what is happening? How do I feel about working with this client? Do I feel open, responsive, and engaged? Do I expect this client to improve and grow? If not, why not? Does this client evoke feelings about my professional competence or expertise – if so, what is that about? How does this client's dance with me reflect his or her style and pattern in relationships in general – or is this dance an exception for this client?
- What has to happen for this client to move – to travel – to expand his or herself? Never mind the clichés of our field about how healing emotion is supposed to play out, what fits for this particular client? For example, does this particular client need to get angry in order to move into assertiveness and agency or not? (With Henny in this volume, she seems to move into agency through contact with her sadness, not with her anger.) Does he or she need to forgive or not – or need to confront parent figures to heal? What is the client's core emotion and central existential drama, and am I clear about it?
- Am I really focusing on and using deeper emotion as the PRIMARY, DIRECT, and MOST SALIENT route to change or am I becoming caught in explanations, coaching specific coping responses, or giving advice? Am I evoking and using new aspects of experiencing to the fullest?

Learning EFIT

There are many ways to learn EFIT. We can list them below:

1. Take the courses – introductions and EFIT Levels 1 and 2 with ICEEFT (www.iceeft.com) led by an EFT-certified trainer and offered both online

and in person. These trainings are also given through other training organizations affiliated with ICEEFT. These courses are a mixture of didactic teaching, the observation of therapy sessions, exercises, and discussion with peers and leaders. Courses are standardized, of high quality, and are constantly evaluated and improved. We expect to excel here as in our clinical work and our research studies. EFT trainers also give regular podcasts and supplementary courses in aspects of EFIT and EFT. This text will complement such trainings and courses. As noted previously, the text, *Attachment Theory in Practice* (Johnson 2019), will augment this primer and help you understand EFT and EFIT better.

Many therapists chose to take an EFT Externship (four days) to learn the basic three modality model before then taking the EFIT Level 1 and 2 courses. Once you have taken any kind of EFIT training with ICEEFT and its many trainers, you are also welcome to join our EFT family by becoming a member of ICEEFT and receiving such benefits as our quarterly newsletter.

2. Enter EFIT supervision with an ICEEFT-certified supervisor – listed on the ICEEFT website. Feedback from supportive peers can also be attained by linking up with your local EFT community – these are also listed on the ICEEFT site. There are learning communities applying EFIT, EFT for couples, and EFFT with families in diverse places, from Egypt to Iran to Finland to New Zealand and all over North America.
3. Learn from those who really know – your clients. The authors of this book first learned the key aspects of this model from mentors such as Bowlby and Rogers but then from taping clients and watching their own sessions. Most of us do not want to do this. When the first author takes Tango lessons the very last thing she wants to do is look in the mirror when her teacher tells her, "Stop and look. What are you doing here?" She prefers to hold on to the illusion that she is eminently graceful and perfect in her moves. However, that way leads to losing touch with the reality of our sessions. It is, in the end, more satisfying to watch what we do and reflect on it so we can see our weak spots and rectify them. Constantly deepening our understanding and expertise allows us to work in flow, to find our creativity, and to avoid stagnation and burn-out.
4. Do the exercises in workbooks and in this text, as well as the ones that arise from watching your own taped sessions. The simplest exercise is to simply ask yourself, "What was the impact of my action here and what other three interventions could I have used?" This primer has offered many transcripts in order to illustrate EFIT in action. We hope you go over them a number of times and reflect on them and how your style might fit with the interventions here.

5. Read the research on the EFT model including the ones that specifically focus on individual change scores such as the study focused on the creation of attachment security (Burgess Moser et al., 2015) and the recent outcome study on resolving emotional disorders with EFIT (Wiebe et al., in press). These studies with their demand for consistently replicable interventions have contributed so much to the practice of EFT. You may also take advantage of the many books, articles, and chapters written about the EFT model and listed on the ICEEFT site and the EFIT training videos also listed on the website showing live sessions using this model.
6. For those who want to immerse themselves on a more personal level, there are also EFT education programs for enhancing couple relationships (based on Johnson, 2008, *Hold Me Tight*) and family relationships, for military personnel, for heart patients and their partners, and for Christian couples (Johnson & Sanderfer, 2016). Many therapists find this personal learning enhances their own lives and relationships, as well as adding a new depth to their professional expertise. Therapists and their clients can also find the online couple relational enhancement program at www.holdmetightonline.com.

It is generally useful to emphasize that it takes time and practice to become familiar with a particular way of seeing, being, and acting, and to trust this new way so that it becomes part of your internal map and your dance with others. It may, at first, feel foreign and difficult. Trainees tell us that the journey is worth it.

EFIT and Diversity

EFT and EFIT is used across many populations and cultures. If we focus on emotion and how it is processed in our nervous system and the drama of attachment, which profoundly affects the process of self-definition, we can begin to appreciate our shared humanity. If we maintain this stance, see and be with our clients in their entirety, the model can move each and every individual toward wellbeing, growth, and connection. We are all part of the same family. Nevertheless, the differences between us matter and have an impact on wellbeing and on the process of growth. Here the clinician may need to tune into a client who literally lives in a completely different context – a different world than the therapist. The commitment inherent in the EFT model is to be open to, responsive, and deeply respectful of each individual on their own terms and this often demands active work by the therapist to attune to very different realities. It is the therapist's job to find a way to connect with and have a felt sense of the experience of clients who have been typically invisible or discounted in their social context, or shamed and stigmatized for

any part of their identity and culture. We then have to actively learn from our clients how cultural and social context define their world and sense of self. A stance of cultural humility is essential to doing this work and is a life-long process.

Mental health status also carries a stigma that can add to problems. The client, Henny, referred to in this book, was labeled as having PTSD by professionals and the stigma that she was therefore "crazy" became a key factor in her marriage and its breakdown. A religious man may be tormented by the idea that he does not deserve God's love because of a particular "sin" and the therapist has to grasp and respect this client's perspective and work within it. A person of color may need additional support and active validation to deal with entry into a profession that is dominated by relatively unaware white colleagues. The goal with marginalized clients, as with all clients, is to help them become clear about the challenges and traumas in their lives and to support and empower them. However, this may be a task of a different magnitude with clients who are less accepted in our society.

Inclusion, equity, and diversity are foundational values in the EFT model in all three modalities – EFIT (for individuals), EFT for couples, and EFFT (for families) – and in ICEEFT, the International Centre for Excellence in Emotionally Focused Therapy (see www.iceeft.com) and we will continue to strive to implement these values in all the countries and contexts where EFT is taught and practiced. The creation of a more secure sense of connection with self and others also holds the promise of creating individuals who are more tolerant of differences and generally empathic and altruistic to others (Mikulincer et al., 2005).

Concluding Statement

In conclusion, EFIT offers a rich model of psychotherapy that brings together humanistic intervention and attachment science. It integrates research and clinical practice and offers a rich protocol for effective intervention with emotional disorders – depression, anxiety, and trauma- and stressor-related disorders. Attachment science has changed the psychology of development and personality forever and has already brought about a revolution in parenting in the Western world. EFT as a general model has also changed the field of couple therapy. No other model has anywhere near the empirical base offered by EFT in this complex therapy modality where both individuals need to change in synchrony and shape a new kind of connection. It is now time to systematically use all this knowledge more explicitly in the service of individual change.

Aristotle said, "What is honored will be cultivated." It is time for psychotherapy, as a field, to honor and to turn back to emotional connection and corrective emotional experiences as a, if not the, primary source of significant

change, and to more fully embrace the relational nature of self. This turning back is not a return to so-called sentiment or catharsis. It is rather the embracing of a sophisticated protocol for engaging with, regulating, and ordering emotion to use as a compass in life and in one's ongoing sense of self-definition. In many ways, this flies in the face of our society's love affair with logic, with rampant individualism, and so-called independence from others. So be it. We are very clear that this is the way forward for a psychotherapy that is at once "magic" which can enchant and a protocol for consistent, effective practice that incorporates empirical validation. There is much talk about the difficulty of integrating science, research, and practice but we suggest that EFT has effectively achieved this and has shown that it is more than possible to connect the research lab and everyday therapy sessions with real clients.

We hope you have enjoyed this primer and that you will use it to expand your practice and your confidence in our field and what this field has to offer to society. The past year, 2020, has shown us once again the crucial importance of a commitment to science, ongoing education on what it means to be human and felt a sense of connection with others if we are to survive and create a society that truly invites a sense of belonging. Society needs a vibrant, alive, relevant psychotherapy that is able to heal both individual clients and key distressed relationships. EFT is our contribution.

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APPENDIX

Extended Play and Practice: Moving Through the Tango
Respond to the brief statements made by Yezda given below by crafting your own version of Moves 1 through 5. To assist you, and for additional context, review the introduction to Yezda provided in Chapter 7.

Move 1 – Mirroring and Reflecting Present Process
Distill the inner emotional pattern of affect regulation and the interpersonal pattern that maintain the client's emotional isolation and link them together in an empathic reflection.

Yezda: I left home over a decade ago but I feel like I am still stuck in the past. The day I got into dance school, only to be told by my mother that I could not attend, feels like yesterday – so vivid. I get so angry, but then I shut down. I do not want to feel those feelings. I want to run away from them. I don't want her to continue to have control over me. I cannot depend on anyone. I don't delegate at work. Any kind of criticism from my fiancé sends us into conflict. I get defensive. I feel like I have to fight to be seen, for my successes to be recognized.

Move 2 – Affect Assembly and Deepening
Assemble this client's emotion, pinpointing trigger, perception, body response, meaning and action tendency, and put them together in a simple reflection, then craft one deepening intervention.

Yezda: I get triggered when my fiancé attempts to provide me with feedback or asks me about my business decisions. I inflate it. I make it bigger than it is. I feel criticized. I get tense – feel tension in my chest. Again, I feel

unsupported, alone. I get angry. I try to defend myself and then I shut down. I get quiet and then I usually leave the room.

Move 3 – Choreographing Engaged Encounters
Capture the emotional music and choreograph an encounter with the therapist and internalized other or part of self.

At one point in therapy, Yezda described in greater detail her disappointments surrounding dance. Specifically, she spoke about getting into her family vehicle after her audition.

Yezda: I was so excited that I had been accepted. I had been talking about it with my parents and I had been rehearsing for weeks. My mom's immediate response to my exciting news was, no, and then there was a string of excuses. I was devastated. The ride home was silent. Inside, I was bubbling with anger. Once home, I retreated to my room. I stared at the walls, the map of the world, the list of universities I wanted to attend. I could not wait for another life.

Move 4 – Processing the Encounter
Now that you have choreographed the encounter, think about ways the encounter might have developed and how you would help Yezda reflect on, respond to, and integrate this experience.

Move 5 – Integrating and Validating
Outline how you would validate Yezda's efforts to grow and deal with her challenges and normalize this process as an inevitable part of being human.

After you have written out your own responses, look at the sample responses below given by the second author. Of course, depending on what you imagine your Move 3 encounter to be, your responses might be very different, especially those pertaining to Moves 3 through 5.

SAMPLE ANSWERS

Move 1 – Mirroring and Reflecting Present Process
What I hear you say is you weren't safe at home, you weren't safe at school, you did not feel a sense of belonging in your community. The one place you felt good, where you could excel and be seen and be celebrated, in the dance community, was taken away from you. You were unable to count consistently on anyone, not even your dad. It was not safe to cry out. It was not safe to feel. You felt deprived, invisible, alone, so you learned to shut people out. Now, it is hard to rely on others. It is hard to trust. It is especially hard to

trust others with your deep feelings. And now, the more you shut people out, and especially when you are struggling with feelings of vulnerability, sadness, disappointment or fear, the more alone you are again and the more the world still feels unsafe.

Move 2 – Affect Assembly and Deepening
After I had identified each element in the affect, I put it together in this way.

Therapist: Let me see if I can get this right, is this how it goes? If your fiancé questions you or shows any hints of criticism, you said you 'inflate it.' You make it bigger. It all gets amplified. In some ways, your mom still has this grip on you. You are sensitive to any indications of feeling controlled or criticized. Your body response is to restrict, retreat. You feel a tightness in your chest. You hear his criticism as some version of, 'You don't see me, I don't matter, I'm not recognized, my successes are not recognized.' And the place you go with that is to get angry, to try to defend yourself, and then eventually, you shut down. You are alone again. If we stay still with you, with that tightness in your chest, and let it build and develop, what do you feel? (Move toward deepening.)

Move 3 – Choreographing Engaged Encounters

Therapist: I hear you Yezda, it is so hard to talk about these experiences with your mom. These feelings of aloneness and anger come over you and you want to run away. If you could close your eyes right now and hold onto those feelings, stay with those feelings, the sense of aloneness, the disappointment, the anger … (Soft slow voice.) What would you like to tell your mom? Can you see her? Can you see her face? (Yezda nods.)

To deepen the experience, and bring her mom alive, I then ask Yezda to provide a description of her mother with detail, especially details about her facial expression and body language. "Good, so she is sitting in front of you, what would you like to say to her right now?"

Yezda replies, "I can't tell her I'm angry or disappointed, she just makes it about her." I validate Yezda and remind her that I am with her and then *slice it thinner.* Can you close your eyes and tell her, "It's hard to talk to you about my feelings, even in my mind, because my sense is you won't listen and I'll feel all alone again." (Validate and move with and through the resistance.)

As Yezda begins to feel and express her feelings in this encounter with her mother, her window of tolerance for these difficult feelings broadens and her awareness also expands.

Move 4 – Processing the Encounter
In processing this encounter, I begin by asking Yezda what it was like to share her experience with her mother and I track and reflect her response (using the elements of RISSSSC). With this, Yezda allows herself to move deeply into core sadness and then begins to describe a sense of relief, a letting go. At this point, she recalls a moment with her fiancé where she did begin to let him in and it felt good. She recognizes that when she feels dismissed or unimportant, she shuts down rather than speaking openly about her feelings and this leaves her alone again, even with those who could respond to her (e.g., her fiancé).

Move 5 – Integrating and Validating
In replaying this sequence, I draw attention to the shift. Yezda is able to encounter her feelings and her mother in a new way and when she does so, she recognizes the contrast between her experience of her mother and that of her fiancé. She begins to realize that if she can share her vulnerability with him, he can be there for her. With her fiancé, she does not need to run away from her feelings and she does not need to be alone.

Therapist: Do you see what just happened Yezda? Do you see what you did? As you shared your feelings with your mother, something that was never safe to do and still feels unsafe, you were able to move into the deep sadness that you have been keeping at bay for all these years and then you felt a sense of relief. It was at that point that you remembered a moment with your fiancé, when you did let him in and he was there for you. So maybe the more you can reach to him openly and directly, the more you are able to get the love and care you deserve. Then you are not alone and then the world feels a little safer.

RESOURCES

Learning Resources
Attachment Theory in Practice: Emotionally Focused Therapy (EFT) with Individuals, Couples, and Families (Johnson, 2019) is highly recommended as a companion text to this primer.

Also recommended are EFT and EFIT trainings offered through ICEEFT and in partnership with other organizations.

Information on training events; becoming a certified EFT therapist; EFIT, EFCT, and EFFT publication lists; and training videos/DVDs of EFT for couples, individuals, and families are available at www.iceeft.com.

Relationship Education Programs
Various educational group and online programs are available:

- **Hold Me Tight®** Conversations for Connection Program
- **Created for Connection**: The Hold Me Tight® Program for Christian Couples
- **Healing Hearts Together**: The Hold Me Tight® Program for Couples Facing Heart Disease
- **Hold Me Tight®/Let Me Go** for Families and Teens
- The **Hold Me Tight® Online** program with Dr. Susan M. Johnson presents 8–12 hours of online relationship education, including video clips of couples, expert comments, cartoons, teaching, and exercises (www.holdmetightonline.com).

Go to www.iceeft.com for more information.

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