

The Therapeutic Relationship in Emotion-Focused Therapy

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Important qualities of the relationship that make it therapeutic are discussed. The relationship is seen as both therapeutic in and of itself and as providing a facilitative environment from specific change processes. The role of the relationship in emotion-focused therapy is discussed within this framework. The relationship in emotion-focused therapy is seen as curative by serving an affect-regulation function, which is internalized over time by the client. This function is accomplished by offering a soothing affect-attuned bond characterized by the therapist's presence and empathic attunement to affect as well as acceptance and congruence. Second, the relationship is seen as functioning as a means to an end by offering an optimal environment for facilitating specific modes of emotional processing. In our view, affect is much more likely to be approached, tolerated, and accepted in the context of a safe relationship.

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Emotion-focused therapy (EFT; Greenberg, 2002, 2010; Greenberg & Watson, 2006) views the relationship, characterized by the therapist's presence and the provision of empathy, acceptance, and congruence, as an affect-regulating bond.¹ Over time, this interpersonal regulation of affect is internalized by the client as self-soothing and enhances the capacity to regulate his or her inner states. In this view, the therapist's overall attitude, not only his or her techniques, is seen as influencing the client's well-being. Elements such as pacing and facial, tonal, and postural communication of affect all create a therapeutic emotional climate. An important goal of EFT is client enhanced self-soothing and emotional transformation, and EFT sees the relationship as both a direct predictor of this change and a context in which techniques can be successfully used to reach this end.

In our view, the relationship thus serves a dual purpose in psychotherapy (Greenberg & Watson, 2006). First, the relationship is therapeutic in and of itself by serving an affect-regulation function, which is internalized over time by the client. This function is accomplished by offering a soothing affect-attuned bond characterized by the therapist's presence and empathic attunement to affect as well as acceptance and congruence. Second, the relationship functions as a means to an end. The relationship offers the optimal environment for facilitating specific modes of emotional processing. Affect is much more likely to be approached, tolerated, and accepted in the context of a safe relationship.

In the most general terms, EFT is built on a genuinely positively regarding, empathic relationship, and on the therapist being highly present, respectful, and responsive to the client's experience. Consistent with this, an abundance of research points to the therapeutic relationship as being central to client growth and change, given that differential therapeutic outcomes may only be minimally attributed to specific techniques (Norcross, 2011). Furthermore,

recent research has identified therapeutic presence as a core therapeutic stance that contributes to the development of a positive therapeutic relationship (Geller & Greenberg, 2012; Pos, Geller & Oghene, 2011). Therapeutic presence is defined as the therapist's ability to be *fully immersed in the moment*, without judgment or expectation, being with and for the client, which facilitates healing. EFT therapists also assume that it is useful to use techniques to guide the client's emotional processing in different ways at different times. The relationship thus is seen as curative in and of itself and as a foundation for specific techniques to work and so is both directly and indirectly related to outcome (Weerasekera, Linder, Greenberg, & Watson, 2001)

Treatment Principles

EFT is based on two major treatment principles: The provision of a therapeutic relationship and the facilitation of therapeutic work (Greenberg, Rice, & Elliot, 1993). As their ordering implies, the relationship principles come first and ultimately receive priority over the task-facilitation principles. In the relationship with the client, the overall therapeutic style combines what EFT therapists call following with guiding. In following, the therapist enters the client's internal frame of reference, empathically following the client's experience and responding to it in an affectively attuned manner. This is combined with a more guiding process-directive style to deepen experience. The therapeutic relationship thus, as well as being curative, also promotes the therapeutic work of exploration, emotional transformation, and the creation of new meaning. With safety, exploration deepens and the client is able to say, "I just feel like I am sinking, sinking into a deep black hole," the therapist responds with "just feeling hopeless like I can try and try but nothing works" (following) and the client responds, "Yes

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¹ Informed consent for purposes of research, training, and publishing have been received for case material presented, and number of details of the client and the situation have been changed to disguise the material for reasons of confidentiality.

and I can see the light but just can't quite reach up it." Here, we see facilitated by the therapist's validation of this painful state, the client enters a domain of emotional processing of painful feelings that would never have been reached without the safety and empathy in the relationship. He allows the client to reach the painful emotion that needs to be processed to move on. Subsequently, in response to the therapist's reflection that the client needs the support of a mother that she never received (guiding), the client both grieves the loss and accesses a sense of having deserved more and begins to reorganize.

Purely following, without a contribution from the therapist and without the sense of direction emerging from a dialogue, can result in therapy not progressing efficiently or just going in circles. At the same time, leading by the therapist without following is ineffective and may be counterproductive, undermining the client's efforts to develop as an empowered, self-organizing person. When disjunction or disagreement occurs, the client is viewed as the expert on his or her own experience, and the therapist always defers to the client's experience. Thus, therapist interventions are offered in a *nonimposing tentative* manner, as conjectures, perspectives, "experiments," or offers, rather than as pronouncements, lectures, or statements of truth.

Relationship Principles

The relationship is built on the following three subprinciples: (a) Empathic attunement: being fully present, enter the client's internal frame of reference and track the client's immediate and evolving experiencing; (b) Therapeutic bond: genuinely communicate empathy, caring, and warmth to the client; and (c) Task collaboration: facilitate involvement in goals and tasks of therapy.

In EFT, the relationship is seen as being curative in and of itself in that therapists' empathy and acceptance promotes breaking of isolation, validation, strengthening of the self, and self-acceptance. The relation with the therapist also provides a powerful buffer to the client's distress by the coregulation of affect. A relationship with an attuned, responsive, mirroring therapist is essential in developing interpersonal soothing and emotion regulation. This type of relationship helps clients regulate their overwhelming disorganizing emotions by breaking the sense of isolation and the unbearable aloneness of emotional pain. Over time, the interpersonal regulation of affect becomes internalized into self-soothing and the capacity to regulate inner states (Stern, 1985). When an empathic connection is made with the therapist, affect-processing centers in the brain are affected and new possibilities open up for the client. This type of relationship creates an optimal therapeutic environment that both contributes to clients' self-acceptance and to affect regulation and also helps the client feel safe to fully engage in the process of self-exploration and new learning. Another important aspect of a helping relationship is establishing collaboration on the goals and tasks of therapy. This is essential to developing the experience that *the two of us are working together to overcome the problem*. Getting agreement on goals and tasks is dependent on understanding the client and what might be helpful to the client and so it is an enactment of empathy. Goal agreement in EFT often is achieved by being able to capture the chronically enduring underlying pain with which the client has been struggling and establishing an agreement to work on resolving the pain rather than setting a behavioral change goal.

The Relationship and Affect Regulation

It is important to explore how affect regulation occurs to understand the important affect-regulating role of the relationship. In our view, emotion regulation is *an integral aspect of the generation of emotion* and coterminates with it (Campos, Frankel, & Camras, 2004) rather than involving self-control of emotion. The type of implicit affect regulation that results from a good therapeutic relationship occurs through right hemispheric processes, is not verbally mediated, is highly relational, and is most directly affected by such things as emotional communication, facial expression, vocal quality, and eye contact (Schore, 2003).

The therapists' facial, postural, and vocal expression of emotion clearly set very different emotional climates and are aspects of their ways of being. Clients' right hemispheres respond to therapists' micro affective communication as well as to their explicit words, and all these influence clients' processes of dynamic self-organization. The therapist who conveys genuine interest, acceptance, caring, compassion, and joy, and little anger, contempt, disgust, and fear creates the environment for a secure emotional bond. In the analysis of the classic film, *Three Psychotherapies*, by Rogers, Perls, and Ellis with Gloria, Magai and De Haviland (2002) studied the emotional climate created by the therapists. This analysis revealed that each of these therapists, in their behavior in the film, in their theories, and more generally in their personalities and personal lives, expressed and focused on very different emotions. Rogers showed interest, joy, and shame. Perls showed contempt and fear and Ellis anger and fear. Anyone who has seen this film can see that they created very different therapeutic environments.

Gloria at points becomes defensive with both Ellis and Perls but not with Rogers whom she sees as a warm father. The categorical emotions such as interest, anger, sadness, fear, and shame, expressed by the therapist are important and strongly influence the relational environment. The vitality aspects of the therapists' emotional expression, such as rhythm, cadence, and energy, are also important in affective attunement.

In clinical work, regulation is thus not easily achieved through the conscious system alone. A validating relationship is crucial to affect regulation. People with underregulated affect have been shown to benefit both from interpersonal validation as much as from the learning of explicit emotion regulation and distress-tolerance skills (Linehan et al., 2002). Problems in vulnerable personalities arise most from deficits in the more implicit forms of regulation of emotion and emotional intensity. Although deliberate behavioral and cognitive forms of regulation—more left hemispheric process—are useful for people who feel out of control to help them cope, over time, it is the building of implicit or automatic emotion regulation capacities that is important to achieve transformation for highly fragile, personality disordered, clients (Schore, 2003). Implicit forms of regulation often cannot be trained or learned as a volitional skill. Directly experiencing aroused affect, being soothed by relational or nonverbal means—a more right hemispheric process (Schore, 2003)—is one of the best ways to build the implicit capacity for self-soothing. Being able to soothe the self develops initially by internalization of the soothing functions of the protective other (Stern, 1985). Soothing then most centrally comes interpersonally in the form of empathic attunement and responsiveness to one's affect and through acceptance

and validation by the therapist. The provision of a safe, validating, supportive, and empathic environment in therapy helps soothe automatically generated underregulated distress. Internalizing the soothing of the therapist is one of the best ways of developing implicit soothing. Empathy from the other over time is internalized and becomes empathy for the self and this leads to a strengthening of the self (Bohart & Greenberg, 1997; Bohart, Elliott, Greenberg, & Watson, 2002; Elliott, Bohart, Watson, & Greenberg, 2011). Over time, this interpersonal regulation of affect is internalized into self-soothing or the capacity to regulate inner states. These optimal therapeutic relational qualities thus facilitate the dyadic regulation of emotion through provision of safety, security, and connection. This breaks the client's sense of isolation, confirms self-experience, and promotes both self-empathy and self-exploration.

When an empathic connection is made with the therapist, affect-processing centers in the client's brain are effected and new possibilities open up for the client (Schore, 2003). This creates an optimal therapeutic environment that not only contributes to clients' affect regulation by providing interpersonal soothing but also helps them to feel safe to fully engage in the process of self-exploration and new learning. Effective therapeutic work is only possible when the client feels safe and secure with the therapist. Developing a sense of safety and security for the client emerges through therapists' ability to be fully present and empathically engaged, in a genuine validating manner (Geller & Greenberg, 2012). When the therapist is fully in the moment with a client, his or her receptive presence sends a message to the client that he/she is going to be heard, met, felt and understood, which elicits a feeling of safety in the client. Current neuroscience research is beginning to reveal the neurological underpinnings of client safety through therapists' presence and affective attunement. Porges's (2011) Polyvagal Theory explains that when clients feel met and felt by the therapist, they not only feel aligned with the therapist, but the brain likely establishes a state of "neuroception" of safety (Porges, 2011). This creates a feeling of security in clients, which allows them to trust the therapist and to open and engage in the necessary therapeutic work. Neuroception is a novel construct created to describe how neural circuits discern safety, danger, or life threat outside the realm of awareness. Neuroception takes place in the primitive parts of the brain as an unconscious process that is manifested in our autonomic nervous system as an adaptive mechanism to prepare us for defensive strategies of fight-flight or shutdown.

For instance, clients with trauma backgrounds may have autonomic nervous systems that preclude the down-regulation of defense strategies and predisposes them to feel unsafe even when there is no observable risk. Hence, challenges in the social world of these clients occur, as they respond defensively even when there is no risk. Hence, in the Polyvagal Theory, the regulators of emotions and physiology are embedded in relationship. The core of the social engagement system in mammals is reflected in the bidirectional neural communication between the face and the heart (Porges, 2011). From this perspective, arousal can be physiological arousal or emotional dysregulation and can be stabilized through social interaction that includes warm facial expression, open body posture, vocal tone, and prosody (rhythm of speech). The therapist's presence and overall safety providing attitude thus influence the client's well-being. Therapists' pacing, facial, tonal, and pos-

tural communication of affect all create a therapeutic emotional climate that leads to physiological soothing.

The Therapeutic Alliance

Numerous studies have shown that a positive therapeutic alliance is associated with good outcome (Horvath, Del Re, Fluckiger, & Symonds, 2011). The alliance reflects three important aspects of therapeutic work, the bond or the feelings the participants have toward each other, the level of agreement that exists between them about the goals of therapy, and the ways in which they will go about meeting those goals (Bordin, 1979). A recent study that looked at clients who were being treated for depression in cognitive-behavioral and emotion-focused psychotherapy found that clients' perceptions of the Rogerian relationship conditions were highly correlated with clients' ratings of the therapeutic alliance in both approaches and that presence and empathy were correlated (Watson & Geller, 2005) and were associated with changes in clients' level of self-esteem, and their self-report of interpersonal difficulties, while therapists' acceptance of their clients was predictive of changes in depression.

The development of collaboration also has been established as an important, empirically supported aspect of the therapeutic relationship (Horvath & Greenberg, 1994). Thus, as well as creating the emotional climate that secures a warm trusting bond, it is also important to foster a collaboration on tasks and goals through the course of therapy, wherein client and therapist agree to work with both avoided emotions and underregulated emotions. With research, we (Horvath & Greenberg, 1989) came to see the client's perceived task relevance and task collaboration as more predictive of outcome than empathy. In fact, perceived task collaboration emerged from an enactment by the therapist of his or her empathic understanding of the client. This enactment might occur by making a suggestion that helped deepen the client's exploration or experience. For example, a response like "if your father was here what would you like to say to him from your anger" enacts an understanding of what the client needed and would be experienced as more helpful than a verbal communication of an understanding of the client's inner world such as "so that left you feeling so angry at him." Proposals thus were enactments of empathy. Collaboration thus became an important foundational principle of an EFT approach and a core ingredient of our theory of relationship.

From this, we have identified a number of ways to assist in the development and maintenance of the task agreement dimension of the alliance when working with emotions. The first of these involves conveying that the primary focus of treatment is the client's concerns and underlying painful feelings. The therapist conveys that a central intention of therapy is to help clients to open up and reveal their inner feelings, meanings, and fears—to risk being vulnerable with their therapists in the hope that together they can come to a better understanding of the clients' inner and outer worlds and effect meaningful change that will ameliorate clients' sense of despair. Without this exploratory goal being adequately negotiated between the parties, the therapy will likely end prematurely or not progress. From the start, the client is implicitly being trained, by the therapist's consistent empathic focuses on the client's internal experience, to attend to this internal experience.

Therapists in the early phase of therapy convey understanding, acknowledge client's pain, validate his or her struggles, and focus

on the emotional impact of events in the client's life. By the therapist's attentive listening, presence, and caring and by the attitude conveyed by the therapist's face, body, hands, and eyes that validates the client specialness, the client comes to feel seen, valued, and respected and is thereby more inclined to trust and be open. By attending to clients' core humanness and expressing unconditional confidence in clients' strengths and capacities for growth, the therapist helps reveal clients' uniqueness and strength. It is by seeing the possibility of growth in another being that this possibility is stimulated. This is an important aspect of the relationship in all approaches. The deeply held therapeutic stance of presence and the attitude of empathy, positive regard, and a focus on strengths and resources help create an emotional bond of trust and respect and help develop the safe environment and a secure base for the exploration that will take place as the therapy progresses.

This is a relational principle that is universal to all helping relationships. In addition to creating a bond, a rationale is provided, right from the start, that the goal of treatment is for the person to access and become aware of underlying feelings and needs involved in their difficulties. If, however, their emotions are underregulated, the goal becomes finding better ways of coping with feelings that seem overwhelming. People are told that their feelings provide important information about how they are reacting to situations and that it is important to get clear on what their emotions are telling them. There is a strong emphasis from the start on validating and accepting the pain that people feel. When people come to therapy they do so because they are suffering and feel some form of pain—it feels like something in their life or inside of them is broken. It is with the quickness and sureness with which the therapist can grasp the nature of the client's chronic enduring pain that an emotional bond and collaboration to work on it will be created. Once the chronic enduring pain has been articulated, the person's sense of isolation is broken. There is a sense of relief that it has been spoken, that someone understands, and that the person now is not so alone in the struggle. Hope is created and agreeing to work on resolving the chronic enduring pain creates an alliance, spurred by this hope. Resolving the articulated enduring pain becomes the goal of treatment and the basis for the working alliance.

Therapeutic Presence

Therapeutic presence involves therapists being fully in the moment on a multitude of levels, physically, emotionally, cognitively, spiritually, and relationally (Geller & Greenberg, 2002, 2012; Geller, Greenberg, & Watson, 2010). The experience of therapeutic presence involves (a) being in contact with one's integrated and healthy self, while (b) being open and receptive, to what is poignant in the moment and immersed in it, (c) with a larger sense of spaciousness and expansion of awareness and perception. This grounded, immersed, and expanded awareness occurs with (d) the intention of being with and for the client, in service of his or her healing process (Geller & Greenberg, 2002, 2012). A more detailed description of our empirically validated model of therapeutic presence can be found in other publications (see Geller & Greenberg, 2002, 2012). Presence is a relational stance that is fundamental to evoking an experiential and neuro-physiological sense of safety in the client, which in turn can promote a positive thera-

peutic alliance and effective clinical work across different therapeutic approaches.

To establish a positive alliance, it is important for therapists first to be present to their clients. A question often asked by trainees is: What does one need to do to help a constricted client access feeling? But this implies that it is something one needs to *do to the client*. My answer is that the ability to access emotions depends first and foremost on the type of *relationship* created. It is the therapist's ability to be present that will help the client access emotion. A qualitative analysis of therapists' experience of presence revealed that therapeutic presence involves being receptively open and sensitive to one's own moment-by-moment changing experience, being fully immersed in the moment, feeling a sense of expansion and spaciousness, and being with and for the client (Geller & Greenberg, 2002). It is these qualities that will help create the climate that will lead clients to attend to their moment-by-moment affective experience. It is important that therapists are able to be receptive and open to their clients' emotional experiences. The kind of "presence" that seems to be therapeutic is the state of mind in which there is an awareness of moment-by-moment emotional reactions as well as thoughts and perceptions occurring in the client, in the therapist, and between them in the therapeutic relationship. This means that therapists need to let go their own specific concerns, the quarrel with their spouse this morning, the falling value of the dollar, or an upcoming vacation and truly show up in the session. To be present for clients is to empty oneself, to clear a space inside so as to be able to listen clearly in the moment to the narratives and problems that clients bring. Therapists need to see their clients' faces and hear their voices. It is through the therapist's undivided and focused attention that clients feel valued and are able to clearly discern their own concerns and difficulties. By giving clients their full attention, therapists are able to more fully resonate with their clients' feelings and their experience of events and provide the level of empathic responding that will be most optimal at different points during the session.

Dialogue of this type often leads to heightened moments of meeting or what Buber (1958) referred to as I-Thou contact. In these moments, people share living through an emotional experience together. Here an intersubjective experience is lived while it is occurring: It is a shared experience of attending to and experiencing the same thing at the same time and knowing that the other is coexperiencing the same thing. Each person experiences something of the other's experience and knows that this is occurring. This creates a strong bond, a sense of togetherness that breaks any sense of existential isolation and promotes trust and openness. It also is a lived moment of experience that remains indelibly stamped in memory. These moments produce therapeutic change both in the people's sense of self and their way of relating.

We see the Rogerian conditions of empathy, positive regard or acceptance, and congruence (Rogers, 1957) as part of a single therapeutic way of that of being *fully present* with the other. Empathy has been established as one of the three empirically supported aspects of the relationship, one that correlates moderately (e.g., $r = .32$) with outcome (Bohart et al., 2003; Elliott, Bohart, Watson, & Greenberg, 2011). The sense that another is accepting and can be trusted, to the extent that one perceives the other as congruent and sincere, is important to the sense that one is valued and liked by the other. Through sensing the therapist's

unconditional acceptance of their experience, clients lose their preoccupation with the therapist and their energy becomes available to turn inward and contact their own experience. Reduction of interpersonal anxiety leads to capacity for tolerance of more intrapersonal anxiety. Clients are able to face and accept more of their experience with the unconditional acceptance of another.

Genuineness and Congruence

The positive real relationship, composed of what Gelso and colleagues term congruence and realism, is an important aspect of the therapeutic relationship that enhances the alliance and client progress (Gelso, 2011; Gelso & Hayes, 1998; Kolden, Klein, Wang & Austin, 2011). Congruence or authenticity can be broken into two separate components (Lietaer, 1993): Awareness of one's own internal experience and the willingness to communicate to the other person what is going on within (transparency). The deeper level intentions include the intentions to facilitate the others' development, to be accepting and noncritical of the other, to confirm the others' experience, to focus on their strengths, and above all to do the other no harm. These intentions, and more, are what determine whether congruence is therapeutic. The case of transparency or the communication component of congruence is much more complicated than the self-awareness component. Being facilitatively transparent involves many interpersonal skills (Greenberg & Geller, 2001). This component involves not only the ability to express what one truly feels but to express it *in a way that* is facilitative. Transparency thus is a global concept for a complex set of interpersonal skills embedded within a set of therapeutic attitudes. These skills appear to depend on three factors: first, on therapist attitudes, second, on certain processes such as facilitativeness, discipline, and comprehensiveness, and third, on the interpersonal stance of the therapist.

The set of skills involved in facilitative congruent communication is best explicated by looking at congruent interaction in terms of the interactional stance taken by therapists as described by a circumplex grid of interpersonal interactions (Benjamin, 1996). This grid is based on the two major dimensions of autonomy/control and closeness/affiliation. Consistent with interpersonal theory, this grid outlines a set of complementary responses that fit each other and that interactionally "pull" for each other. Thus, attack pulls defensiveness or withdrawal, and affirmation pulls for disclosure and revelation. The skill of congruent responding involves not reacting in a complementary fashion to a negative interpersonal "pull" of the client, like recoiling when attacked; but rather, to act in such a way as to "pull" for a more therapeutically productive response from one's client, such as clear expression. This would be achieved by an empathic understanding response to an attack rather than by recoiling.

What to do when the therapist is not feeling affirming but is feeling angry, critical, and rejecting and cannot get past this feeling, to something more affiliative? As we have said, an interactional response to be facilitatively congruent involves first connecting with the fundamental attitudes or intentions of trying to be helpful, understanding, valuing, respecting, and nonintrusive or nondominant. This will lead to these feelings being expressed as disclosures. If the interpersonal stance of *disclosing* the difficult feeling is adopted, rather than the complementary stances of expressing it by attacking, or rejecting, or seducing then this con-

gruent response is more likely to be facilitative. It is not the content of the disclosure that is the central issue in being facilitative; rather it is *the interpersonal stance of disclosure in a facilitative way* that is important. What is congruent is the feeling of wanting to disclose in the service of facilitating, and the action of disclosing. The different ways of being facilitatively congruent in dealing with different classes of difficult feeling thus are to some degree specifiable. They all involve adopting a position of disclosing. Expressing a feeling that could be perceived of as negative, in a *stance that is disclosing*, rather than expressing it in the stance that usually accompanies that feeling, will help make it facilitative because disclosing is an affiliative and nondominant form of interaction whereas being angry is clearly nonaffiliative and may be dominant. Disclosure, implicitly or explicitly, involves willingness to, or an interest in, exploring with the other what one is disclosing. For example, when attacked or feeling angry therapists do not attack the other but rather *disclose* that they are feeling angry. They do not use blaming "you" language. Rather they take responsibility for their feelings and use "I" language that helps disclose what they are feeling. Above all they do not go into one up, escalatory, positions in this communication, but rather openly disclose feelings of fear, anger, or hurt. When the problem is one of the therapists experiencing nonaffiliative rejecting feelings or loss of interest in their clients' experience, the interactional skill involves being able to disclose this in the context of communicating congruently that the therapist does not wish to feel this. Or therapists disclose these feelings as problems getting in the way and that they are trying to repair so that they will be able to feel more understanding and closer. The key in communicating what could be perceived as negative feelings in a congruently facilitative way is to communicate it in a nondominant affiliative disclosing way with appropriate nonverbals. Both timing and type of client need to be considered in deciding whether or not to disclose.

Coaching as an Aspect of the Relationship

In addition to presence and being with the client, EFT therapists also lead and guide client processing—an activity that we have termed coaching. In EFT, certain client in-session problem states are seen as markers of underlying emotional processing difficulties that offer opportunities for differential interventions best suited to help facilitate productive work on that problem state. Thus, if a client enters a self-critical state, this is an opportunity to intervene with a two-chair dialogue to resolve splits. The therapist is thereby seen as setting a task for the client to work on. Therapeutic work thus involves engaging clients in particular tasks suitable to states that the clients enter into in the session.

We have come to view a therapist who works in this way as emotion coaches (Greenberg, 2002). Coaches provide guidance on how to process emotions and emotion-related problems in adaptive ways. The therapist both promotes and validates awareness and acceptance of emotional experience and coaches clients to engage in tasks that promote new ways of processing emotion. Coaching entails both acceptance and change. The nondirective following style provides change toward acceptance of what is while the more leading style provides guidance, introduces novelty and the possibility of change.

Emotion coaching involves a partnership of coexploration in a growth-promoting process aimed at helping people achieve goals

of emotional awareness, regulation, reflection, and transformation (Greenberg, 2002). It involves facilitating awareness of emotions, new ways of processing the emotion, and provides guidance in ways of soothing or regulating the emotion. Awareness in turn involves helping clients verbally label emotions while they are being felt, helping them accept the emotion and talking with clients about what it is like to experience an emotion. In addition, coaching clients involves facilitating the utilization of adaptive emotions, usually anger and sadness, to guide action and transform maladaptive emotions usually fear, shame, or anger. It is important to note that people often cannot simply be taught new strategies conceptually for dealing with difficult emotions, but rather have to be facilitated experientially to engage in the new process and only later explicitly taught what to do. For example accessing anger or a getting to an emotionally experienced need or goal may be very helpful in overcoming a sense of depressive hopelessness or defeat. However, explicitly teaching people that this is what they should do is not nearly as helpful as interpersonally facilitating this by asking them at the right time in the right way what it is they feel or need.

Some clients, however, are extremely externally focused and helping them contact their feelings can be challenging. A persistent gentle pressure to focus on current internal experience is required by means first, of empathic responding and emotion inquires, and later, by process directives that focus the client's attention on internal experience. The client is encouraged to become aware of internal experience and to develop mindful awareness (Perls, Hefnerline, & Goodman, 1951). Later process directives like suggesting the client repeat key phrases that stimulate emotion in the session can be used to intensify experience and make it more vivid. A balance needs to be struck between allowing clients to tell their story and tracking their reactions, and explicitly directing their attention internally. Questions that are used in this phase and throughout therapy are: What are you aware of as you say this? What is happening in your body? What is it like inside right now?

Using empathic exploratory responses and emotion awareness questions, the therapist therefore coaches clients to approach, tolerate, regulate, and accept their emotional experience. Acceptance of emotional experience as opposed to its avoidance is the first step in emotion awareness work. Having facilitated the acceptance of emotion rather than its avoidance, the therapist then helps the client in the utilization of emotion. Here clients are helped to make sense of what their emotion is telling them and to identify the goal/need/concern which it is organizing them to attain. Emotion is used both to inform and to move.

In addition, believing that clients cannot leave a place before they have arrived at it, the focus in the relational dialogue is on acceptance and validation of emotion rather than on modification of cognition or awareness of, or insight into, interpersonal patterns. It is only after validation of what is being experienced as shown in the transcript below that transformation via accessing new affect and creation of new meaning comes into play. The relational emphasis is more on facilitation of strength than correction of error.

Case Example

An example of a therapist responding to a client's sense of isolation after the loss of her father is given below to exemplify

the type of empathic attunement and exploration characteristic of the relational style in EFT. A number of details of the client and the situation have been changed for confidentiality.

T53: Do you think you could put your friend in the chair and talk to her?

C54: No [pause]

T54: It's really hard a one for you. [Pause] What are you feeling right now?

C55: [small voice:] Scared. [= Vulnerability begins to emerge]

T55: [gently:] Scared. [Pause] Uh-huh. Just so scared about . . .

C56: What will happen to the little [rueful laugh:] relationship that we have.

T56: Uh-huh, scared that if you assert yourself here, you could lose her.

C57: What change will it bring in her, toward me. I don't think I could handle it. (T: mhm)

T58: "If I assert my feelings or if I express my true feelings of anger toward her, will it ruin the shred of a relationship that we *do* have? (C: mhm) Will it ruin the little bit of contact I *do* have." It might destroy even those little threads, and it's so scary to think about not having that relationship. (C: mmmm mhm)

C59: Yeah. It is such a risk. I don't know if I can bear the loss. Without her it's like I would have nothing.

T59: Just a feeling that, "Without that connection I will be left totally alone."

C60: Yes, that's how I would feel, totally alone, not anything to anybody.

T 60: Uh-huh, without any value to anyone.

C61: Yes, it's like feeling that I could die without anyone knowing.

T62: No one would even know.

C62: Yes. I feel tight in my throat (T: mhm). My stomach hurts.

In the above segment, the therapist responds empathically to the client's vulnerability in a prizing and congruent manner. This helps the client's vulnerability emerge at C55, when she reports feeling scared. The therapist validates the scared feelings, and in C59 the client begins to articulate the unbearable sense of loss. This leads her toward focusing on a bodily felt sense of pain and the therapist as shown below guides her to regulate the feeling and to explore it to access the implicit meanings.

T64: That's good. [Pause] Good calming breaths [Pause] [Whispers:] Take a minute, just to relax. Quiet down inside [long pause]. So there's this feeling inside. What's it like?

C65: Sometimes it's just like I want to go crawl in my bed and just stay in there and nobody bother me [= vulnerability emerges further]

T65: Mhm, mhm. "I just want to shut my eyes and shut all the pain shut out (C: Mhm, mhm) And shut all the people out. Yeah (C: mhm). I just want to make all the pain go away."

After a deepening to get to core vulnerability, the acceptance and validation by the therapist helps the client stay with the painful vulnerable feelings, while the therapist listens for what is worst or most painful about the whole thing.

T68: What hurts the most right now? I know it's really hard (Pause). What part of it is hardest?

C69: It's like I'm drowning, (T: [whispered:] drowning) and I keep reaching up, and I've been struggling since I was a kid.

T69: [whispering:] Like you're drowning, and a little piece of you, one hand, one arm just keeps reaching up.

At the same time as witnessing and receiving the helpless aspects of her experience and making vivid the depths of the client's despair, the therapist is listening for the genuine emergence of adaptive emotions and for the wants and needs in the personality. This begins to emerge above in the image of reaching up and is developed through exploring feelings tied to an episodic memory of a time in her childhood when she nearly drowned. She then reorganizes into a more resilient state and begins to access her need for contact and comfort and safety from others and begins to reach out for it by saying "I would like to hold onto my relationships with them (friends and siblings). There are moments when I know I can make it. It's just sometimes it feels so overwhelming and I go to that place."

Conclusion

People develop from infancy to their demise in relationships. Relationships are crucial to healthy human development, and therapeutic relationships are a major vehicle for personal growth and development. In this article, I have argued that the relationship is first and foremost an affect-regulating bond, one that is, in and of itself, facilitative of psychological change and conducive to growth and well-being. Second, the therapeutic relationship, characterized by presence, empathy, acceptance, and congruence, helps clients to feel safe enough to face dreaded feelings and painful memories. These I have argued are universal principles of all therapeutic relationships.

Empathic responding by therapists helps clients become aware of their emotional experience, label it in awareness, and modulate it so that it is not overwhelming or excessively muted so that its message is lost. Empathic exploration facilitates the client turning inward to explore and unpack their inner subjective world views and feelings about events (Elliott, Watson, Goldman, & Greenberg, 2004). In addition acceptance in the mind of valued person can have profound effects on physiological processes. Warmth, compassion, openness, and respect toward the client's experience, caring for the client as a separate person, with permission to have his or her own feelings and experiences, is a crucial aspect of a therapeutic relationship. Warm, accepting, empathic relationships with a genuine therapist lead to greater self-acceptance and cure the pain of isolation.

In EFT, once an alliance, consisting of a warm bond and collaboration between client and therapist, has been consolidated and safety established, the therapist guides clients toward new ways of processing emotion, coaching them to become aware of, regulate, reflect on, and transform their emotions. It is in the blending of these various elements of a curative relationship with the facilitation of specific change processes that successful therapy emerges.

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