Working with Identity and Self-soothing in Emotion-Focused Therapy for Couples

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This paper will outline new developments in Emotion-Focused Therapy for Couples (EFT-C) (Greenberg & Goldman, Emotion-focused couples therapy: The dynamics of emotion, love, and power, Washington, DC, American Psychological Association, 2008). People are seen as primarily motivated by their affective goals and the regulation of emotional states. The three motivational systems of attachment, identity, and attraction/liking, viewed as reflective of the core concerns people bring to therapy, are briefly outlined and elaborated. The five-stage model of EFT-C is briefly described. The paper will then provide two illustrations, one that demonstrates how EFT-C therapists work with core issues related to identity, and the other that shows how therapy can promote self-soothing. In the first example, annotated transcripts taken from therapy sessions illustrate how an EFT therapist addresses issues of identity in a highly distressed couple. The second example demonstrates how to facilitate work with individuals within the couples’ context to engender and develop capacities for self-soothing, seen as fundamental for the promotion of healthy emotion regulation and couples’ overall health.

Keywords: Emotion; Identity; Soothing

In Emotion-Focused Therapy for Couples (EFT-C), emotions are treated differentially depending on which emotion is expressed and how it functions for both the individual and the couple. We have recently outlined ways to help both couples and individuals regulate anger, sadness, fear, shame, love, and other positive emotions (Greenberg & Goldman, 2008). In addition, we have adopted a lens of affect regulation to provide a comprehensive framework for working with emotion and to help us understand the variety of interactions and motivations that govern couples’ functioning.

Couples conflict can be seen as resulting from breakdowns in both other- and self-regulation of affect. A hallmark of the original model of emotionally focused couples’ therapy (Greenberg & Johnson, 1988) was the strong emphasis on people expressing underlying vulnerable feelings to undo negative interactional cycles and the encouragement of the expression of adult unmet needs and responsiveness to these expressions. Support for this hypothesis has been demonstrated in a recent study (McKinnon, 2013; McKinnon & Greenberg, 2011) showing that the in-session expression of vulnerable emotions predicts outcome. In our expansion of the original model, in EFT-C, we also work toward self-change and the resolution of pain stemming from unmet childhood needs that affect the couple interaction, in addition to working on interactional change.

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We thus explicitly integrate our work from individual EFT (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2002; Watson, Goldman, & Greenberg, 2007; Greenberg & Watson 2006; Greenberg & Goldman, 2007; Paivio & Pascual-leone, 2010) with our approach to couple therapy, to form a more comprehensive approach to treating couples. The Emotion-focused therapeutic view of human functioning (Greenberg, 2002; Goldman & Greenberg, 2005; Goldman & Greenberg, 1997; Greenberg & Johnson, 1986a, b, 1988; Greenberg & Paivio, 1997; Greenberg & Safran, 1987) purports that the ability of individuals to access, soothe, and transform core maladaptive emotion schemes (emotional wounds) based on core fear, sadness, and shame is central to self-change. Dealing with each partner’s pain of unmet needs from the past and helping them to self-soothe is important in couple therapy in working toward relationship satisfaction and enduring change. The focus on self-soothing, when necessary, helps restructure emotional bonds and ensures more enduring and stable change. This is a finding that has been well borne out in research by Gottman (1999, 2011) that has shown that self-soothing is an important element of successful marriage in addition to interactional change.

We will first discuss how emotion functions in couple conflict and how change in couples’ emotion systems occurs in EFT-C. A five-stage model of the major stages of therapy will be outlined and strategies to promote emotional change in couples will be discussed (Greenberg & Goldman, 2008). We will then take a specific focus on the two concepts, one being identity, which has been developed since its initial formulation as dominance (Greenberg & Johnson, 1988), and the other, self-soothing, a practice that has been developed more recently in Emotion-Focused therapy for Couples (Greenberg & Goldman, 2008). Each of these concepts will be illustrated and elaborated with case material below. In addition, the importance of affect regulation as an organizing construct will be discussed briefly.

AFFECT REGULATION

In our view, basic emotions are the raw material of existence. A number of primary emotion systems have been identified by facial expression such as, in ordinary language, anger, sadness, fear and disgust, joy and interest/excitement, or by more basic neurochemical/physiological processes labeled by Panksepp (Panksepp & Biven, 2011) more formally as systems of SEEKING, RAGE, FEAR, LUST, CARE, PANIC/GRIEF, AND PLAY. Many of these emotions are highly relationally oriented and lead us to seek out and react to the other. As Panksepp and Biven (2011) highlight, behaviorists who focused on behavior (defining it as all the organism does) rendered emotions outside of the realm of scientific investigation. They failed to see that all mammals feel, and that many stimuli are rewarding or punishing because of how they lead the organism to feel. Essentially, the unconditioned stimuli were stages of feeling and need: approach and avoidance are predominantly governed by how stimuli make us feel. Thus, we avoid a particular situation because we avoid feeling the fear associated with it. By extension, like behaviors, interactions are governed by what they make us feel: we approach because we associate the stimulus with a good feeling. At the most fundamental level of functioning, it is the feeling that is the reward or punishment. In addition, it is of great importance in understanding human functioning to see that we come into the world with a differentiated set of basic psychoaffective-motor programs (identified above) and that these are far more differentiated than the pleasure and pain of Freud or reward and punishment of Skinner. People seek to have certain affects that feel good and to not have those that feel bad. In addition, it is important to note that different affects feel different: the feeling good of touch differs from the feeling good of interest or of play, just as the fear of danger differs from the anxiety of
separation. Emotional life is built from these building blocks and we seek to have certain emotions because the goals in these emotions—to approach, withdraw, push away, run away, cuddle, or seek out—helped us to survive (Greenberg & Goldman, 2008).

In Emotion-focused therapy then, affect regulation is seen as the process that governs motivation. Affect regulation is neither mono-motivational (not for example solely the motivation to attach, to self-actualize, to predict or control) nor bi-motivational (libido and aggression, pleasure-seeking, and pain-avoidant), but rather motivation is seen as deriving from affects, which are multiple in nature. In this view, higher level motives such as attachment, establishing coherence/identity, exploration, control, and achievement are all constituted by affect because how these make us feel (confident, calm, interested, afraid etc.) has aided survival. In other words, we attach in order to feel good and as such we are motivated by affect regulation. Emotions guide motives; without fear and sadness there would not be attachment; without shame and pride, there would not be identity. Using this view of affect regulation as a base, we will look below at some of the higher level motivations important in our EFT approach to couples.

ATTACHMENT

In Emotion-Focused Therapy for couples, we view the attachment bond and the security it provides as a central concern of most couples. Johnson (2004) has emphasized the role of attachment, and in EFT-C and we see it as a central form of affect regulation, governing both emotional arousal and approach and avoidance. We suggest, however, that we attach in order to regulate affect rather than vice versa. In other words, without fear at separation, joy at connection, and sadness at loss, there would be no attachment. Thus, affect regulation is seen as a core motive that leads to attachment (Greenberg & Goldman, 2008). Put simply, motivation is seen to work because of affect regulation rather than to simply produce it.

Bowlby (1988) proposed that early emotional relationships were the foundation for later ones. He suggested that if our personal history is one of having received security, we are able to form secure attachments. If our early relationships were experiences of having been separated, let down, or disappointed, we face a harder task in forming trusting relationships with others in adulthood. What Bowlby called “maternal deprivation,” a lack of continuous nurturing relationship in the first 3 years of life, would make it difficult, sometimes impossible, for a person to form trusting intimate relationships in adulthood.

Hazan and Shaver (1987) extended Bowlby (1988) to adult romantic relationships, arguing that adults appear to experience bonds of attachment toward romantic partners that have some of the same characteristics as infant–caregiver bonds. They propose that the emotional and behavioral dynamics of infant–caregiver relationships and adult romantic relationships are governed by the same biological system (Hazan & Shaver, 1994; Shaver & Hazan, 1988). Partners become distressed when loved ones leave or are unavailable for any length of time.

Adults’ basic concerns in intimate relationships mirror the infant’s tendency to monitor for caregiver proximity, availability, and responsiveness. While this helps adults regulate affect and feel secure, this is different than it is for the young child. For young children, these are mostly automatic responses, while adults often (although not always) are able to articulate their felt needs and beliefs with regard to their needs for care. This need for attachment is an adult, not an infantile, need, and only becomes unhealthy if a person cannot tolerate need frustration and flies into a rage or becomes depressed at loss, separation, distance, or nonresponsiveness.

In addition, in long-term adult relationships, as opposed to in infant–caregiver relationships, the attachment and caregiving roles are interchangeable, making adult attachment...
quite different from infant attachment. Adults also are able to self-soothe and need to develop this ability if they cannot. What is important and unique about attachment figures in development is that we internalize their functions so we can feel their soothing effects without their physical presence. Anticipating their soothing responses thus regulates our emotions. It is this very function that we assume when our adult partners are not available to us in adult romantic relationships. Thus, to assume that adult attachment parallels infant–caregiver bonding is a stretch and to call this love is a problem. Love is clearly more than simply attachment and we will discuss this in a further section.

While we generally see adults as sharing similar, although not identical, attachment styles to children, we find a two-dimensional framework (Mikulincer & Goodman, 2006) that views people as organized as either anxious or avoidant most helpful in understanding adult relationships. This is in contrast to other modern attachment theorists who see adult attachment patterns as being directly derived from childhood attachment patterns and falling along lines of secure, insecure, or disorganized (Ainsworth, 1985; Main & Hesse, 1990). Anxiety relates to the degree of anxiety and vigilance concerning rejection and abandonment, avoidance relates to the degree of discomfort with closeness and the dependence or a reluctance to be intimate with others. People are thus seen as monitoring and appraising events for their relevance to attachment-related goals, such as the attachment figure’s physical or psychological proximity, availability, and responsiveness, and then regulating their attachment behavior. For example, to regulate attachment-related anxiety, people can orient their behavior toward the attachment figure or withdraw and attempt to handle the threat alone. These responses lead to the pursue-distance cycles we so often see in therapy.

We stress that people are fundamentally relational and need connection from others (Fishbane, 2007; Jordan, 2010). We suggest, in addition, that our relational needs are beyond needs for attachment to and security from others. In our view, attachment has come to be seen as the master motive by many theorists and practitioners and, as such, has been over-applied to explain almost all of human functioning, couple distress, and even love itself. We view adult love as more than, but including, attachment. Furthermore, not all romantic or couple relationships are attachment relationships and not all couple problems are attachment problems. Finally, relationships serve other fundamental and important functions beyond soothing, separation anxiety, and providing security.

IDENTITY MAINTENANCE: INFLUENCE, DOMINANCE, AND CONTROL

In our view, an understanding of the relational and emotional processes in the formation and maintenance of identity and self-esteem, and the influence cycles that ensue (e.g., dominance/submission, and overfunctioning/underfunctioning) when identity is threatened, is another crucial piece of the puzzle of how to help couples resolve conflict (Greenberg & Goldman, 2008). Our intimate relationships are important in influencing how we see and feel about ourselves. In this section, we elaborate an emotion-focused perspective on how to work with threats to identity, and the dominance struggles that result from partners’ efforts to ensure a sense of worth.

Hierarchy and issues of dominance and control in the maintenance of self have long been recognized as significant issues in couples and family functioning. Partner inequality undermines relationship success while equality promotes it (Freson & Williams, 2003; Goldman & Greenberg, 2008; Knudson-Martin & Mahoney, 2009). Intimate relationships that require the sharing of vulnerabilities can be challenging in environments that support traditional gender role frameworks wherein males more typically have more “gendered” power. In this therapy, we take a focus on who holds more emotional power in the
intimate relationship; whether the individual be male or female, acknowledging that this can be influenced by social and economic power in a larger framework. We also recognize, however, that in our clinical work the question of who is more “dominant” in the relationship appears to cross gender lines. That is, in heterosexual relationships, it is sometimes the case that women more often define what is important, receive more attention, are more strongly accommodated, and take a stronger focus on their own well-being (Knudson-Martin & Mahoney, 2009). That said, we have definitely seen the reverse and it is less clear-cut in same-sex relationships. This may be owing to the fact that same-sex relationships do not have a framework of ready-made, complementary gender role expectations to structure them.

When identity is threatened, people act and interact to protect their identities. Shame, fear, and anger are the resulting emotions. People attempt to exert influence and control to regulate their affect, that is, to not feel the shame of diminishment and the fear of loss of control or to feel the pride of recognition and the joy of efficacy. We thus work toward helping people reveal and subsequently soothe the emotions of shame and fear that underlie dominance and the anger and control that ensues from threats to identity. We have found that self-soothing, in addition to other-soothing, often is important in helping people deal with identity threats and in resolving influence and dominance cycles. In dominance conflicts, it is each partner’s concern with how they are perceived (their identity) by self and other and whether their needs for agency or recognition are being met, rather than concerns with closeness and connection, that becomes primary. In these conflicts, partners argue not about being close or needing distance (as is the case when attachment-related needs for safety and security are activated), but about being validated and respected or about not being seen or feeling unimportant or diminished. They argue to maintain their identities (Greenberg & Goldman, 2008). It is important to note that dominance struggles, although hinging on identity needs, can still exert a strong influence on the attachment bond by producing abandonment anxiety and insecurity as a secondary response, captured by phrases such as “If you see how awful I really am, you may leave me” or “If you cannot validate me, I may leave you.” In these situations, each partner’s core needs are to be valued or respected, rather than to be close. Threats in the identity domain then activate needs related to attachment. What must be addressed in therapy, first are the identity needs and, secondarily, the attachment fear.

Struggles over the definition of reality and issues of power and control are often the most difficult interactions to deal with in therapy. In one form of a dominance/identity struggle, the central concern is whose definition of self and reality is right, and who has the right to define what’s right. In another, it is whose needs are more important. In struggles about what’s right, partners fight to defend their view of reality and they defend themselves against the humiliation of being found wrong or lacking because feeling wrong makes them feel unworthy, inferior, deficient, or incompetent. Partners attempt to stave off dreaded feelings of catastrophic disintegration and loss of control. They also fight to influence decisions and courses of action, to feel recognized, and to maintain status and a sense of autonomy. They fight to protect their ability to operate by choice under their own volition rather than being coerced. Alternately, partners give up their identities and become fused to avoid conflict, but excitement and positive feelings get lost in the process. When people are seen negatively by their partners, or feel over-exposed or powerless, they often shrink in shame and want to hide. When they feel seen, accepted, and validated they open themselves to the other and express their innermost thoughts and feelings. In order not to feel this primary shame and in an attempt to avoid these powerful, uncomfortable experiences people often respond with anger and attempts to dominate (Greenberg & Goldman, 2008).
Differences and conflicts related to dominance and control thus often emerge in couple relationships out of threats to identity as aggressive attempts to regulate shame. Fear of loss of control also leads to efforts to dominate and control. Partners who can stimulate positive affect in the other tend to find this a far more satisfying way to receive recognition and identity validation, rather than through coercion. This can often be achieved interpersonally by arousing positive feelings of care, concern, attraction, and liking that in a sense form a buffer and protect against negative emotions.

We thus see the differentiation between attachment and identity as a core distinction that influences how we work with our couples in therapy. First, it guides our understanding and assessment of clients’ core emotions that are fueling the negative, escalating interactions that bring them to therapy. This in turn influences which emotions we deepen and explore, and which associated needs we encourage expression of to partners. In particular, we understand different core needs to be associated with particular fundamental, maladaptive emotions. In general, fear is associated with needs for comfort and closeness that require proximity and responsiveness to provide security and safety while shame is associated with needs for acceptance and validation of ‘who I am’ that require nonjudgmental acceptance and empathy from the other (Greenberg & Goldman, 2008). These discriminations also influence pathways to healthy interaction, and whether to promote self-soothing or other-soothing. For example, at times, helping partners learn to tolerate and regulate their own fear and shame rather than being controlling and/or flying into a rage to regulate self-esteem and maintain identity, is an important goal of couple therapy.

**ATTRACTION AND LIKING**

The third motivational system, attraction and liking, also needs to be considered when promoting emotional bonding in couples. The positive feelings that are generated when partners are interested in, like, and feel attracted to each other are important in the maintenance of intimate bonds. This is supported by research by Gottman (2011) on the fondness and admiration system. Feeling excited by and enjoying each other help couples stay together. Being reminded of feelings of attraction and liking, feeling warmth and appreciation and cherishing and valuing the other as other, leads, in our view, to both pleasure in and compassion. Engaging in activities that stimulate these feelings builds a storehouse of positive feelings that act as an antidote to negative conflicts when they arise in future. Without positive feelings, a relationship may be functional, but it will not flourish and therefore may not last. We thus emphasize this third motivational system and the related set of feelings of excitement and joy and liking as important ingredients of what makes relationships work (Greenberg & Goldman, 2008).

**EMOTION IN INTERACTIVE CYCLES IN COUPLE THERAPY**

Negative interaction cycles arise when core identity and attachment needs are not met. However, it is emotion that organizes cycles. Emotions organize both the self and interactions with others. Members in a family are highly connected to each other through this emotion system. They read each other’s emotional signals with great care and this reading guides their interactions. The amygdala, at the core of the emotional brain, has been shown to be particularly attentive and reactive to subliminal facial expressions of fear and anger, indicating how automatically and rapidly people react to facial expressions of emotion (Schupp, Ohman, Junghofer, Weike, & Stockburger, 2004).

Emotions influence interactions in various ways. They change the interaction by changing the self. In anger, for example, the individual transforms by swelling up and thrusting forward, and is both physiologically and cognitively organized to attack or defend. The
action tendency organizes the person to thrust forward or alternately to flee, thereby changing the person’s relationship with the environment. The emotional organization plus the facial expression of anger in addition signals angry intent to the other. Emotion thus is our primary signaling system and influences interaction by nonverbal communication. Affective expression is a crucial form of communication that regulates self and other.

Given that relational conflict most often results from unexpressed hurt feelings and unmet needs related to security and identity, it is important to help partners deal with their own and their partner’s emotions and related needs. Simply helping partners get in touch with or express any feeling will not lead to a resolution of conflict because not all emotions serve the same function. It is important to distinguish between different types of emotions, and understand which emotions need to be acknowledged and expressed, which need to be bypassed, contained, or soothed, which need to be explored, and which need to be transformed to resolve conflict. Our approach to treatment is based on the idea that some emotions are adaptive and some are maladaptive. As other writings have made clear, we distinguish between different types of emotion; primary, secondary, and instrumental as well as between adaptive and maladaptive emotions (Elliott et al., 2004; Goldman & Greenberg, 2006; Greenberg, 2002; Greenberg, Rice, & Elliott, 1993; Greenberg & Safran, 1987). Maladaptive emotions were once adaptive in earlier environments (i.e., fear in response to an abusive parent), but are no longer adaptive (i.e., fear in response to a loving partner). In current life, maladaptive emotional states are indicated by intense and escalating interactions. Such states lead the partners to say and do things that later are seen as not representative or ‘real,’ or as them having gone “a bit crazy.” Once in them people may begin to yell at each other rather than speak to each other, or they may cut off and not listen. They probably have repeated these fights before, resolved them, and forgiven each other many times, only to have it happen again. They can even see it coming, but once they enter these unhealthy emotional states of threat, violation, or humiliation, they are transformed into their other maladaptive selves.

Fear and shame are the core maladaptive emotions that accompany invalidation of core needs. However, couples in therapy are more likely to express rapid-acting anger and anxiety-based withdrawal. The work of therapy then is to identify the negative rigidified interactional cycles and the core underlying emotions embedded within them, so that both can be transformed.

Stage model

Greenberg and Johnson (1986a,b, 1988) laid out nine steps of treatment of EFT-C that were subsequently organized by Johnson (1996) and Johnson (2004) into three stages of negative cycle de-escalation, restructuring the negative interaction, and consolidation and integration. We present here an expanded five-stage framework of EFT-C which is in line with our incorporation of a stronger self-focus. It includes additional steps that focus on each partner’s intrapsychic emotional process. This is a summary of the five-stage model. For a more detailed description of the 14 steps, please refer to Greenberg and Goldman (2008).

STAGE ONE: VALIDATION AND ALLIANCE FORMATION

The most important initial goal of the first stage is establishing safety and a collaborative alliance. The empathic relationship allows clients to feel safe enough later to reveal their vulnerabilities and their position/role in the cycle. Validation of feelings and needs by the therapist helps calm each partner’s anxiety and the empathic understanding by the therapist of each partner’s emotional pain, to some degree, soothes the hurt of not being heard by the partner.
STAGE TWO: NEGATIVE CYCLE DE-ESCALATION

The therapist in this stage relationalizes the couple’s presenting problems in terms of the cycle, thereby identifying the cycle as the problem rather than the partners. Once the cycle is identified, the therapist begins to focus on helping the partners label their underlying emotions and most importantly to identify and explore the underlying core sensitivities that are being activated in the cycle. The therapist also explores to see if there are some important psychogenetic origins of the wound. Getting a sense of partners’ families of origin stories helps to identify interacting sensitivities or vulnerabilities (Scheinikman & Fishbane, 2004). If the sensitivity is not from family of origin it may come from previous relationships or life experiences. These sensitivities are not viewed as pathological, but as understandable vulnerabilities and are still seen as current adult unmet needs.

STAGE THREE: ACCESSING UNDERLYING VULNERABLE FEELINGS

This stage emphasizes the actual experiencing and revealing of the underlying emotions. It is important to note that it is the display of vulnerable emotion that is so important in changing interaction. Seeing the face of each other evokes experience; we are impacted by the ways others face us. How we imagine the face of the other also is important in how we feel and what we do even without the other present. The face, however, is an ambiguous text open to interpretation and so how we react to others also is subject to interpretation. In therapy, we also want each partner to express in words what they feel in such a way that there is no doubt about what is being felt, so that it is not misinterpreted.

An important skill that an EFT-C therapist must learn, to help partners access underlying vulnerable emotions, is how to identify blocks to, and interruptions of, underlying feelings and how to help partners overcome these blocks. If the couple is ever to move beyond “talking about” their feelings to true “revealing,” they have to feel safe enough with both the partner and therapist to overcome their usual avoidance of their core more vulnerable feelings and their fear of revealing them. One of the main methods for dealing with interruptions and avoidances is to understand and validate their protective function. Using the metaphor of “a wall of protection” is often useful here. Therapist operations that are helpful in overcoming blocks to revealing, especially when an injury or betrayal has occurred, or when there is a lot of distrust and vulnerability in one partner, are Reaching in and speaking for (Wile, 2002) and Focusing on the fear of opening. Here, the therapist needs to make explicit what is being protected and what is not being said, and say it for the partner. The therapist needs to reach in and pull out the underlying vulnerability. This is reminiscent of Virginia Satir’s (1967) sculpting method of teaching, where she would have someone act as the vulnerable child part of the person and she would pull it out through the person’s legs.

STAGE FOUR: RESTRUCTURING THE NEGATIVE INTERACTION AND THE SELF

This stage emphasizes the enactment of new ways of being with each other. In restructuring the interaction, it is the partners’ acceptance of the expressed vulnerable underlying feelings that is paramount and it is this that sets up a new interaction. When one partner has nonblamingly revealed a primary feeling about an identity vulnerability or an attachment insecurity and the listening partner is unable to respond with validation or caring, attention needs to be turned to what is blocking more bonding and validating responses from the listening partner. This is usually a 2-step process. Working with the blocked partner, the therapist helps the client identify and acknowledge that there is a block, which in turn allows the therapist to “hold” and contain the vulnerable partner.
while exploring what may be blocking him or her from responding more acceptingly and compassionately to a revealed vulnerability. Once acceptance has been achieved, the expression of and response to heartfelt needs is promoted. This is often expressed in an enactment in which the partners turn toward each other and express and respond to each other’s feelings and needs. These expressions result in a change in interaction. This is also one of the points at which the promotion of positive interaction to promote closeness and validation is emphasized.

Once partners are more accessible and responsive and interactions have been altered to ensure enduring change, individuals also may need to develop their own capacities to *self-soothe* and to *transform their own maladaptive emotional responses*. These often are responses to unmet childhood needs or past trauma, rather than to the partner’s lack of responsiveness. The capacity to self-soothe also is important when the partner cannot be emotionally available or responsive. Often with less dysregulated couples, restructuring the interaction involves first developing more responsiveness to each other. With more dysregulated couples, the work of restructuring will often first require helping partners at an earlier stage of the treatment to self-soothe when they become highly dysregulated in response to the other’s nonresponsiveness or unavailability. At this point, helping partners transform their own responses, which often are based more on unmet childhood needs than on the current context, is also helpful. The focus on self-regulation of emotion, be it an early step for more extreme behaviors, or a later step to facilitate self-change and more enduring interactional change by focusing on transforming emotional responses based on childhood unmet needs, involves helping people to tolerate their own painful emotions, soothe them, and make sense of them. Emotions can be used for constructive action and interaction rather than hold their partner responsible for their feelings.

**STAGE 5: CONSOLIDATION AND INTEGRATION**

This final stage embodies the behavioral and narrative focused work of therapy. Both interactional change and new narratives are supported. Partners are asked to reflect on what is different now. The therapist encourages the articulation of a new narrative of the relationship and of each partner’s self by eliciting examples of their personal and relational growth. This is another point in therapy at which positive feelings are a focus and their expression is encouraged. Discussion centers upon developing strategies for undoing negative cycles through the expression of underlying feeling and needs. The couple also is asked to practice new behaviors involved in their positive cycles and to identify what they could each “choose to do” to precipitate the *negative cycle* if they wanted to return to a more dysfunctional way of relating. This gives them a sense of their own role and responsibility in, and control of, their negative interactions. In addition, the new ability to take a “self” focus rather than an “other” focus is emphasized and practiced.

**WORKING WITH IDENTITY AND DOMINANCE: SANDY AND RON**

This is a couple with whom the therapist had a long-standing therapeutic relationship, a strong alliance, and good empathic rapport. Both were Caucasian and in their late thirties. This was the third period the therapist had seen the couple over 10 years. The two prior periods had each been about 12 sessions and occurred 2–3 years apart. Previously, they had identified a negative emotional interactional cycle that was more centered upon attachment needs, where Sandy most typically pursued for closeness, and upon feeling rejected became angry and critical. In turn, Ron, her husband, typically distanced, becoming emotionally withdrawn and unavailable, but also somewhat passive–aggressively
critical of her. The following excerpt will focus on an identity/invalidation cycle. Therapy had helped them identify that her core vulnerability was in relation to feeling rejected and alone and that his was to feeling inadequate and unworthy. The therapist had last seen this couple 5 years prior, but they had recently called back seeking further treatment because Ron was feeling suicidal. At this time, Sandy expressed a great deal of concern and worry that Ron was emotionally inaccessible and depressed. The therapist chose to meet first with each of them alone. When the therapist met with the husband, he disclosed that he had been feeling quite distressed and unhappy. As they talked, he began to express how trapped he felt in his marriage, and expressed this through passive suicidal ideation. He described an event where he had fantasized about driving his car into oncoming traffic. In the individual session, the therapist conducted a brief suicide assessment and determined that Ron was not actively suicidal. He had no plans to take his own life, but rather was expressing his unhappiness. They thus proceeded with couple therapy to address the issues between them. The following excerpt occurs about 20 minutes into the first conjoint session in this third period of therapy.

T and so that’s in both your hands, on the one hand, it’s, I mean it would be great if you (Ron) wouldn’t withdraw and would stand up but somehow, repeatedly, you don’t—and it seems there is something in your relationship, that makes it difficult for you. You used the word to push back and then Sandy is saying she does compromise and negotiate, she does try to please—but you either, lose sight of that, don’t agree with her or,

S or he discounts what I do, in his head...I don’t need much, just some appreciation, and recognition

R things are dynamic in the sense that—there are times when, I have gone to Sandy with, something and she’s been—open to listening to me, and then there are times when she hasn’t been, so—it just; maybe it depends on her mood

T but it is like ‘I’m so afraid—of if I come to you, you’ll blow up? and therefore I end up feeling like it’s not worth it if I start coming to you with what’s upsetting me,’ or—

R well, I guess what happens is I don’t recognize it but it’s still there—um, or by the time I do—something else has happened now, I guess and then it’s built up again, or—I—I don’t know, I forget about it, I don’t do anything about it, I haven’t brought it up and—she doesn’t know anything about it

T so somehow we are focused on you, Ron, as a big part of the problem, and I am wondering what your part in this might be, Sandy....

S well I do have a part in it in some way, obviously. Whether it’s his perception of my behavior, there is some part of me that must keep it going, you talked about how I intimidate you or how I—you don’t feel close to me all the time, there’s—is

R (deep sigh)

T so, Ron, it’s like when she’s vulnerable and it is really hard for you to be vulnerable, Sandy—as we talked about you know, as a function of your mother but that Ron, you respond—better to, or feel closer—not when she is sort of all destroyed, or weak but, if she’s actually—letting you in, and you don’t often feel that
R I guess that is true when I’m close to her, recently, is when I see that there’s a certain amount of turmoil.

T right—and how do you normally see her then?

R I don’t normally see her like that. I normally see her as—going around, and doing stuff around the house and—look out, here I come and—don’t get in my way and—um

S huh, you make me sound like WWF wrestling, babe

T (laughs)

R well—maybe that’s how it is sometimes, I mean you run the household, and it’s, like—and I feel like I got to just get out of your way a little bit, because—like when I try to make a decision about what’s going be done, you’ll undermine me.

S—not always normally its just when you want to give them sugar (laughs)—before bed time (laughs & makes irritated, angry noise)—but

R (laughs)

T wait wait let’s just look at what happened—he makes the complaint X, you wittily, humorously, diffuse it. You laugh...

S yeah, yeah

R (deep sigh) you’ve quickly discounted what I’ve said

S but do I always have to agree with all of your decisions?

At the beginning of this excerpt, they talk about how they fall into a pattern where she feels alone and he withdraws. They discuss how it would be ideal if she could feel more recognized and he could stand up to her. Ron talks about the difference between times he does and does not feel comfortable approaching Sandy. They identify that he does not always realize when he is upset, perhaps minimizes his response, ends up withdrawing, but bottles up resentment. They also clarify that when she is more vulnerable, he feels more comfortable to approach her. This prompts the therapist to ask how he normally perceives her and he gives a characterization that portrays her as quite dominant. She reacts to this wittily, but in a somewhat hurt tone, saying he makes her “sound like WWF wrestling babe” and then proceeds to discount his response. When he questions her response, she quips back defensively saying “do I always have to agree with your decisions?” In our observation of partners who generally take the more dominant role in the couple, we find that they often demonstrate this type of quick ability (often faster than their partners) to come back with undermining retorts such as this—often attributing the “controlling behavior” to the other. Again we want to emphasize that we see this behavior as present across gender lines, although perhaps expressed differently by men and women. In this role, women may more typically be seen as “bossy” or “nagging” while men may be seen as “over-controlling” or “rigid.” In general, we strongly convey a nonjudgmental stance toward the behavior, simply naming it without using pejorative language. We understand this type of response largely as an attempt to define reality and are more curious about how it is used to cover or not allow vulnerability. With this understanding, the therapist will want to make sure to explore the underlying vulnerability; however, it is often first necessary to help both partners become aware of the dominant partner’s behavior or style. Understanding the function of the dominant behavioral strategy and accessing and exploring the underlying vulnerability are both important in leading to
more enduring structural as well as momentary emotional change in the interaction. Accessing vulnerability without helping increase awareness of dominant behavioral strategic attempts will sometimes produce structural change; however, this often is not enough. In the above example, after allowing them to continue a few minutes, the therapist makes sure to maintain the alliance with Sandy by looking at her with concern, and, using a caring voice, intervenes to help them become aware of how Sandy continuously strives to gain the upper hand, without turning inward to look at her role or responsibility.

so let’s look at what has happened here...

I’m thinking ‘oh, okay, here we go again’ we’re+ out of here. you’ve quickly discounted what I’ve said (note: here he asserts himself. This is a novel behavior that has been encouraged in the prior individual session and nonverbally reinforced by the therapist, who has glanced over at him for a response)

but whenever you make a decision around the house, I discount it—well, is it that you want me to always agree with your decisions? (again she attempts to counter define)

no but—that’s what you’re saying that you kind of laugh and what happened right now

I deflected it...yeah, I did to a degree—yeah

and look what just happened now also, the same pattern, but now not with humour. But again you took charge, of the conversation (Sandy is intermittently sighing and laughing) you kind of questioned him, as a lawyer for the prosecution, right, he began to have to defend his statement, he became, more cautious. I mean you are more (identifies her role)

my personality is more -

dominant

dominant

right—for lack of a better word, right

yep, that’s the WWF (laughs) I think he sees, in me I guess (acknowledges)

you see I think this is the more sort of subtle, more -

that’s why he likes, or feels closer to the, more vulnerable

because I’m not—feeling like I’m being +dominated, my personality becomes very, dominated—I begin feeling kind of subservient

and overshadowed as-

overshadowed

(deep breath)

and: yeah—nobody does I’m sure so—at some level I guess I start to get angry because I can’t seem to do anything about it (identifies his experience)

okay well that part I do understand

I: I feel that way
R and it’s really like, well I’m just like no good, I-, you know—and I kind of feel that,

S (very deep sigh)

They have both gained a new view and of each other as well as awareness of the cycle by which she feels hurt, and jumps quickly to a more dominant style to hide her vulnerability leaving him to feel “dominated,” overshadowed, and powerless. Again the therapist sets them on a course, helping them to be aware of this cycle, but exploring further their underlying primary (maladaptive) emotions, so that they can work toward changing the problematic cycle:

T and it’s not something you can just change, right, but I mean it’s something that you both have to work with, because you are more active Sandy, right. you’re not as verbal, Ron,—I don’t know, I mean then you end up, being quite hurtful to her with your criticisms and it’s your way of eventually, giving voice to some of this, aggression

R yeah

T and it involves both of you—in couples there’s usually one who’s more—dominant, more controlling, quicker, faster there’s one who’s more—withdrawn so I mean it’s like you got to negotiate but you both got to be very clear (conducting experiential teaching)

Sandy then asks:

S so do I consciously, shut my mouth and let him finish? Because in the house that I grew up in, everybody talked at the top of their lungs and a mile-a-minute and it was like to be heard you always had to (snaps 4x) jump in and say what you needed to say or you didn’t get heard.

To answer this, the therapist takes them back:

T when you said ‘do I always have to agree with you?’ you actually feel, wrongly or unfairly criticized—then, you come back with a defense, which is an attack, actually, you say, “do I always have to agree with you” very quickly, but actually you must be feeling wronged, or hurt, I think, when he says “you’re not doing this”

S it does, it’s a whole 16 years of criticism

T right—built on top of a mother of criticism (refers to the family of origin antecedents)

S that’s why I have a lonely child inside (referring to vulnerable feelings of self-from early couple therapy; she was identified as having a lonely child and he a frightened child)

The client has begun to access the underlying maladaptive emotions that can be sourced back to her childhood self, trying to defend against her mother and fight for her own identity. The therapist helps her experience how this part of her is enacted and operates in her relationship. He then conjectures about the primary emotion underneath and she connects this back to her relationship with her mother and re-experiences the feelings of shame that were evoked by her mother’s invalidation. From an emotion-focused perspective, it is this re-experiencing of past painful emotion in relation to her mother and then feeling new emotions in response to her mother’s shaming, such as empowered anger at the violation, sadness of grief at the loss of what she had needed, and compassion for her childhood
pain that leads to a new self organization. Awareness and recognition that emerges from this type of self-organizing process is much more meaningful coming from the client rather than being offered only by the therapist. She goes on to explore her hurt of invalidation by her mother and the therapist facilitates the further exploration:

T but a, a lonely street kid, who comes back as a legal street kid who is always going to protect herself, somehow, your speed like this (snaps fingers 4 times) is leading him to—feel, submissive to your dominance somehow, underneath your very active dominant, person, is someone else who is actually feeling hurt, misunderstood, but that’s not what comes out, where you sort of, put him on the defense, and then he withdraws, right

S this is all a repeat with my relationship with my mother, really very much so, cause she always criticized me, terribly and I would—have to go on the defense to protect myself so I guess that reflex is there (snaps fingers) whenever I feel he’s—criticizing me, the little voice inside me goes, “no you’re okay, defend yourself” cause I had to with my mother she was just a force to be reckoned with—(laughs) you, you couldn’t be mealy mouthed around her

T and with apologies to Ron, I mean he’s telling you, he’s very unhappy, he wants to leave, he can’t take you. That hurts like hell

S I’m not going to cry today (laughs, and begins to cry)

T because?

S (deep breath) it’s just—been a lifetime of hurt—people—(sad voice) basically telling me I’m no good that’s what I figure, my mother—for years and years you know telling me ‘1 day you’ll have a daughter as different from you as you are from me and then you’ll understand’ (deep breath) well, I was different, but what was wrong with being different? (identifies core identity injury)

T I want to be accepted and validated just for me

S it was always conditions, with my mother, same thing, had to jump through hoops, had to meet her guidelines in order to be loved. Love was withheld, unless I was, what she saw as her perfect daughter and it’s kind of replicated itself in a way (here we see it wasn’t closeness or security on the affiliation interactional dimension needed from the mother but acceptance and validation on the influence interactional dimension)

They have begun to explore her maladaptive feelings of worthlessness and the sense that she was not good enough, and her subsequent loneliness and feeling of being unloved. The therapist is encouraging her to share her core vulnerability with her partner, asking her to turn to him and talk to him about this feeling (stage four of model). In attempting to do so, she hits upon her pathogenic belief that she is “too much” for him and cannot be loved as she is. They address this:

T right, so actually, you need to be able to show him, how much it hurts—how much you hurt

S (deep sigh)—I don’t know if he can handle it (laughs)

T if he can handle me?

S yeah

T    uh-hmm—can you—look at him, I mean it's a very tough place, right, to feel I
don't think you can handle me but really, inside, it's like I really need you to,
I want you, to love and accept me as I am (empathic conjecture)

S    yes! doesn't, everyone want that?

T    yeah, yeah, and I want you to still be able to hold my vulnerable part and not
criticize and the paradox (laughs) he's sort of saying when you are vulnerable
I can hold you

R    when she's in that state, that vulnerable state, I can also feel that I can talk to
her about, what's bothering me without her attacking me, she seems
accessible.

Later in the session, they come back to the issue of her feeling unworthy as she is and he
only loving her when she is vulnerable. The therapist says:

T    It just strikes me as a paradox of, this idea that he hates your protective wall
and you're doing that to protect you, and it's ending up getting the very thing
that you least want, you know, but I mean this is the dilemma but he has to
understand, that underneath, there's a very vulnerable you, and the proof of
that is how much you try to please him

S    uh-hmm—well it, it would be a lot easier if I didn't love him so much—
(laughs) but I keep trying

T    yeah and you know, seeing that vulnerability and remembering that it's
there, even if she puts up a fight, you need to remember that behind the wall
is a vulnerable child who really needs to be validated

S    yeah

Toward the end of the session, Sandy puts all the pieces together:

S    I know what the pattern is—I think: when he wants to talk to me, my first
reaction is 'huh?!' (drawing in breath) he's going to criticize me again or
something he doesn’t like or he's going to want to change another part of me,
and I just “whoop” (snaps finger) that wall goes up, he's going to hurt
me, again. It's a reflex mode, it's so easy to bamboozle him. It's survival for
me, I've learned it with my mother, I had to do it, I grew up in a family that
said 'Sandy, you'd be a great lawyer.' It's funny you used that analogy
because I'm just so quick and I know it, I get his head spinning, it's just
(weak voice) because I'm so afraid he's going to hurt me.

In this session, Sandy acknowledges how her underlying fears and vulnerabilities lead
her to engage in behavior that is survival based, self-protection that can be traced to her
relationship with her mother. Unfortunately, this survival tactic served to push her hus-
band away, leaving her feeling lonely. This was a pivotal session for this couple, as they
were able to address how her dominant behavior was activating a core sense of inadequacy
in her husband, leading him to either withdraw or become passive–aggressive. By connect-
ning her dominant style of relating to her underlying inadequacy and needs for recognition
and validation, they were able to address these core issues and even encourage her to
reveal her underlying needs to her husband, thereby moving toward healing original
wounds that sprang up in her earlier relationship with her mother. In future sessions,
Sandy was more able to directly access her core vulnerabilities while Ron, no longer pas-
sively suicidal or depressed, felt much closer to Sandy and more able to assert his needs
when necessary.
Self-soothing to address identity wounds: Diane and Eric

Recent developments in EFT-C, involving further discriminations between attachment and identity-related concerns, have led us to import into the EFT-C treatment model a technique used in EFT with individuals, called self-soothing. Self-soothing is seen as complementing other-soothing and a necessary capacity associated with overall healthy emotion regulation in people (Goldman & Fox, 2010; Goldman, 2012; Greenberg, 2010). We adopt a one-factor theory of emotion regulation wherein regulation is seen as taking place simultaneously with the generation of the emotion (Campos, Frankel, & Camras, 2004). This is in contrast to a two-factor theory of emotion regulation that sees regulation as involving a different set of processes coming after emotion is elicited and involving the more deliberate management of the generated emotion.

In EFT-C, self-soothing is aimed not at too much disruptive emotion or the wrong type of emotion, but rather the goal is to have the desired emotion at adaptive levels at the right time. We recognize that at times it is necessary to work with dysregulated emotional arousal to help people develop a working distance from an emotion, rather than intensify it and this is often necessary at an earlier stage of therapy. This is a different process, however, and involves more deliberate cognitive approaches and direct relaxation techniques (McMain, Korman, & Dimeff, 2001), such as cognitive reappraisal and meditation helpful in regulating arousal (i.e., counting to 10 when angry, taking a hot bath to distract when distressed). The type of self-soothing we are promoting at this later stage, however, involves an automatic, internal process of being able to comfort, soothe, and calm oneself, particularly in the face of emotional injury.

In couple therapy, the capacity for self-soothing becomes especially important when partners are unavailable (Greenberg & Goldman, 2008). In addition, in our observations of psychotherapeutic work with couples, we have found that problems or difficulties that can be traced to core identity concerns such as needs for validation or a sense of worth are often best healed through therapeutic methods directed toward the self rather than to the interactions. For example, if a person’s core emotion is one of shame and they feel “rotten at the core” or “simply fundamentally flawed,” soothing or reassuring from one’s partner, while helpful, will not ultimately solve the problem, lead to structural emotional change, or alter the view of oneself. In other words, hearing that one’s partner will not leave if one chooses to reveal shame about the self may feel comforting, but will not lead to healing of the shame itself. On the other hand, emotional changes made within the self, such as transforming the shame by accessing a sense of pride and self-confidence that are then witnessed and supported by a partner, can lead to a sustained change in one’s view of oneself. This type of change, in turn, feeds back into the relationship as one has a more positive view of self and is seen in a new way by one’s partner.

The self-soothing task itself is initiated in therapy when there is a verbal indication that one partner is struggling with issues of self-worth and is struggling due to an inability to feel compassion toward one’s wounded self. Reassurance from the partner has not been met with an increased sense of self-worth. This difficulty is also accompanied by a sense of pain and despair, and statements indicating that the person feels there is little hope of this changing. In EFT for individuals, the therapist would bring out a chair to facilitate emotional deepening, but given the logistical complications this might present with couples, the therapist will rather put out a hand to represent an ‘other’ aspect of self and ask the person to direct expression toward it. The ‘other’ part of self is best represented as a small, often vulnerable, child. The therapist will ask the person to assume the role of an adult caregiver version of themself, and express compassion toward the small child. The therapist will then ask the person to assume, in imagination, the position of the small child and express the experience of being soothed. The therapist will validate and

underline the importance of the needs (previously unmet) of the small child and reflect and validate positive, internalized feelings that result from the task. This method is different than self-soothing used in Dialectical-Behavior Therapy, which is designed to help people regulate intolerable affect that can lead to self-cutting and suicide attempts, and which often involves more deliberate cognitive and behavioral procedures such as cognitive modification and mindfulness meditation (Linehan, 1993). It is more similar to task-directed imagery used in object-relations approaches (Meier & Boivin, 2011), but does not assume that the ‘other’ is necessarily an internalized parental object, but rather another aspect of self.

The following excerpt from a therapy session illustrates a method of working to promote self-soothing in the context of a couple therapy at a later stage of therapy. Diane and Eric had been in EFT couples therapy on a semi-regular basis for the past 18 months. Both were Caucasian, in their early sixties, and together they had two children, both in their late twenties. The fundamental maladaptive cycle that they typically engaged when in conflict was one where she pursued for closeness and connection, often felt rebuffed, and then became angry and critical. This would lead to him feeling scolded, and to either withdraw and seek validation elsewhere or become angry and sullen. Historically, his mother had been demanding and critical, holding him to very high standards as a first-born son. In turn, he had responded very positively by complying and becoming a highly achieved professional. It was only later in life, once he felt successful in his career and his children had become more independent, that he questioned his career choices and life path. He felt that the choices he had made were largely designed to please his mother and live up to standards she had created for him. He held a great deal of resentment toward her. At the same time he felt it incongruent to be angry and tended to “stuff” his feelings. He was also highly self-critical and continuously questioned his worth, particularly when he and Diane became embroiled in conflict. A great deal of couple repair work had been done prior to this session and they had both been able to share many underlying fears and vulnerabilities. He in particular would get stuck, however, when it came to self-validation. Even when Diane was open and validating with him, it was difficult for him to absorb and internalize it. Together with the therapist, they had identified that his harsh self-criticism was a difficult stumbling block. Just prior to this session, Eric had undergone an ear surgery and was struggling with feelings of vulnerability relating to feeling weakened. For her part, Diane was vocal about feeling more isolated from him than usual, as she felt he had chosen not to share his more vulnerable feelings with her.

At this point in the session, he is talking about being more aware of and allowing vulnerability. It is important to note that the therapist and client had developed a previous narrative where he had talked about a younger, more vulnerable himself. He had described a specific autobiographical memory from primary school, where he had entered a contest and won a medal, but had chosen not to accept it, giving it up to another girl in the class. He had regretted doing so afterward, had always remembered this event, puzzled as to why he had relinquished it. It is the therapist who first invokes the “little boy”:

\[
\begin{align*}
T & \quad \text{What about this little boy?} \\
E & \quad \text{He is such a cute, cute boy.} \\
T & \quad \text{If this little boy were sitting right here, what would you say to him? (therapist holding out hand 5 feet in front of client to indicate that he should direct his expression toward it. Note: It is important that the therapist hold out a hand or use some sort of prop to aid the client in actually entering the experience in imagination. This will help deepen the emotion.)}
\end{align*}
\]
I have not seen you for so long, it is so nice to see you (stops 5 seconds, looks out and turns to therapist). He was a nice boy. He loved everybody.

He was a really loving little boy (therapist deepening with expression of empathy). Tell him.

You are a very nice boy, very playful. Very good little boy. He was good to everybody.

yeah, can you say that again (therapist heightening the emotional experience by asking him to repeat)?

You were a very good little boy.

And if you were the little boy now, if you could be the little boy. If he were here now, what did he need? (therapist puts out her hand out again) What would he say? What does he feel when he hears you talk about how good he was? (Note: It is important for the client to actually change positions, even in imagination, to access the experience of the little boy)

He would say that makes me feel really good. It is nice to hear that. (Nodding, tears beginning to form.) And he would give me a hug. He deserves to be loved.

He would give you a hug and it would feel really good. So this seems like what the little boy really needs. He likes being hugged and taking a hug, and feeling he deserves the hug. He has needed to know he is a good little boy. (Here the therapist emphasizes the needs of the boy as this is seen as important in both deepening emotion and eventually helping to access alternative, positive emotions)

yup (slapping hands on his knee and drawing in breath).

And then there is this sadness that comes. It's like this is what I have always needed (therapist reaching in, empathically conjecturing, and speaking for the client).

Yeah, and it wasn’t always there, as we have discussed (crying) that little boy missed a lot.

He didn’t get much of that and he missed it over a lot of years (empathic deepening).

Yeah he never got it. Not for a long time.

Yeah he never did. He never heard that he was good, ever (empathic validation).

He was a very little vulnerable boy. He was a very fragile boy...nodding...

and he needed a lot of comfort (validation of needs).

and he needed the medal.

yeah the medal.

to know that he had value and worth.

it was so hard for him to ask.
He turned it down cause he thought he didn’t deserve it, that is the way I see it. He denied his worth and gave it away because he wanted someone else to have that recognition.

So you are saying he really wanted the recognition given by the medal, but he didn’t feel he deserved it.

I have never gotten over that.

And now hearing you are a good boy, as the 6-year-old boy, what do you feel hearing that you really deserved the medal?

Well I am kind of over it now. But I have never really thought about it like that. Now I have sort of connected the dots. I always remembered the story but it didn’t really mean anything but now I understand. I have a whole new perspective on it.

And now it means a lot and you have a sense of where it comes from, more from that vulnerable boy and you can really access the warmth and sadness for the boy.

I can feel that I can really relate to that little boy. That is me. Let’s face it. It is who I am. I wish I could see him right now. Cute little cowboy outfit. I am going to bring you a picture.

And now it means a lot and you have a sense of where it comes from, more from that vulnerable boy and you can really access the warmth and sadness for the boy.

I can feel that I can really relate to that little boy. That is me. Let’s face it. It is who I am. I wish I could see him right now. Cute little cowboy outfit. I am going to bring you a picture.

Yes, please bring me one. What is like for you, Diane, when you hear this?

Oh, it is wonderful! And the energy he has for the boy....

Yeah and the affection he has for the boy. how does that touch you?

Well, foremost what hits me is just the sadness that is there, and being able to access it. I also feel the joy he has for the little boy, and being able to provide him with what he needs.

Yes, so you are saying I feel very accepting of the little boy and I feel a lot of affection for him and I want to take care of him.

Absolutely (smiling at one another. She is looking at him in a nurturing way).

In this process, the therapist guides Eric toward exploration and acceptance of his sadness, but also enthusiastically recognizes the joy and affection he has for the internalized boy. Eric is able to accept and validate his own need for recognition and thereby self-soothe, providing self-validation. Through the emotional exploration, Eric is now able to connect and make meaning from this experience. He now begins to experience himself in a new way and understands (“connects the dots”) rather than puzzles over the persistence and significance of the memory. In the end, the therapist brings Diane back into the picture and she astutely observes that he has been able to access sadness, but also joy and affection for the boy. She is clearly attuned and connected to him throughout and after this process. His wife expresses her concern for him and validates his worth. He for the first time has been self-affirming and leaves the session feeling strong and worthwhile.

CONCLUSION

This paper has outlined developments and advances that have been made in Emotion-Focused Therapy for Couples (EFT-C). Affect regulation is seen as a key motive that deter-
mines the core processes of attachment and identity. The further discrimination of both attachment and identity as related, but distinct, underlying core processes has implications for both conceptualization and the choice of intervention by the therapist. The method of self-soothing has been outlined and elaborated as helpful in engendering emotion regulation in individuals, which in turn can help couples repair and change. Specifically, issues of power and dominance require specific therapeutic interventions aimed at identifying dominant behavior and working with underlying vulnerability. Similarly, self-soothing has been illustrated as a useful technique to be integrated into therapy as a means of helping people who have suffered emotional injuries to their identity to heal and develop the capacity for emotion regulation. This can ultimately help couples build stronger selves and more solid bonds.

REFERENCES


