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Clinical Handbook of Emotion-Focused Therapy

Chapter 9

Emotion-Focused Therapy for Depression

NOTE FROM THE AUTHORS: In the present version, there are some discrepancies and changes regarding the final, accepted chapter version. Therefore, authors refer readers to the final chapter version which is to be found in the actual book.

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Emotion-focused therapy (EFT – Greenberg, 2002, 2004, 2008, 2012) also know as process-experiential therapy (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, Rice, & Elliott, 1993) is an empirically supported treatment for depression (Elliott, Greenberg & Lietaer, 2004). EFT views emotions and feelings (taken as synonyms in this chapter) as fundamental to the construction of the self, since they provide a *gut level* immediate source of information (a pre-conscious evaluation of stimuli), that is used by human beings to discern among competing priorities, orient to action, adapt to environments and promote well-being (Greenberg, 2004, 2008; Greenberg & A. Pascual-Leone, 2006; Greenberg & Safran, 1989). Furthermore, emotion is considered to play an essential role in adaptive and maladaptive human functioning. For EFT, change is achieved through changing emotion with emotion and by developing the ability to experience, tolerate, symbolize, and express emotions (Greenberg, 2002; Greenberg, Rice & Elliott, 1993; Pos & Greenberg, 2007). In this chapter we aim (1) to describe how depression is understood within EFT, (2) to clarify how the generic principles of change within EFT can be applied to depression, (3) and to specify how the intervention in EFT for depression takes place.

Depression under EFT lenses

Clinical depression is one of the most common mental disorders (Kessler & Wang, 2002; Richards, 2011), standing as a leading cause of disability worldwide, and the leading contributor to the global burden of disease in developed countries (WHO, 2010). Major Depression Disorder, as well as other related forms of mood disorders, such as Dysthimia, is characterized mainly by persistent depressed mood and/or by a loss of interest or pleasure in daily activities, complemented with other enduring symptoms, such as: sleep disturbance; weight variation; psychomotor

agitation or retardation; lack of energy; diminished ability to think, concentrate or decide; feelings of guilt and worthlessness; and thoughts about death, including suicidal ideation. According to the DSM-V (American Psychiatric Association, 2013) Depression is basically an affective disorder, which means that it disturbs the way people feel about themselves and the world.

From a phenomenological point of view, depression can be experienced in many ways. Some people go through a permanent state of despondency after a failure, others succumb to a state of exhaustion after anxiously trying to keep up with extremely high demands and expectations or even threatening conditions; some suffer from a prolonged grief after a significant loss of someone. Feeling down is frequently coupled with anxiety and agitation. The self is experienced as weak, defective, worthless, and self-narratives tend to become rigidly dominated by these themes and lack of specificity in episodic memories (Boritz, Angus, Monette, & Hollis-Walker, 2008; Williams, Barnhofer, Crane, Herman, Raes, Watkins, & Dalgleish, 2007). Hopelessness tends to prevail, feeding ideas about death and suicide (Shahar, Bareket, Rudd, & Joiner, 2006).

According to EFT, in depression the self has lost the sense of vitality and resilience, mainly by loosing contact with needs and emotions (Greenberg & Watson, 2005). Problems in the adequate emotional processing of their experiences, lead people to become distant from their own inner resources and needs. Inadequate emotional processing, involves different but overlapping problems: i) not fully processing previous experiences; ii) blocking emotional experiences; or iii) lingering on maladaptive experiences that remain unchanged. These experiences leave the person stuck in the "same old story" (Angus, 2012; Angus & Greenberg, 2011) or problematic narratives (Goncalves, Matos, & Santos, 2009; Gonçalves, Ribeiro,

Stiles, Conde, Matos, Martins, & Santos, 2011), feeding complex and resistant cognitive-affective states characterized by hopelessness and helplessness.

EFT for Depression: An evidence-based treatment

According to the Division 12 of APA, EFT is an empirically supported treatment for Depression (American Psychological Association, 2006; Strunk, n.d.). Three clinical trials of 16 to 20 session-treatments compared the efficacy of EFT in comparison with client-centered therapy (York I depression study – Greenberg & Watson, 1998 and York II depression study – Goldman, Greenberg & Angus, 2006) and with cognitive-behavioral therapy (University of Toronto study conducted by Watson, et al., 2003). When combining the samples from York I and II, EFT clients exhibited statistically significant differences in the level of depressive symptoms at termination and at 18-months follow-up when compared to the client-centered sample, and significantly lower rates of relapse at 18 months (Ellison, Greenberg, Goldman, & Angus, 2009). When compared with the cognitive-behavioral sample, EFT clients exhibited the same levels of symptomatology improvement at treatment termination, although there were some differences at the interpersonal level (EFT clients were significantly more self-assertive and less overly accommodating or compliant to others – Watson, et al., 2003). Another trial comparing EFT with CBT for depression was developed in Portugal, at ISMAI (University Institute of Maia), largely replicating the University of Toronto study, and the first results suggest that EFT is at least as effective as CBT (Salgado, 2014). Finally, Counselling for Depression, an adaptation of EFT for UK routine practice is currently under scrutiny (Sanders, & Hill, 2014).

Major forms of depressive self-organizations

EFT for depression is based on a dialectical constructivist view (Greenberg & Pascual-Leone, 1995, 2001; Greenberg, Rice, & Elliott, 1993; Pascual-Leone, 1987, 1990, 1991). Human functioning is understood as the result of a dialectic tension between one more tacit, affective and automatized mode of processing experiences, in which perceptions, emotions and feelings play a vital role; and a more explicit, rational, and reflective processing. This dialectic is largely based on previously developed self-schemes that provide automatized reactions to perceived events, on the one hand, and on the more consciously elaborated self-narratives developed throughout development, on the other.

The dominant emotion schemes in a given moment determine to a large degree the current self-organization, which is the emergent product of the emotional schematic processing and is the experiential referent for reflective awareness, symbolization, meaning-making and narrative organization. The activation of a scheme of loss will generate a self-organization around feelings, memories and narratives of sadness or even grief.

People who are depressed tend to be dominated by specific forms of self-organization, which have an early interpersonal origin, in the formative years, involving past experiences of loss, rejection, humiliation, or abandonment. Specifically, Greenberg and Watson (2005) hypothesized that two kinds of self-organization prevail in depression: feeling unlovable or worthless, and feeling helpless or incompetent. To these two forms, we will propose a third one, associated with sadness and loneliness.

A first and frequent form of self-organization in depression involves a sense of failure in meeting internalized social standards from which people derive their sense

of worth and value. The self is, then, organized around a cognitive-affective sense of defectiveness, worthlessness, and hopelessness ("self as bad" – Greenberg & Watson, 2005), with high levels of self-criticism and self-coercion. This way, maladaptive core-shame is activated leading to processing failures, mistakes, personal defects or social mishaps, as lingering experiences of humiliation and shame.

A second form is dominated by a core maladaptive attachment related fear. In depression, it is frequent for clients to have an impaired sense of protection, becoming dominated by an intense and maladaptive fear and avoidant tendencies of the events-to-be. This sets in an anxiety-based insecurity or a sense of a "weak self" that underlies many clinical depressions (Greenberg & Watson, 2005). In these cases, the person may feel fearful of abandonment, assuming a submissive interpersonal style, for example.

A third kind has to do with core maladaptive sadness. Due to experiences of lack of love and support, or highly traumatic losses, some people with depression tend to feel lonely. Here, sadness usually prevails, and a sense of an annihilating isolation sets in. This sadness is maladaptive, since it does not promote any seeking for support or caring from others; actually, it is quite the opposite, as these clients feel that nobody will care about them, and, therefore, feel helpless.

These forms of self-organization are usually combined in complex and varied ways. For example, a core dreadful fear of separation is commonly seen in clients that have intense self-criticism and coercion. In some of these cases, self-diminishment is actually explained by a more nuclear fear of separation, which prevents people from asserting and defending themselves at violation. Another possible combination of these three forms of self-organization involves a maladaptive destructive anger, usually related with previous history of abuse or even interpersonal complex trauma

(Paivio & Pascual-Leone, 2010; Pascual-Leone, Gilles, Singh, & Andreescu, 2013). Therefore, maladaptive destructive anger can be an attempt to adapt to extremely severe conditions. Other parallel examples may exist, and it is a task for the therapist and the client to build a shared understanding of their core complex issues.

These maladaptive self-organizations disrupt the ability to process and regulate current experiences and feelings, which become overwhelming or intolerable. In depression, the person shuts down as an attempt to avoid those overwhelming feelings. During depressive episodes, people frequently do not have access to their core maladaptive and painful feelings or even to the voices disclaiming their own experiences (Greenberg & Watson, 2005). However, this produces a sense of powerlessness and weakness, since they become unable to own part of their experience, while losing contact with their own adaptive needs. For example, when facing a disappointment, the person may quickly feel depressed, instead of accepting the negative experience and pursuing other ways of obtaining recognition, love or success.

A generic model of schematic processing in depression

Greenberg and Watson (2005) proposed a generic model of schematic processing in depression, depicted in figure 1. We introduce here some slight adaptations to the model, extending it to cover maladaptive core sadness and giving a clearer role to narrative production. The depressive states and their core emotional schemes are usually activated by current stressful experiences, or by episodes interpreted as loss or failure. These events trigger an initial primary adaptive emotion, such as sadness at loss. Such sadness would promote healthy actions of seeking comfort and support, paving the way to compassionate intersubjective encounters that

would promote acceptance, relief and soothing. However, this tends not to happen in people who are vulnerable to depression, generating isolation and loneliness due to the activation of maladaptive emotion schemes, based on previous experiences of rejection, abandonment, humiliation or diminishement. Overall, a sense of self as lonely/abandoned (maladaptive sadness-based scheme), weak (maladaptive anxiety-based scheme), or defective (maladaptive shame-based scheme), dominates the person. As indicated in figure 1, these different voices may co-exist and interact, but usually one tends to dominate one's core pain.

In any case, all these voices produce negative self-evaluations, generating a loss of self-esteem, and initiating a secondary reaction where hopelessness and depression set in. Affectively, the person feels down; narratively, the person becomes dominated by some problematic dominant narratives (Angus, 2012; Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011; Gonçalves, & Stiles, 2011; Stiles, Honos-Webb, & Lani, 1999). No escape seems possible, since the person is reliving and retelling the "same old story" (Angus, 2012; Angus, & Greenberg, 2011); or, by facing such overwhelming schematic memories, the person resorts automatically, pre-consciously, to a depressive state as a way of not getting in touch with those core emotions (Greenberg & Watson, 2005). Therefore, these narratives can also become "empty-stories" (Angus, 2012; Angus, & Greenberg, 2011). Behaviourally, the person may engage in maladaptive forms of coping, such as withdrawing from social life, avoiding daily tasks, or finding ways of numbing and escaping the ever-present bad feelings.

Finally, since the underlying core feelings are not attended and resolved, when trying to coach oneself on how to get out of depression, the person fails to do so and becomes more and more self-coercive and self-contemptuous, which in turn increases

the sense of failure and powerlessness. Usually, when starting the therapeutic process, it is this secondary process of creating hopelessness that starts to be explored, and only later becomes possible to gain access to the core painful issues.

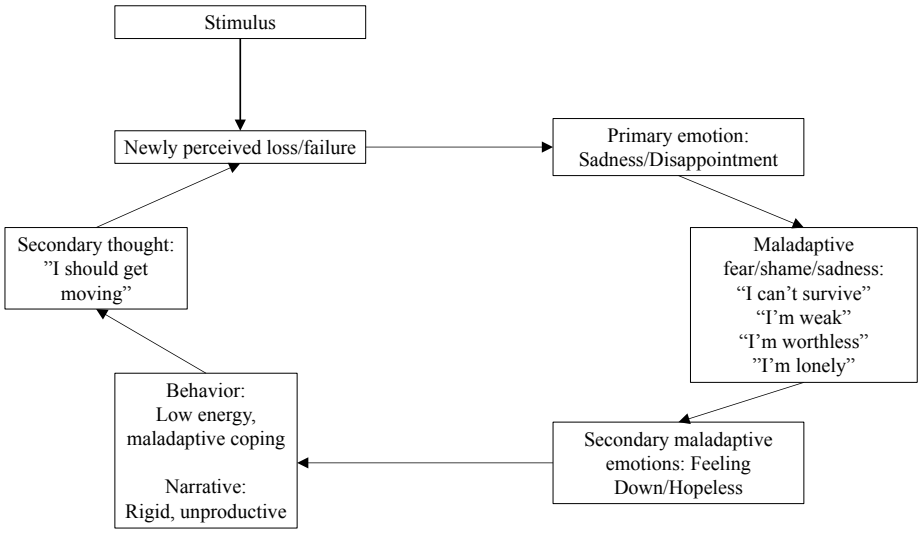

Figure 1: Emotion schematic cycle of responses to loss or failure leading to depression (adapted from Greenberg & Watson, 2005, p.54)

In sum, it is the activation and synthesis of core depressive schemes and the difficulties in processing their unresolved feelings that lead to depression (Greenberg, Elliott, & Foerster, 1990; Paivio & Greenberg, 1998). These schemes activate overwhelming experiences, dominated by fear of abandonment, insecurity or loneliness that are usually not fully processed, leaving the person in a state of depressive hopelessness. Finally, this tends to escalate into harsher forms of self-criticism and self-coercion, since the clients are not successfully overcoming their depression.

Change processes in EFT for Depression

Transforming depressive emotional patterns into adaptive emotional experience

In depression, feelings of hopelessness or diffuse anxiety are very common forms of secondary emotions (reactions to more primary emotions) and in some cases clients may also show some instrumental emotions, in order, for example, to seek support. These are usually the result of more in-depth difficulties of emotion processing. Typically, the therapeutic work evolves from empathically exploring and working upon these emotions in order to reach to the core primary ones.

When reaching these core primary emotions, we may find two kinds of feelings: *adaptive* and *maladaptive* (Greenberg, 2002, 2008; Greenberg & Safran, 1989). Adaptive emotions are the ones we want to promote, since their experience reconnects the person with core needs and vitality. However, in depression (and in many other clinical conditions), underneath secondary emotions we often will find *maladaptive emotions,* i.e.*,* emotions that are the result of repeated dysfunctional emotional learning experiences, so that they became automatic and implicit. They may have been adaptive in the past, but they are no longer useful or adaptive in the present and need to be regulated and transformed. For example, if a client is systematically unable to be assertive towards a colleague at work due to a history of parental abuse, this indicates that this submissive interpersonal pattern – despite the protection that it may have provided in the past relationship with a violent parent – is no longer functional. In depression, we will find eelings of core shame and inadequacy, core fear of abandonment and insecurity, or core sadness and loneliness.

In a simplified view, by providing an appropriate therapeutic relationship, and by facilitating the therapeutic work, EFT for depression starts dealing with secondary emotions, such as feelings of helplessness or diffuse anxiety, paving the way to the

empathic exploration of maladaptive emotions of deep shame, sadness or anxiety (primary maladaptive emotions) and, on a later phase, to the experience of primary adaptive emotions, such as sadness at loss, pride, assertive anger, or joy. When this later step happens, it means that the person is reconnecting to the core needs of the self, while being able to better cope with previous threatening, humiliating, or grieving experiences.

In EFT for depression, this process of changing towards more adaptive forms of emotion and to new and healthier forms of meaning-making, is governed by the general principles of change: (a) increasing awareness of emotion, (b) enhancing emotion regulation, (c) reflecting on emotion, and (d) transforming emotion (cf. chapter 2 of this book; Greenberg & Watson, 2005).

Intervention phases in EFT for Depression

EFT for Depression is generally guided by two main intervention principles: establishing an empathic, healing relationship and facilitating the resolution of tasks (Greenberg, Rice & Elliott, 1993; Greenberg & Watson, 2005). These principles globally develop through three phases (cf. chapter 2 of this book; Greenberg & Watson, 2005).

The first phase refers to an initial stage of treatment, which is focused on establishing a therapeutic bond and promoting client awareness. This is centered on building a safe and empathic therapeutic alliance and relationship, as well as setting a shared focus for the process, which allows clients to shift their attention inwards and become more aware of their experiences. In the second phase, focused on the evocation and exploration of core difficulties of emotional processing, the main goal is to help clients experience their core vulnerabilities by attending, arousing and

exploring their maladaptive schemes. Gradual exploration of these experiences allows reaching to the core experiences of vulnerability. In this phase, therapist and client work together in order to access and process the "core pain". In depression, this usually takes the form of dreadful fear of abandonment or core maladaptive shame or even despair while grieving. These core issues need to be gradually accessed, aroused, regulated, symbolized, reflected and, later on, transformed.

These core negative experiences in depression are usually totally or partially disowned and avoided. Their intensity, negativity and threatening features make them more prone to some sort of emotional avoidance, which can take many forms. By revisiting them, and letting oneself experience the associated emotions, not only the client becomes more aware of their impact, but also becomes better able to access and regulate one's emotional reactions, building a sense of mastery over previously disowned but overly dominant experiences. Therefore, this evocation and exploration helps clients re-own their life experiences, even though shameful, dreadful or despondent as they can be, and more fully master their own destiny.

The third and final phase, focused on emotion transformation, involves the construction of alternatives by producing new emotions and building new alternatives and meanings (Angus & Greenberg, 2011; Cunha, et al., 2016). This stage starts when clients have already processed their emotional difficulties. When that happens, it allows clients to better understand why they have some emotional responses, what triggers them in terms of stimuli and interpersonal events, and what these responses are. Now, the therapist can facilitate the development of alternative responses. These are usually rooted in core needs that were previously dismissed, blocked, or avoided. For example, accessing the need for self-protection may release an assertive anger that was previously blocked by a maladaptive fear of abandonment by that client; the

need for love and support may prompt another client to seeking soothing experiences with others' or even self-soothing, helping the person to better cope with losses and failures. It is in this phase, then, that clients substitute old maladaptive emotions by more adaptive and productive ones. For that, the therapist helps clients generating these new emotional responses, as well as promoting reflection upon these new forms of experiencing oneself and the world, while validating a new, emergent and revised sense of self, that can be consolidated by a process of self-narrative reconstruction (Angus & Greenberg, 2011; Cunha et al., 2016).

Markers and Tasks in EFT for Depression

EFT is *marker-guided*, which means that a specific marker calls for a particular task, invited or introduced by the therapist. Globally, there are six central tasks in EFT for depression (cf. Table 1), even though others can also be used if necessary (Elliott, et al., 2004; Greenberg, Rice & Elliott, 1993; Greenberg & Watson, 2005).

Table 1: An overview of central therapeutic tasks in EFT for depression

(Greenberg, Rice & Elliott, 1993, p. 138)

MARKER	TASK	END STATE
Problematic reaction point (Self-Understanding Problem)	Systematic Evocative Unfolding	New view of self in-the-world-functioning
Absent or Unclear Felt Sense	Experiential Focusing	Symbolization of Felt Sense; Productive Experiential Processing
Self-Evaluative Split (Self-Criticism, Tornness)	Two-chair dialogue	Self-acceptance, Integration
Self-Interruption Split (Blocked Feelings, Resignation)	Two-chair Enactment	Self-Expression, Empowerment
Unfinished Business (Lingering bad feeling regarding a specific, significant other)	Empty-chair Work	Forgive Other or hold other accountable, Affirm Self/Separate
Vulnerability (Painful emotion	Empathic Affirmation	Self-Affirmation (feels understood,

related to self)	hopeful and stronger)

Greenberg and Watson (2005) proposed that when working with depression, it may be useful to distinguish emotional processing problems that are more related with interpersonal issues from those that are more associated with self-to-self relations. This brings some further discrimination of the markers presented above. Interpersonal issues are usually revealed by emotionally-laden statements and narratives that signal that the person has unresolved feelings and unfinished business concerning a present or past relationship with a significant other, usually involving loss, abuse or neglect. When that happens, empty-chair work and empathic exploration are usually indicated for promoting a resolution for unfinished business.

Other markers associated with depression come in the form of maladaptive forms of self-to-self relationships. Typically, depressed clients suffer from either detrimental self-criticism or some form of self-neglect (Greenberg & Watson, 2005). Some others may even suffer from a blend of all of these manifestations.

Self-criticism in depression usually comes in the form of very negative statements, involving anger or contempt directed inward and this calls for two-chair work. A variation may be self-coercion, in which clients place extremely high demands on themselves, leading them to burnout and depletion. Many depressed clients suffer from these inner attacks and collapse to these critical voices by identifying themselves with those criticisms. When that happens, the person may feel deeply ashamed, sad or anxious, and hopelessness and despair set in. Two-chair work helps clients, first of all, to differentiate two sides on their experience: the voice of the critic and the voice of the experiential self. Then, by acting as the critical voice and feeling the consequences of those self-assertions, they become more aware of what

they are doing to themselves with these self-attacks and start realizing how harmful these attacks are. Finally, when clients collapse in the face of the critic, becoming hopeless, two main options are left to pursue as eventual ways-out of that apparent dead-end (cf. Elliott et al., 2004). The first is to empathize with the collapsed self, which may involve exploring with the clients how awful this dead-end looks like, how much one wants to get out of that "place", and helping clients to communicate their protest towards the critic. The other option is to invite the client to intensify criticisms from the critical chair, making them more unbearable, increasing awareness of their harm and promoting a more adaptive response from the experiential self when switching to the other chair. In either case, the goal is to get in touch with needs and actions of self-assertion, and self-protection, activating feelings of adaptive anger.

Another depressive process implies some form of self-neglect that usually involves loosing contact with one's feelings (Greenberg & Watson, 2005). This happens in various ways: not knowing what one is feeling at all; having difficulty in focusing inwards, when invited to do so; dismissing or downplaying feelings, considering them as not important or even signs of weakness or defect, or disregarding their intensity. These types of problems most of the times present themselves as markers of unclear felt sense or problematic reactions, which call for empathic exploration, or experiencing tasks such as focusing and evocative unfolding, as a way to develop an internal focus of attention.

When depressed clients become very analytical, in a dry, distant and emotionless way, which is another form of disregarding feelings, it can also be important to do evocative unfolding and imagery work with concrete events. These clients may present some frequent signs of problematic reactions (e.g., difficulties in holding their tears in unexpected situations). Yet, even in the absence of a clear

marker, evocative work may also be very useful, as a way of making episodes more alive in the here and now, and preparing the clients to focus inwards, access feelings and develop a therapeutic focus for the session.

Finally, self-neglect can take the form of self-interruption. Usually, this involves non-verbal actions, like clenching a fist, holding on tears, or freezing. The clients' attention and discourse also may derail to another subject, or the client may stop talking. When that happens, the therapist may start to empathically explore what is going on inside. This task promotes awareness about how the process of interruption is done, and therefore, and how it can be undone.

This separation between self-criticism and self-neglect as two usual forms of developing and maintaining depression should not obviate the possibility of their coexistence in the same client. Usually, one of them tends to prevail, but they can easily co-occur. It is also possible that their importance changes across the therapeutic process.

Interpersonal issues and self-to-self problems can also be intertwined, with implications to the kind of interventions to pursue. In self-splits, the critical voice is often the internalized result of previous interpersonal experiences with critical, humiliating others, who have created an emotional maladaptive scheme of core shame. In some cases, this may also include a history of interpersonal complex trauma, which may demand some adaptations to the therapeutic work beyond the scope of this chapter (see Paivio & Pascual-Leone, 2010, and chapter 10, this volume). When the client feels the critical reprimands as the voice of someone else, therapists may proceed with their work placing the significant other in the critical chair (empty-chair work for unfinished business), and proceed with the usual two-chair dialogue. In that circumstance, therapists help their clients to assert their own

needs and feelings by, for example, setting limits to the critical voice, which subsequently tends to soften and be open to negotiation. However, this may reveal deeper core unresolved feelings, related with loss, abandonment or rejection, which will demand empty-chair work. In some circumstances this is revealed by interruptions involving fear, such as fear of rejection or abandonment by the significant other. As Greenberg and Watson (2005) recognize, all self-to-self problems are mainly embedded in the way clients experienced past significant relationships and how self-organization took place, and therefore, it is no surprise that the usual work in depression combines these issues.

The case of Claudia

As stated previously, a very common depressogenic process has to do with self- splits, in which a very critical or coercive stance attacks the experiential self, who then collapses and feels powerless. Another sort of very common emotional processing difficulty in depression is the unfinished business towards significant others. However, it is quite common to start working with self-splits that are actually fed by more in-depth unfinished business with significant others, which may actually work as very critical, coercive or even "bullying" internal figures.

Claudia, a case drawn from the ISMAI Depression Project, combines these two processes. She was a 57 years old single woman, employed and with a college degree. When she began psychotherapy, randomly assigned to the EFT condition, she initially disclosed great difficulties in affirming herself and complained about feeling sad and lonely most of her time throughout almost all of her life. Her BDI-II score at intake was 25, but increased at the first session to 31 (in a pre-session assessment), suggesting severe depression. She related her mood, though in vague way, to a long

and unsatisfactory current relationship with a man who had had repeated affairs with other women. At the same time, she was also having difficulties in dealing with the death of her mother, which happened 6 months before. She had a history of great dependency toward her mother, with whom she lived, almost all her life. Claudia also showed different forms of self-neglect and self-interruption. For example, she disregarded her own complaints. The initial assessment revealed that she had been depressed for most of her adult life, yet she was not really sure if she was depressed or not, and if her complaints were relevant enough to enter psychotherapy. Nevertheless, she was feeling depressed on a daily basis, facing prolonged grief after losing her mother, and maintained a degrading relationship with her partner because of fear of living alone. She had difficulties in getting in touch with her feelings of loneliness and sadness, disregarding them as signs of weakness.

After an initial period of intense empathic exploration, at session 4, Claudia and her therapist (the first author, a PhD male psychotherapist, with 20 years of clinical experience and 3 years as an EFT therapist) were able to reach an experiential clinical formulation of her situation. Her dependence upon her unresponsive and unfaithful partner, as well as a submissive pattern around her mother all revolved around a pervasive fear of rejection and abandonment.

Claudia: "I feel fear, fear, fear. Afraid to assert myself, afraid of everything, afraid to say anything. I am always in touch with this fear, it is always here. This fear limits me. Afraid to express myself because if I do so others will abandon me and I will be alone. (session 4)

By addressing this fear with a two-chair dialogue between the experiential self and the coercive voice, the therapist invited her to threaten herself:

Client: Yeah, I think about doing that (affirming self)*, but there is something, I'm afraid. [Therapist: I'm afraid.] I'm afraid, afraid of the consequences.*

Therapist: Okay, come here (client moves to the other chair, of the critic voice). Hmm-mm. There is a part of you then that scares you when you say I want to assert.

Client: (sigh) Yes, there is.

Therapist: How does it scare you? How does it do that?

Client: You will be alone.

Therapist: You'll be alone.

Client: yes, I think that's what I am afraid of.

Therapist: You will be alone. You will be alone.

Client: Yeah. That's it. Be alone, very afraid of it. (session 4)

Claudia was very fearful of any prospect of interpersonal conflict and had terrible difficulties in becoming assertive, going to extremes in order to avoid other experiences of abandonment. When facing signs of lack of respect, she would shut herself and become submissive, which then fed a secondary self-criticism about being so subservient. Hopelessness and helplessness were the result, because she saw no way out of this cycle: her healthy need of self-affirmation was sabotaged by her dominant fear of rejection. The consequence was a depression that endured for the majority of her life, probably since her adolescence.

This split which created her fear of rejection was actually derived from some other deeper core issues. By exploring this self-critical stance, she was gradually able to get in touch with her core pain, which revolved around unfinished business with her very critical mother, deceased 6 months ago. Her death was still a very difficult

subject to address, revealing an intense, unresolved hurt. She was reluctant but progressively acknowledged that her mother was felt as a rejecting and even abusive mother to her, throughout her entire life. By inviting her mother to imaginatively sit in the empty chair, the therapist helped her evoke and enact these feelings to deal with her unfinished business:

Therapist: What does that part say? So what does your mum say to you? Even if it is the mother who's inside you.

Client: "Ah! You´re stupid, you do not know anything! You are never still. You only mess things up." That's what she always told me.

Therapist: hmm-mm. You only mess things up!

Client: You only mess things up! (session 4)

Memories of repeated physical punishments, very harsh criticisms and situations where she was completely dismissed emerged. For example, Claudia remembered being slapped on her face publicly by her mother at a party when she was 40 years old, something that still evoked intense feelings of shame and sadness. This type of events left her with core feelings of shame, which led to intense fear of rejection, neediness, and dependency. On the one hand, her inner mother voiced very harsh self-criticisms, in which a sense of "self as bad" was developed, which called for a need of self-affirmation and protective anger; and on the other hand, her mother also evoked unfinished business revolving around longing for unmet love and prizing. These unresolved feelings of longing proved to be the most important emotions. Initially, Claudia, very frequently, interrupted herself , mainly due to guilty feelings activated by her complaints about her mother. These self -interruptions were dealt with in therapy with two-chair enactments. Gradually, she became better able to

access and deal with her unresolved feelings of anger and sadness.

Meanwhile, spontaneously and without any previous warning or discussion during therapy, she decided to break up her relationship with her partner, which sprung out of her need for self-respect and autonomy (around session 6). This also created some fear of being by herself and feeling lonely. This shifted the focus of the following sessions away from her core issues; yet, in session 8, while doing a two-chair dialogue to deal with her self-critical and coercive stance, she recognized spontaneously that her critical voice sounded like her mother's. This created an opportunity to further develop chair-work to deeper levels, culminating in a very poignant and emotional recognition of her longing for love (session 8):

Client (talking to the self chair, while in the critical chair): *You've got no personality, you don't know how to affirm yourself… (*looking to the therapist) *this was left here, it is stuck.*

Therapist: Left by whom?

Client: By my mother (laughs). (resuming the critical voice and looking to the other chair) *You don't have personality, you don't know how to affirm yourself, other people make fun of you.*

Therapist: Hmm-mm. Ok, ok. So let's give a voice to your mother. Be that voice.

Client: [as her mother] *You don't have any personality: You don't know how to affirm yourself.*

Therapist: Come here (inviting to change chairs to the experiential self chair) Hmm-mm, ok. What can you tell her?

Client: I was really sad, oh, and I rebelled myself, rebelled and always told to myself that the truth was that she was wrong…but then deep down I…

Therapist: Hmm, what is it? Can you stay with that sadness? [Therapist focuses on her sadness to help Claudia access her core pain]

Client: Ah I'm... it's too strong. It's painful to be in here.

Therapist: Painful. How is that feeling? Can you tell me about that feeling?

Client: It's tightness. [Therapist: A tightness…] Tightness. I don't know, something that's here, inside. I need to take a deep breath to get it out.

Therapist: To get it out… Stay with that for a moment. So it's almost like you are being…constrained.

Client: Squeezed.

Therapist: Squeezed, hurt?

Client: That's it..

Therapist: Almost trampled.

Client: I felt many times like that, completely trampled.

Therapist: Hmm-mm, so that's the feeling of tightness, anguish. That has to do with that expression of… criticism from your mother?

Client: Always my mother!

Therapist: Of some depreciation.

Client: Always, always.

Therapist: Yes, if we give it a voice… what does it say?

Client: Angry, I'm angry for those criticisms.

Therapist: Hmm-mm.

Client: For discrimination.

Therapist: Hurt, rejected?

Client: I think that the word would be rejection.

Therapist: I'm not having… what is it that you're missing?

Client: (cries) It's difficult.

Therapist: It's difficult to tell.

Client: But I won't cry. I don't want to.

Therapist: Hmm-mm, but…

Client: It's care, attention.

Therapist: Hmm-mm, support.

Client: Yes, that's it.

Therapist: Are you able to tell her that?

Client: (7 seconds of pause and the client starts crying)

Therapist: Because it's hard, it's painful and because of that it's hard for you to stay in touch with that.

Client: I know...what I miss…

Therapist: What is it?

Client: Love. (session 8)

Gradually, Claudia was able in this dialogue to set some limits towards her mothers' criticisms. Thus, some moments later in this session, she addresses her mother in a self-affirming way, achieving a partial resolution of her criticisms:

Client: Oh, I know yes, I know that you were convinced that you were doing the best to me, that you were protecting me or making me aware of the danger. It's that ah, that's what I want to tell you, that you let me grow up, let me.

Therapist: Hmm-mm, ok let me grow up.

Client: Let me grow up but I told her that many times.

Therapist: Ok, but tell her now 'let me grow up'.

Client: Let me grow up.

Therapist: I know how to take care of myself.

Client: I know how to take care of myself. I need to believe that I'm important, that I know how to assert myself and that I have a personality, I am different from you but I have my own way. (…) I need to let go of these moorings. I need to believe in me, I need to believe that I am important.

Therapist: Take a deep breath. (session 8)

Claudia gradually developed her need for more autonomy and confidence, even though the unresolved feelings toward her mother were more difficult and slow to change. However, by the end of the process she was showing a higher capacity for dealing with those issues in the sessions, by letting go of her need of approval and acceptance. In session 15, Claudia was invited to do another empty-chair task with her mother. After differentiating her sorrow in tearful moments of sadness, she was able again to express her unmet need for support. However, when assuming her mother's voice, there was no acknowledgement by her mother of her lack of support:

Client: [Claudia addressing her mother] *Look, you have to value me. It is mandatory for you to value me, that you have pride in me, that you support me and accept me.*

Therapist: That you accept me… (…)

Client: If that's what you were feeling for me, uh, you have to express it. You do not have to hide. You have to show that you feel love for me and affection and pride. You have to show it. (…)

Therapist: Can you come here? (Client switches to the other chair).

Client: [Claudia as her mother] *I have always valued you* (harsh tone).

Therapist: Can you tell her?

Client: Yes, I can. What she would say is that you are silly because I always loved you. I never distinguish between you and your brothers. (…) You are silly…

The expression of her unmet need was not followed by any significant change in her mother's voice. Given that her mother appeared dismissive, Claudia was stuck between her need for recognition and the invalidation by her mother. This created a deep unresolved sadness and feeling of abandonment. So, a few moments later, after returning to her chair, she repeats this cycle of neglect. At this moment in therapy, even though the feeling of neglect still lingered, now it had become fully acknowledged, as well as her basic unmet need for respect and prizing.

This represents a therapeutic impasse, given that Claudia's demands did not evoke any change in her mother's internal voice. This is something that is likely to happen when the person has been subjected to a long history of maltreatment and abuse, as she had. Therefore, the only way out of this dead end was to let go of the unmet need. Claudia reaches this point some moments later (session 15):

Client: I have to live like this. I have to know how to live.

Therapist: So what can you say to her?

Client: I have to live without…

Therapist: I will live without your support…?

Client: I will live without your support and I won't let that affect me. It's like that, I have to accept.

Therapist: Accept that…

Client: Accept that you are just like that.

Therapist: So what do you do about your need? What was her support about?

Client: To feel safety. [Therapist: Ok.] I needed to feel safe.

Therapist: So, I will find that security and safety.

Client: Ah yes, even without you I will achieve that safety.

Therapist: I will become a secure person, even without you.

Client: Yeah, yeah.

Therapist: Even without your support.

Client: Even without your support I will become a secure person, not so fearful of others, less fearful of others' criticisms.

Therapist: I will be me.

Client: I will accept me.

(she goes on reaffirming her self-acceptance and self-trust)

Claudia, on the one hand, was letting go of her need of obtaining prizing, respect and recognition from her mother, which was important for her to feel safe and independent. Without her mothers approval she tended to feel flawed, but realizing that this approval would not happen, she clearly stated that she would find her own way ("I will achieve that safety"). On the other hand, by letting go of this need, she was also able to assert herself and set limits on the inner critical voice that was internalized, coming from her mother. There was a feeling of freedom appearing that was later reaffirmed by Claudia, which let her appreciate the benefits of an autonomous, own voice, and a higher sense of self-respect and support.

By the 16th session the process was terminated (according to the design of the ISMAI Depression project), and her BDI-II score had dropped to 6. In her 3-months follow-up she scored 1 at BDI-II, and in another follow-up after one year and half of the end of therapy, Claudia maintained that same score, which suggested an enduring change.

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