Final published version: Elliott, R., & Macdonald, J. (2020). Relational Dialogue in Emotion Focused Therapy. *Journal of Clinical Psychology: In Session, 77(2)*, 414-428. ©2020, Wiley.

Relational Dialogue in Emotion Focused Therapy

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Abstract

Objectives: In Emotion-Focused Therapy (EFT) (Elliott et al., 2004) relational processes between the therapist and client are not normally an explicit focus unless therapist and client encounter difficulties that interfere with therapeutic work. When this does happen, however, relational dialogue (including meta-communication) becomes necessary. We present the principles and stages of the EFT task *Relational Dialogue for Alliance Difficulties.*
Method & Results: After describing this little-known task, we illustrate its application in the successful treatment of a severely socially anxious female client with complex trauma and emotional fragility. Using transcripts and detailed descriptions we highlight the alliance difficulty marker subtype, relational dialogue principles and the stages of EFT alliance difficulty work.
Conclusion: The EFT Relational Dialogue task is likely to be particularly important with clients similar to the one presented here but requires more research to test and refine it.

Keywords: emotion-focused therapy, alliance difficulties, therapeutic relationship, social anxiety

Relational Dialogue in Emotion Focused Therapy

Emotion Focused Therapy (EFT) is a relational therapy in which therapists seek to provide the Rogerian conditions of empathic attunement, unconditional positive regard and congruence or genuineness (Rogers, 1957). Relating to clients in this way is considered one of the main processes of therapeutic change in its own right because it provides a corrective emotional experience, and helps clients internalize a caring, understanding self-relationship (Greenberg & Elliott 2012; Greenberg, Rice & Elliott, 1993). Additionally, genuine therapist empathy and prizing are seen as creating the interpersonal safety needed for clients to explore, deepen and transform painful emotions using a variety of different ways of working (referred to as "tasks") (Greenberg et al., 1993; Rice 1983).

The six basic treatment principles of EFT mirror these two interconnected functions of the therapeutic relationship. The first three concern the relational quality of therapy: 1) *Empathically enter and track the client's immediate and evolving experience;* 2) *Communicate genuine empathy, caring, and presence to the client;* and 3) *Facilitate collaborative involvement in the goals and tasks of therapy* (Elliott, Watson, Goldman & Greenberg, 2004). These relational strategies underpin and enable therapist guided experiential tasks such as two chair work with a self-interruptive or self-critical internal process. The three principles concerning work with tasks have evolved somewhat over time: 4) *Attend carefully and responsively to different important client processes (i.e., task markers, steps within tasks, and ways of processing emotions);* 5) *help clients use key therapeutic tasks to move themselves from stuck to productive emotions through an emotional deepening process,* and 6) *Foster client growth, empowerment and choice* (Elliott & Greenberg, in press). Thus, in EFT, the therapist pays particular attention to creating empathic attunement and relational safety and collaboration (using the relational principles) so that the client can focus inwardly and deepen their awareness of their own "self to self" and "self to other" processes in therapist guided therapeutic tasks (using the task principles).

The therapeutic principles reflect EFT's status as a neo-humanistic therapy which integrates the approaches of Carl Rogers' Person-Centred Therapy (1961) and Fritz Perls' Gestalt Therapy (Perls, Hefferline & Goodman, 1951) with contemporary emotion research (Greenberg & Safran, 1987). This integration evolved and continues to evolve in a culture of empirical quantitative and qualitative psychotherapy research concerning both the relational and the task elements of the therapy (Goldman, 2019).

What is a rupture from the perspective of EFT?

When the therapeutic relationship is functioning well in EFT it is in the background, enabling client and therapist to work together on the client's difficulties. From an attachment perspective, this is somewhat analogous to the way in which a securely attached infant, knowing they have a safe base, can be more curious and confident about investigating their surroundings (Farber & Metzger, 2009). Clinical literature on the relationship in EFT has largely concentrated on the skills and qualities required to establish a secure therapeutic relationship based on the Rogerian relational conditions. Over time research has demonstrated that these relational qualities are robustly associated with good client outcome (Elliott, Bohart, Watson & Murphy, 2019; Farber, Suzuki & Lynch, 2019; Kolden et al., 2019).

Elliott (2013) pointed out that Rogers' facilitative conditions for therapeutic change can be reframed as warnings about the counter-therapeutic effects of their opposites: non-empathy (e.g. misunderstanding or making inaccurate assumptions about the client), conditionality (e.g. being judgemental of the client), negative regard (e.g., disliking the client or disapproving of something about them) and a lack of genuineness (e.g. saying supportive things in an insincere manner or even with covert criticism). Research has long born out the

harmful effects of even subtle negative therapist communications of these kinds (see e.g. Strupp, 1993; Moyers & Miller, 2013, for reviews of some of this literature). Empathy, prizing and genuineness can therefore be seen as antidotes to common relational problems in therapy and so in themselves are likely to minimize the occurrence of alliance difficulties or ruptures.

Nevertheless, it is accepted that even therapists skillful in establishing empathic attunement, prizing and genuine therapeutic relationships inevitably encounter difficulties in the alliance (Elliott, 2013). This is particularly, but not exclusively, likely to be the case with clients who have suffered from extensive childhood mistreatment and abuse and whose expectations of caregivers are characterised by mistrust and fear (Elliott et al., 2004; Paivio & Pascual-Leone, 2010). Perhaps surprisingly, given the relational basis of EFT, relatively little attention has been given in EFT to the challenge of resolving tensions or alliance breakdowns once they have occurred. To date the most comprehensive coverage can be found in Elliott et al. (2004) and Elliott (2013). Our review draws heavily on these two sources.

Elliott et al. (2004) distinguished between alliance problems which occur as part of the client's socialization into a productive mode of working in EFT, and alliance problems which occur later in therapy. Early alliance formation difficulties involve problems which interfere with the process of helping clients engage productively in the baseline EFT activity of empathic exploration, which requires the client to attend to their inner experiences, explore their unclear or painful aspects, and put them into words (Elliott et al., 2004). Problems at this stage can be a result of client ambivalence about change (e.g., being at a pre-contemplation stage of change, Prochaska, DiClemente, & Norcross, 1992); divergent ideas about mental health difficulties and their treatment (e.g., believing that emotion should be avoided rather than explored); discrepant expectations of the therapeutic relationship (e.g., difficulty accepting the boundaries of therapy or difficulty with the client task of self-disclosure); the client pulling for content-directiveness by the therapist (e.g., wanting the therapist to tell them what to talk about or what to do); and problems attaining an internal focus (e.g., the client struggling to go beyond a purely external description of their difficulties that omits their inner experience, or becoming emotionally overwhelmed by painful emotions) (Elliott et al., 2004).

In general, although they may be a precursor of later alliance difficulties, early alliance formation difficulties such as those described above do not require an explicit focus on the dynamics of the therapeutic relationship. Instead they are most likely to be addressed through a combination of (a) offering specific rationales for EFT processes (termed "experiential teaching") and (b) guiding the client through experiential tasks designed to help them overcome blocks to turning their attention inward. For example, a client who does not see how paying attention to emotions can be therapeutic might be offered a brief rationale for experiential work. This could cover how emotions can indeed be problematic when, as a result of unresolved painful emotional situations in the past, our emotional responses seem to be "stuck." This might be followed by inviting the client to slow down and look inside in order to focus on implicit feelings to help unblock emotional experiencing as a source of energy, helping them find out and describe what is important (Elliott et al., 2004). Clients who are easily overwhelmed by emotion might be offered a rationale that emphasises the importance of "having our emotions rather than them having us." A client with this difficulty might also be supported to sustain an internal focus by engaging in an emotion regulating task such as *clearing a space* (Elliott et al., 2004).

In contrast to early alliance formation difficulties, later problems in the alliance often require joint exploration of the therapy relationship (Elliott et al., 2004). The EFT conceptualization of later alliance difficulties, and how they can be resolved, draws on

psychotherapy research on hindering events in psychotherapy (Elliott, 1985; Elliott et al., 1990), relationship challenges (Agnew, Harper, Shapiro & Barkham, 1994) and Safran and Muran's (2000) work on alliance ruptures. Drawing on Agnew et al. (1994) and in parallel with Safran and Muran (2000), Elliott et al. (2004) distinguish between two broad categories of "alliance difficulty marker" – *confrontation* difficulties in which the client directly challenges the therapist, and *withdrawal* difficulties in which the client disengages from the process. Elliott et al. (2004) add a third category of *therapist-specific* difficulties. In practice these categories can overlap and sometimes be intertwined in complex ways.

Whilst noting that their taxonomy is not comprehensive, Elliott et al. (2004) and Elliott (2013) outlined six main alliance difficulty marker subtypes in EFT (see Table 1). First, clients may refuse to engage in therapeutic tasks, such as empty chair or two chair work (*Self-consciousness/task refusal*). This can occur for a variety of reasons, including experiential avoidance (a tendency to avoid painful emotions), self-interruption (stopping oneself from feeling or doing something), or a perception that the task is not relevant to their goals. Second, *power and control issues* may interfere with the alliance, when the client feels the therapist is being too directive or controlling and pushes back, or feels the therapist lacks the legitimate authority to guide the client's process. For example, some male clients have difficulty working with women in authority, or some clients may feel their therapists are too young or inexperienced. Third, clients may come to feel that their therapist does not really care for them or even dislikes them (*Attachment/bond issues*). For example, a client may find it hard to engage in exploration because they believe the therapist only appears to care because they are paid to do so. Fourth, the client may withdraw from engagement in covert and non-obvious ways (*Covert withdrawal difficulties*), for example, by deferring to the therapist instead of disagreeing; this can be hard for therapists to detect but has been documented by various qualitative researchers (Rennie, 1994; Rhodes et al., 1994; Watson & Rennie, 1994). Fifth, the therapist may have strong negative reactions to the client or their behavior as a result of their own unresolved emotional issues (*Therapist conditionality*). Finally, the therapist may be impaired by exhaustion, stress or preoccupation with their own difficulties, leading to empathic failure or less competent functioning (*Therapist impairment*). These six alliance difficulty marker subtypes are summarized in Table 1.

Alliance difficulty markers in the working phase of therapy signal the need for EFT therapists to change gear. Rather than operating silently in the background, the therapeutic relationship is brought into the foreground and the therapist initiates an exploration of each person's experience of the problematic relationship dynamic. In EFT this approach to resolving alliance ruptures is known as *Relational Dialogue*.

Resolving Ruptures in EFT: The Relational Dialogue Task

Like other *task models* in EFT, the model for Relational Dialogue task specifies (a) a set of markers (described above), (b) the thing the therapist generally does to help a client carry out a therapeutic task (referred to as the *general task environment*) and (c) the ideal sequence of steps or microprocesses that a client goes through to reach resolution – in this case repair of the relational difficulty. Task models include a description of interventions that therapists typically use to help clients through the steps towards resolution of the task. Resolution is generally not seen as an "all or nothing" accomplishment, but rather something that can be more or less partial or complete.

As always in EFT, relational dialogue is unlikely to succeed unless it is offered in the context of a solid bedrock of the relational conditions described earlier. Elliott (2013) surveyed the relevant literature in the humanistic and experiential therapy traditions and suggested a number of specific principles and conditions that should guide therapists when choosing to address alliance difficulties. These fall into three areas of consideration: First,

the decision of whether (or not) to bring up a particular alliance difficulty with the client (marker conditions); second, the therapist's internal readiness to raise and work with the difficulty (therapist readiness conditions); and third, the nature and quality of the therapist's communication when actually addressing it (relational dialogue principles).

Marker Conditions. Deciding whether to address the alliance difficulty is most relevant to situations where therapists have a negative reaction to the client or perceive that there may be an alliance difficulty that the client themselves is not drawing attention to. Elliott (2013) suggests that fleeting negative reactions by the therapist should on the whole be put aside, and even recurrent minor negative reactions be reflected on and or brought to supervision initially, rather than being brought up with the client. However, if the negative reaction persists, is striking, or reaches a threshold where it is interfering with the therapist's ability to be empathic, non-judgemental and genuine, the difficulty likely needs to be addressed directly with the client. The therapist should also take into account whether the difficulty is interfering with the client's ability to benefit from therapy, and whether the client is sufficiently robust (non-fragile) to be open to the therapist raising the difficulty.

Therapist Readiness Conditions. A second set of principles relates to the therapist's internal readiness to engage in communication with the client about the difficulty. As both Elliott et al. (2004) and Elliott (2013) point out, the therapist's emotional maturity and self-awareness are key. The therapist needs to have the self-acceptance to own their negative or vulnerable reactions rather than suppressing or rejecting them. Furthermore, they need to be able to distinguish between adaptive (congruent) negative emotions (for example irritation or fear in response to hostile client behavior) and maladaptive (incongruent) emotional responses (e.g., a secondary feeling of guilt emerging in response to their own adaptive anger). Maladaptive emotions are likely to reflect more about the therapist's own past emotional learning experiences, while adaptive emotions are a source of "fresh" information about the current state of the therapist's relationship with the client. The ability to accept vulnerability and distressing emotion prepares the therapist to take responsibility for their own emotional reactions and style of communication in the Relational Dialogue, as well as modelling this for the client. In addition, the therapist's capacity for self-compassionate acceptance of their own uncomfortable experience needs to be matched by a parallel compassionate acceptance of the client's uncomfortable experience in the relationship. Relational Dialogue therefore depends on the therapist having a well-developed capacity for congruence, empathic attunement and prizing, even in the face of client criticism and hostility.

Relational dialogue principles. Table 2 provides a set of eleven more specific guiding principles that help define the task environment believed to be important in successful relational dialogue for alliance difficulties in EFT. These principles in the first place put a premium on therapist self-awareness; an ethical stance of respect, empathy, beneficence, autonomy, and authenticity; and accomplishing the sometimes-difficult balancing act between commitment to the client and supporting their ability to choose whether to end or continue therapy (Principles 1 – 3). They also point to the importance of fostering a conversation that is open, direct, collaborative, but also tentative, curious and open; this includes meeting and matching the intensity of the client's concern about the situation, even when they are angry (Principles 4 – 8). In addition, these principles guide a dialogue in which both sides of the difficulty are explored, including owning the therapist's contribution to the difficulty and expressing a willingness to compromise on the goals and tasks of therapy (Principles 9 – 11).

Relational dialogue task model. More specific details about what the Relational Dialogue task looks like in practice are presented in Table 3, which sets out the sequence of stages through which a client moves in the process of resolving an alliance difficulty. The

second column summarizes the therapist interventions that can facilitate the client's progress during each of these stages (Elliott et al., 2004). In the next section we illustrate the relational dialogue principles and task model using case material from a successfully resolved alliance difficulty in EFT for social anxiety.

Case Illustration

Client Description, Presenting Problem, and Case Formulation

The client, whom we will call Claire, was at the time a single professional woman of Scottish origin, in her late 20's, who initially entered therapy as part of a comparative trial of EFT for social anxiety and was seen by the first author (RE). She presented with severe social anxiety, generalized anxiety, and work difficulties. On the Personal Questionnaire, an individualized outcome measure (Elliott et al., 2016), she listed her most important problems as "all consuming worry" about a difficult work situation; emotion dysregulation ("tearful, shaky", not in control), feeling under pressure; and feeling her self-esteem could be "easily damaged."

Initially, she quite liked the structure provided by EFT. Over the course of the first ten sessions (out of 20 specified in the research protocol), they explored the basis of her social anxiety, identifying a sense of deep despondency or depression underneath it, which they then traced back to her mother's death when Claire was a little girl. They eventually established that her social anxiety was organized around core feelings of shame and guilt for herself as "rubbish" and "a lost cause" because she had not been able to save or support her mother (who died was Claire was 5) and more recently her father when he too was dying; it was this that she feared others would see in her. As therapy progressed, she revealed a history of complex trauma (from childhood physical and emotional abuse) and continuing emotional fragility including current suicidal thoughts and plans.

Relational Dialogue Work

Lead-up to Relational Dialogue. Although initially Claire did well in the therapy and her social anxiety declined substantially, from session 10 on she began to struggle with a wide range of EFT practices, including open-ended exploratory questions (to which she responded "I don't know"), Focusing (which relies heavily on exploratory questions), Empty Chair Work ("I don't talk to dead people"), and Two Chair Work ("I don't talk to chairs, either"). At the same time, she gradually became more distressed, as frightening memories and other experiences began to emerge. As a result of her increasing emotional dysregulation and her continued rejection of his usual ways of working, the therapist began to feel frustrated and de-skilled.

Elliott (2013) summarised some aspects of this episode of alliance difficulty work in a previous publication based on therapist case notes and recollections; here we provide a much more detailed presentation, based on the audio recording and transcript of sessions 14 and 15 and highlight the therapist activities associated with each stage of the Relational Dialogue resolution model. We join Claire in session 14, where the building problematic process in the therapy became increasingly salient; we then follow the repair process as it unfolded in session 15, when the therapist initiated a Relational Dialogue.

Session 14: Pre-marker identification and Marker Confirmation (Stages 1 and 2). At the beginning of session 14 Claire complained that her head felt "messed up", and alternated between thinking this was due to forgetting to take her antidepressant medication and that "this therapy thing" was doing "weird things to my head." She described her irritation with various people in her life, and impatiently pushed back an invitation by the therapist to say where in her body she was feeling her irritation (a focusing task): "I don't know where it is. It just is." This is an example of the Alliance Difficulty marker subtype of *Task Refusal* (see

Table 1), characteristic of Claire in this and earlier sessions, which had resulted in the therapist struggling to help Claire deepen and explore her experience.

Around eleven minutes into the session Claire said, "I'm fed up with people telling me what to do and what to think" and she described a fear of feeling out of control when others made demands on her: "People want things I can't give them." Although this relates to interpersonal patterns outside the session, it hints at the possibility that the Alliance Difficulty might also have features of the marker subtype of *power/control issues* (Table 1). The therapist took Claire's comments as an opportunity to suggest that a similar process might have taken place in the previous session: "I wondered if in our last session I was trying to do that too? Trying to persuade you not to be so down on yourself." This was an attempt by the therapist to confirm the marker (Stage 1 of the resolution process, see Table 3). However, Claire responded, "That's your job!" to which the therapist exclaimed: "Not normally!" (Persuasion is not an EFT mode of communication). He continued by sharing a perception that he may have been "too pushy," but Claire said, "No, … I would tell you if I did feel pushed."

At this point the marker had been disconfirmed by the client and, in spite of the therapist's awareness of the potential alliance difficulty, the two of them remained embedded in it for the rest of this session, neither able to move into working on the difficulty nor able to do much else. Claire frequently blocked the therapist's initiatives by either disagreeing with him or saying, "I don't know," in response to exploratory questions. For his part, the therapist mainly followed the content of what the client said, falling back on the EFT baseline activity of empathic exploration and energetically teasing out the affective import of her statements with empathic reflections (his speech turns tend to be considerably longer than hers). At times he also adopted a "persuading" tone in which, in response to Claire's tendency to detach emotionally, he offered a rationale for deeper emotional processing, most likely trying to build consensus with Claire for engaging in EFT processing tasks, although probably unwittingly reinforcing the potential *power/control* alliance difficulty by prompting Claire to withdraw more, and violating principal 2 (client autonomy, Table 2). Because the difficulty was disavowed by the client, this amounted to a *covert withdrawal* difficulty marker subtype, and illustrated the difficulty this can present to therapists.

The session ended with Claire refusing an invitation to a two-chair conflict split task after she had revealed how self-critical she was (*task refusal*). The therapist acknowledged that this was an instance of the Alliance Difficulty: "So when I ask you to do something it just feels like I'm asking you to perform and then that's an evaluation […] All that stuff, right!" (Claire: "Yes!"). He suggested that Claire try the conflict split work on her own (where she wouldn't feel like she was performing) and then did a state check: "So where are you right now?" Claire responded, "I don't know. I never know what to say." The therapist realized that Claire was feeling pressured (*power/control issues*) and the session ended awkwardly after Claire acknowledged that she did feel pushed and, in response to being asked how that feels, said, "Nothing. Just I would like to get out please." The relational difficulties were now overt, which would make them easier to work on going forward.

Session 15. Between sessions 14 and 15, the therapist had been worrying about how session 14 went and especially how it ended. Thus, after the first few minutes of the session the Relational Dialogue picked up again. There is not space to describe all of this work here, but we will highlight significant therapist activities and client responses at each of the stages of task resolution (see Table 3).

Marker Confirmation (Stage 1). Claire opened the session by saying she did not feel "great" and had just received critical comments on a course assignment which she couldn't bring herself to read. The therapist suggested that they focus on this, as this was a central issue for her. Claire sighed and said, "Oh, I don't know. No, I don't know." The therapist

abandoned this tack and asked Claire what she needed. Again she replied that she did not know, but "I just don't want to feel like this." He suggested they focus on this current bad feeling. Claire agreed, and the therapist offered an EFT task (*Clearing a Space*) which is often used when clients are overwhelmed by negative emotion. Claire responded to this with a clear Alliance Difficulty marker (Marker 1: Task Refusal): "I don't know. I'm just worried that none of this helps." At this point the therapist picked up the Relational Dialogue by confirming the marker (Stage 1). As this is a confrontation marker (i.e., the client had directly expressed a complaint about the therapy), he acknowledged the complaint, and empathically tried to capture her experience as thoroughly as possible and to match the intensity of her level of concern (Table 2, Principles 4, 5, 6, and 8):

Therapist: Yeah, OK. You're worried that none of the therapy helps either?
Claire: Yeah.
Therapist: And here we are, session fifteen. [This adds an empathic conjecture that Claire's concern is related to the approaching end of therapy, which she confirms].
Claire: Yeah, it's supposed to be sixteen sessions you know.
Therapist: Well, I've been assuming we go to twenty, but…
Claire: Yeah.
Therapist: Because we have a sixteen to twenty, but, I don't know if that helps, but you still feeling that…
Claire: Well, it helps in that I'll do what it takes, but I don't know that I'm doing the right thing.
Therapist: As a client? In the therapy?
Claire: Mmhm.
Therapist: Right. So somehow you feel like you're not, what…?
Claire: I don't know.
Therapist: Doing what I expect you to do? [empathic conjecture]
Claire: Mm.
Therapist: What I want you to do?
Claire: Yeah.
Therapist: Yeah. Yeah. So that somehow you're letting me down?
Claire: [Sighs]. I don't know.
Therapist: See if that fits. Right. Does it feel like you're letting me down or is that not quite right?
Claire: Partly, maybe, yes.

As can be seen from this exchange Claire was tentative about communicating her difficulty in therapy, and it is easy to imagine her withdrawing her complaint if the therapist is not encouraging, as happened in session 14. It was therefore essential that the therapist help her to feel safe, especially that it was OK for her to voice her difficulty with him in particular (Principle 2: *offer strong empathy/validation*). Key here was the baseline EFT activity of empathic responsiveness. Shortly after the exchange above, the therapist offered an evocative reflection: "It feels horrible. And that's actually gotten worse maybe over the therapy". Claire agreed and the therapist continued: "Right. Right. And so, you're now wondering, 'Is this worth it?' Is this, you know, and you don't know whether to sort of feel like it's your fault [Claire has just blamed herself] or whose fault [more evocative reflection]." He added a moment later "Yeah, I mean it would be hard for you to blame me I guess if it was my fault [empathic conjecture]." (Principle 10: *Own your contribution to the difficulty.*)

Initiating and Deepening Relational Dialogue (Stages 2 and 3). In this example Negotiating/Initiating work (Stage 2) occurs in parallel with the Deepening process (Stage 3) of the therapist considering and disclosing his own possible role in the difficulty, as the therapist was running a bit ahead of the client in order to provide scaffolding for her side of

the work. The following speech turn by the therapist shifted from Initiating (Stage 2) to Deepening (Stage 3) and came after the client had clarified her tendency to blame herself ("I have a history of not measuring up"):

> Therapist: Right, but, for us then to enact that history in therapy [pause] feels like that's not helpful either, right? [Claire: Mm]. So, um, it seems, I just know when things are difficult and there is a problem in the therapy that it's really good to, for both people to look at what's happening and how each person is contributing to it. [Claire: Mmhm]. So, um, I assume that you bring something to our work that's made it difficult for you to engage and made it difficult for you, and in some cases has made things worse, but I also assume that I've done some stuff. I've missed stuff. I know I have missed stuff, uh. I know I have communicated to you, or I believe that I've communicated to you some kind of disappointment that you won't do chair work. I suspect that I communicated that to you.

As he proposed the Dialogue task, the therapist set the stage by making it very clear that the difficulty was a shared responsibility and that he was open to considering his own part in it (Principle 6: *Make it a shared responsibility*).

There were many instances in the first fifteen minutes of the session of the therapist reflecting on his own contribution to the difficulty (a key part of *Deepening,* Stage 3), and opening this up with a sense of genuine curiosity, indicating that he did not yet know exactly what he did that contributed to the difficulty, but was really curious to discover this. He had some hunches as to what he might have contributed (inviting the client to share her perception about what he did that affected her as well). This included sharing his own vulnerability, as in the following passage around fourteen minutes into the session:

> Therapist: I keep asking and you keep saying "I can't answer that" right? And, yeah, I mean basically, you know, I mean, I've been pushing you really hard. 'Cos I feel time pressure. [Claire: Mm]. And I think that just increases, and just makes it harder for you. And I'm aware of that. Um. And you know just as you feel anxious about the approaching boundary, end of the therapy, I also feel anxious because I feel like somehow, you know, we haven't quite got to, you know, and I'm also aware that you're in a place where things are worse right now for you. [Claire: Mm].

He continued shortly thereafter, illustrating Principle 11: *Be ready to compromise on goals and tasks*:

> Therapist: OK. Um, so my experience is that somehow I haven't been quite creative enough to work with your process. And I pride myself on being able to do that. And, being flexible and creative, you know. So somehow, I'm not quite sure what it is, and, I mean a piece of it is that, is that I don't fully know how to work with these processes outside of chairs [referring to EFT empty chair and two chair tasks]. So that I know really well. And then it moves us to an area where I don't feel that I know so well, and then I don't feel quite as competent. You know. So then I feel like I'm kind of letting you down some, somehow. I don't know if that makes sense?

Claire responded by denying that she thought the therapist was letting her down. However, as the therapist continued to offer empathic scaffolding and support to her efforts to differentiate her own experience of the difficulty, she began to articulate what was at stake for her:

> Claire: It's hard to talk about [painful emotion] and […] And I pretend it's not there. Yeah.

About fifteen minutes into the session there was a turning point as they jointly clarified how this process played out in the therapy:

Therapist: But I mean the issue is, you know, what can, I mean how can we work more effectively with each other, I think, um, is worth considering. Right. And that, I usually address by saying, you know, "What do you need?" and you say –
Claire: "I don't know!" [Both laugh]
Therapist. Exactly. Right. Yes. Right. Yes.
Claire: "I'm fine!"
Therapist: Right. Yes.
Claire: Yeah. "Nothing." Uh huh. Mmhm.
Therapist And you're aware of that strategy?
Claire: Mm.

This shared acknowledgement of the process they were in together marked a shift in the session and Claire seemed more curious about what went on inside her. Shortly after this she began to explore important internalized experiences relating to her tendency to keep others, including the therapist, at a distance:

Claire: I don't know if I don't feel things – or people have told me not to.

This was empathically elaborated, leading to Claire sharing painful childhood experiences that made her distancing understandable. Claire was exploring what was at stake for her in the difficulty, a part of *Deepening* Dialogue (Stage 3).

At this point, the Alliance Difficulty receded into the background. Claire engaged in deeper more inwardly focused work and began to disclose significant vulnerable feelings that were connected to her early attachment experiences and her current experiences of driving away people who cared about her. This moved the Dialogue to *Partial Resolution* (Stage 4) without the need to elaborate the latter stages of the process. Part of the therapist's activity in the Partial Resolution process (Stage 4) was to summarize a shared understanding of the difficulty. There was some suggestion of this with Claire around 35 minutes into the session, although this was succinct, partial and relatively unelaborated, as the focus had now shifted to Claire's internal processes and attachment history:

Therapist: What's really, what's kind of, the therapy exposes is this big sore wound in your life [Claire: Mmhm] around your mum. [Mmhm]. And missing her.

The later stages of the Relational Dialogue task are less prominent in this illustration, likely because the Deepening work (Stage 3) appeared to have broken the logjam in the therapy so that productive client "self to self" work could continue, and the therapy relationship resumed normal functioning without needing special attention. However, the broader Partial Resolution (Stage 4) element of client and therapist developing a shared understanding of the sources of the difficulty was perhaps reflected in the productive work that unfolded around the origins of the client's difficulties expressing her feelings in her early life.

Exploration of general issues and practical solutions (Stage 5) of the Task Model has various threads, including helping the client explore and reflect on the personal issues raised by the difficulty, encouraging the client to reflect on how to overcome the difficulty and the therapist offering changes in their own way of conducting the therapy. In the current illustration there is some evidence of this kind of work in the middle of the session, paving the way for a phase of productive emotion work towards the end of the session. After moving from Marker Confirmation (Stage 1) to Deepening (Stage 3) in the first twenty or so minutes, the session moved forward with productive exploration of the experiences in Claire's childhood which made emotional disclosure painful. Around thirty-six minutes into the session the therapist thought aloud about modifying his normal ways of working in order to overcome the difficulties they had identified earlier in the session. For example, he mused on how to "figure out a creative way around [using chair work]." In the remaining part of the session he abandoned EFT tasks such as empty chair or two chair work and instead moved

the work forward using short moments of experiential teaching (similar to the kinds of rationale that might be used for Alliance Difficulties early in therapy) combined with empathic reflections and affirmations. This change of emphasis in his approach (compared to Session 14) enabled Claire finally to express and explore her intense vulnerability and core pain of being "crushed" and not being "good enough for anyone or anything," supported by empathic affirmation from the therapist. An example of the therapy process and therapist's responses later in the session is this moment around one hour into the session:

> Therapist: But it's really painful [Claire exhales] for you, isn't it. [Claire: Mm]. Yeah. I can see the tears. It's really painful for you to not measure up.

Full Resolution (Stage 6) encompasses client satisfaction with the outcome of the Dialogue and renewed enthusiasm with therapy. In the current example this is implicit in Claire's ability to deepen expression and exploration of her core pain in the latter part of the session (post Relational Dialogue). As we saw in discussion of the process in Session 14 and at the beginning of Session 15, this was particularly difficult for her. The therapist does not explicitly encourage further processing of the dialogue at the end of the session, likely because the session had run over time, with the Alliance Difficulty clearly no longer a barrier to Claire's engagement.

Course and Outcome of Therapy

After Session 15 Claire's therapy ran to the allotted study protocol maximum of twenty sessions. Claire had entered therapy with a PQ score of 4.13, indicating moderate distress. (Her scores on most of the other outcome measures were also in the clinical range.) However, as she resolved her social anxiety difficulties over the course of her first 10 sessions, her PQ score dropped to 2.75, well below the clinical cut off value of 3.25 (Elliott et al., 2016). Because she had shifted her focus to new issues of emotion dysregulation, she then chose at the beginning of session 13 to recalibrate her PQ by adding several new items, resulting in a score at 4.11. By session 20 her score on her revised PQ had dropped to 3.22, again in the nonclinical range.

However, she suffered a serious relapse a month after completing therapy when an anniversary reaction to her father's death triggered a resurgence of traumatic memories and emotional dysregulation. As a result she requested additional therapy, reporting a PQ score of 4.89. Although her social anxiety appeared to be largely in remission at this point, her emotional fragility and accompanying suicidality were serious enough that she was offered another 20 sessions, which was eventually extended to 100 sessions of mostly supportive empathy-based EFT over the course of 4 years, with an ultimately successful outcome (PQ: 2.20), which according to occasional updates from the client has been maintained for (so far) seven years post therapy.

Discussion of Case Illustration

Claire's case illustrates an expert therapist using the EFT task of Relational Dialogue to collaboratively resolve an Alliance Difficulty in the working phase of what eventually became a successful long-term psychotherapy. It provides a clear example of the EFT stance of presenting Alliance Difficulties as a shared responsibility, with the therapist owning their own part and exploring his own feelings of vulnerability explicitly with the client. It highlights the key role of therapist empathic responsiveness in creating sufficient interpersonal safety for Claire to expand and explore her difficulty. The case also highlights the importance of therapist creativity and expansiveness in resolving alliance difficulties, as the therapist faced the dilemma that his usual ways of working had failed and required him to step back, let go of his usual ways of working and try a different tack.

At the same time, this case illustration does leave some elements of the client's part of the interpersonal process less explicit and unarticulated. This is no doubt in part due to some continuing discomfort on Claire's part in challenging the therapist's authority and in part because a fruitful focus emerged with Claire's observation that people have told her not to feel things, and the rich associations this leads to with her childhood experiences. It might have been useful for the therapist to have helped Claire further articulate the links between her experience in the therapy and her similar experience of pushing other caring people in her life away (Stage 5 *Exploration of general issues and practical solutions*). This could have cemented her new experience of disclosing deep pain in an empathic relationship by celebrating her achievement of this in the session with the therapist (which would have contributed to Stage 6, *Full Resolution*).

From a broader perspective, this case illustrates the application of EFT with clients with the combination of social anxiety, complex trauma and significant emotional fragility, where more than the usual 15 – 20 sessions are needed. As was the case here, in our experience clients with this presentation are more likely to present relational challenges than clients with less complex presentations. Addressing such challenges is likely to be necessary for successful outcome, and also provides therapists opportunities to sharpen their Relational Dialogue skills.

Conclusion

We have summarized key features in the EFT conceptualization of and resolution of difficulties in the therapeutic alliance, illustrating these with direct quotations from a Relational Dialogue in the case of an eventually successfully treated client with severe social anxiety, complex childhood trauma, emotional fragility and suicidality. We conclude by pointing out that this important task in EFT has not yet been subjected to empirical scrutiny. We recommend that the model described here be further tested and refined by EFT researchers using intensive change process research methods such as task analysis (Greenberg, 2007), conversation analysis (Smoliak, Strong & Elliott, 2018), and comprehensive process analysis (Elliott et al., 1994).

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Table 1.
Common Alliance Difficulty Marker Subtypes in EFT

Alliance Difficulty/Marker Subtype
1. *Self-consciousness and task refusal* (= withdrawal difficulty): Client refuses to do suggested therapeutic activity (e.g., exploration of painful experiences or emotion) or active task (e.g. two-chair work).
2. *Power/control issues:* Client sensitivity to power differences in therapy leads to task refusal (withdrawal difficulty) or complaints of being controlled, imposed on, or not duly considered (confrontation difficulty).
3. *Attachment/bond issues:* Client develops the feeling that the therapist does not really care for or even dislikes them (can be either confrontation or withdrawal difficulty).
4. *Covert withdrawal difficulties:* Client disengages from therapy process without saying why, either by missing sessions/coming late or by remaining on an external, superficial level.
5. *Therapist conditionality* (therapist-specific difficulty): Strong negative reactions to the person of the client or to the client's behaviour (e.g. antisocial behaviour or substance abuse).
6. *Therapist impairment* (therapist-specific difficulty): Exhaustion, illness, preoccupation with own difficulties disrupts empathy and competent functioning in therapist.

Table 2.
Principles of Relational Dialogue for Alliance Difficulties in Emotion-Focused Therapy

1. Be aware of your own reaction; offer yourself self-compassion/self-soothing as needed.
2. Offer strong empathy/validation; be respectful and valuing of the client, putting their well-being and autonomy/personal agency first.
3. Try to balance: (a) nonattachment to whether client continues or ends therapy with (b) strong commitment to continuing to work with the client if they desire.
4. Face the difficulty directly and explicitly; refer directly to relationship (meta-communication).
5. Be tentative, curious, and open to further discovery.
6. Try to create a sense of collaboration by making it a shared issue; avoid the expert role.
7. Disclose your concern/empathy about the client finding the discussion difficult.
8. In your responses match the level of the client's emotion to create strong connection.
9. Explore the client's side of the difficulty, including their needs/goals/understandings for therapy.
10. Own your contribution to the difficulty.
11. Be ready to compromise on what you are working toward with the client (=goals) and how you and the client will get there (=tasks).

Table 3.
Relational Dialogue for Repair of Alliance Difficulties

Task resolution stage	Therapist activities
0. *Pre-marker identification*	Listen carefully and nondefensively for possible alliance difficulties.
1. *Confirm marker:* Nature of possible difficulty is presented to client.	*Confrontation difficulties:* Acknowledge complaint; begin by offering a solid empathic reflection of the potential difficulty, trying to capture it as accurately and thoroughly as possible. *Withdrawal difficulties:* Gently and tactfully raise the possibility of difficulty, to see if client recognizes it as a difficulty as well. Therapist manner is slow, deliberate, and open.
2. *Task negotiation/initiation:* Task is proposed and exploration is begun.	Suggest to client that it is important to discuss the difficulty, including each person's part in it. Present difficulty as a shared responsibility to work on together. Client and therapist begin by laying out each person's view of what happened.
3. *Deepening:* Dialectical exploration of each person's perception of the difficulty	Model and facilitate the process by genuinely considering and disclosing own possible role. (May include focusing on own unclear feeling about the difficulty). Help client explore what is generally at stake for him or her in the difficulty (may invite the client to use focusing to support this).
4. *Partial resolution:* Development of shared understanding of sources of the difficulty.	Summarize and confirm overall shared understanding of the nature of the difficulty and confirm this with the client, adjusting as necessary until both are satisfied that it is accurate.
5. *Exploration of general issues and practical solutions*	Help client explore and reflect on the more general personal issues raised by the difficulty. Encourage client exploration of possible solutions; ask what client needs. Offer possible changes in own conduct of therapy.
6. Full resolution: Genuine client satisfaction with outcome of the dialogue; renewed enthusiasm for therapy.	Encourage processing of dialogue. Reflect client reactions to the work.

Note. From *Learning emotion-focused therapy* (p. 160) by R. Elliott et al., 2004, Washington, DC: APA.