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The role of corrective emotional experiences in the counsellor-client attachment: a model for processing emotions in therapy

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ABSTRACT

Even though emotions are central in many counselling modalities, how best to work with emotions has not often been clearly articulated or practically presented for counsellors. In this paper I outline a brief history of the science of emotion, highlighting the role of emotional regulation in the counsellor-client attachment and present a five-step model of working with emotions in therapy, adapted from the work of Canadian developmental psychologist, Gordon Neufeld. The paper provides a theoretical and practical framework for understanding the crucial importance of a corrective emotional experience for client healing.

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Introduction

For many decades counselling research has focused on cognitive interventions, such as Cognitive Behavioural Therapy (CBT). This may be due to research funding favouring quantifiable data, rather than the softer, qualitative data that is generated by the study of emotions and client's felt experiences. In recent decades, the research focus has been shifting towards emotional processes (Schore, 2012; Schore & Schore, 2008), especially with regard to the therapeutic alliance and the role its emotional component plays in the healing process (Lyons-Ruth et al., 1998; Norcross, 2002; Norcross & Wampold, 2011; Satterfield & Lydodon, 1998). Recent advances in neuroscience have validated much of what counsellors have intuited about the healing power of emotional connection with clients (Horvath & Bedi, 2002). Current research in neuroscience, attachment and emotion regulation, as well as developmental models of emotional functioning, is being integrated into clinical models (Roussouw, 2014), radically altering our understanding of the dynamics of counselling (Schore, 2012).

Over 25 years of practice, I have tried, tested and synthesised various approaches to working with client emotions. In this paper I present a five-step model for working with emotions in therapy, adapted from Neufeld (2015), integrating a developmental, attachment-focused perspective applied to the therapeutic context. Before presenting the model, a brief overview of the history of the science of emotions will be presented, including insights from attachment research and neuroscience, which provide a theoretical framework for understanding the crucial importance of a corrective emotional experience for client healing (Lyons-Ruth et al., 1998).

History of affective science – the science of emotions

Since the rise to prominence of behaviourism and cognitive-behavioural therapy from the 1940s–1980s, treatment developers in psychology have sometimes overlooked the topic of emotion

(Southam-Gerow, 2013, p. 3). In the 1980s, some researchers considered emotion a “nuisance”, or “troublesome intra-psychic” variable, within the interpersonal or systemic perspectives dominant at the time (Neufeld, 2015). Although emotion is mentioned in the Cognitive Behavioural Therapy (CBT) model, it has been argued that much of the psychological research focuses on interventions aimed at behaviour or cognition (Southam-Gerow, 2013, p. 3).

However, beginning in the late 1980s, and continuing through to the 2000s, a renewed interest in emotion emerged in some areas of psychology (Fosha, Siegel, & Solomon, 2009). During this period, some psychoanalysts, many psychotherapists and counsellors began emphasising “the primacy of emotion, the importance of engaged, empathic relatedness for the regulation and processing of emotion, and the value of experiential models of treatment that privilege bodily rooted experience” (Fosha et al., 2009, p. viii).

In the last two decades, counsellors and counselling researchers have overwhelmingly embraced the client’s emotions and been satisfied with softer, less quantifiable data of client feelings and experiences. Nevertheless, it has taken recent advances in the study of neuroscience, for the majority of psychology researchers to accept the study of emotions. In particular, a better understanding of the emotional circuitry in the brain has made emotion more “observable” and thus, for some, a legitimate focus for science (Southam-Gerow, 2013, p. 4). It is now clear that just as emotionally traumatic events can damage the fabric of individual psyches and families, so too can emotion be a powerful catalyst for healing (Fosha et al., 2009, p.viii).

Defining terms: emotion

Lewis (2008) has noted that “despite the recent attention to emotion in some of the research literature, emotion is a poorly defined concept in qualitative research” (p. 64). So as not to repeat this mistake, I will use Mauss and colleagues’ definition of emotions as “multi-faceted, whole-body phenomena that involve loosely coupled changes in the domains of subjective experience, behaviour, central and peripheral physiology” (as cited in Gross & Thompson, 2007, p. 4).

The purpose of emotions are not only to make us feel something, but also to make us feel like *doing* something (Frijda, 1986). Emotions move us, physically and metaphorically (Neufeld, 2014, 2015). They are also integral to making meaning of human experience (Spinelli, as cited in Lewis, 2008, p. 64).

Defining terms: emotion regulation

The concept of emotion regulation emerges as one of the most far-ranging and influential processes at the interface of emotion and cognition (Koole, 2009, p. 4). It involves the “ability to respond to the ongoing demands of experience with a range of emotions in a manner that is socially tolerable and sufficiently flexible to permit spontaneous reactions as well as the ability to delay spontaneous reactions as needed” (Cole, Michel, & Teti, 1994, p. 73). A lack of healthy emotion regulation has been implicated in many forms of psychopathology (Neacsiu, Bohus, & Linehan, 2013), in social difficulties (Lopes, Salovey, Côté, & Beers, 2005) and even physical illness (Sapolsky, 2007). Contemporary research on emotion regulation has its roots in the study of psychological defences, psychological stress and coping (Lazarus, as cited in Gross & Thompson, 2007), emotion theory (Frijda, 1986) and attachment theory (Bowlby, 1977, 1973, 1980, 1982, 1988).

It has been posited that emotionally intelligent people regulate their emotions according to a logically consistent model of emotional functioning (Mayer & Salovey, 1995). Emotion regulation has been understood to develop firstly at an interpersonal level (where the primary attachment figure co-regulates the child), before becoming an intra-psychic process where the child creates internal working models of regulation from mentalisations of contingent, attuned care, eventually leading to the ability to self-regulate (Fosha et al., 2009). It is important to note that the dynamics of co-regulation of emotion also occur within the context of the therapeutic encounter (Alford, Lyddon, & Schreiber,

2006; Lyons-Ruth et al., 1998; Marks-Tarlow, 2011; Satterfield & Lydodon, 1998). Therefore, for our clients to thrive, they must be able to regulate and integrate their emotions in a healthy manner.

Attachment research and the neuroscience of emotional regulation

When Bowlby first formulated attachment theory it was conceived as a trauma model (Bowlby, 1977, 1969, 1973, 1980). Schore (2012) posited that modern attachment theory has become an emotion regulation theory, as the emotional, bodily-based processes are non-consciously regulated or communicated between the primary attachment figure and the child. He emphasises the importance in a newborn's life of a secure, primary attachment to a psycho-biologically-attuned empathic caregiver, whose role it is to soothe and calm as well as enhance joy, interest and excitement. This shapes the child's ability to communicate emotions and influences the critical wiring of infant brain circuits (Schore & Schore, 2008).

I do not subscribe to the clinical classifications of secure vs. insecure attachment as a binary positioning (with the sub-types of insecure: avoidant, ambivalent and disorganised), but rather see attachment along a more fluid continuum from secure to insecure. Perfect parenting which leads to a perfect "secure attachment" does not exist in the world. Therefore, instead of defining the term "secure" attachment as a totalised state of being, I advocate Winnicott's notion of the "good enough" caregiver as a healthy working attachment. So, in this article, when using the term "secure" it is the notion of a "good enough" attachment to help the child or client self-regulate.

Moreover, a good enough attachment between the counsellor and the client is equally valid for emotion regulation in our therapeutic work (Alford et al., 2006; Berry & Danquah, 2016; Satterfield & Lydodon, 1998). What good therapists do with their clients is analogous to what successful parents do with their children, providing them a secure base from which to explore their world (Bowlby, 1988; Holmes, 1993). In the interdisciplinary field of Interpersonal Neurobiology, Siegel has explained how self-regulation occurs within emotionally-attuned interpersonal experiences by the amplifications of shared positive states and the reduction of negative affective states (Siegel, 2012, p. 304). A similar process occurs in counselling. According to Cozolino (2016), early interpersonal environment may be:

imprinted in the human brain by shaping the child's neural networks and establishing the biochemical set points in circuitry dedicated to memory, emotion, safety and survival. Later these structures serve as the infrastructure for social and intellectual skills, affect regulation and the sense of self. (p. 10)

Since our capacity for emotion regulation and our sense of self continue to develop across the lifespan, these principles also apply to the healing and ego development within the counselling relationship. Cozolino (2016) believes that "the processes of attachment and affect regulation [are] central to psychotherapy":

Many of our clients start the therapeutic journey with high levels of alarm in the limbic brain, experienced as anxiety, highly aroused adrenal systems causing hyperventilation and hypervigilance. They are continually scanning for danger in their environments and relationships. An understanding of the neuroscience behind emotional regulation helps shed light on the relational dynamics in counselling which can address these presenting issues. (p. 8)

The relational dynamics of the therapeutic alliance involve the phenomenon of limbic resonance, which is the basis of implicit or automatic emotion regulation from infancy onwards (Lewis, Amini, & Lannon, 2000, p. 154). Limbic resonance is linked to our capacity for empathy and nonverbal connection, forming the basis of our intimate connections and the foundation of our healing. Changes in respiration, heart rate, blood pressure, body temperature and hormones – consistent with other people's emotional states – occur when one person interacts with another, particularly when there is eye contact (Lewis et al., 2000, p. 155). In this sense, a child gets his first taste of his feelings "second-hand; only through limbic resonance with another can he begin to apprehend his inner world" (Lewis et al., 2000, p. 156). Similarly, anxious clients may be regulated by the calm, non-anxious presence of the counsellor, who gently holds their gaze.

Since emotional regulation happens primarily in relationships, it is important that these relationships are emotionally safe “good enough” attachments. A securely attached relationship provides a neural bridge for regulating distress (Nash, Prentice, Hirsh, McGregor, & Inzlicht, 2014). In the context of counselling, it is important to understand that our client’s earliest experiences taught them the skill of understanding another person “in direct proportion to his [or her] parents’ ability to know, understand and attune to him [or her]” (Lewis et al., 2000, p. 207).

If this skill did not develop in childhood, there is still hope for healing through earned security. By developing secure attachments as adults, or good enough attachment experiences, and experiencing emotional dysregulation followed by corrective emotional experiences, healthy emotional regulation can develop. Thus, we can learn to regulate our emotions through good enough attachment experiences, helping us to access and regulate those emotional states that are too overwhelming or intense to face alone. This is in line with the goal of attachment-based therapy (Hall & Maltby, 2014).

Thus, the client-therapist dyad helps clients emotionally regulate by the “felt security” or earned security generated in the relationship. Take, for example, the case of a very anxious middle-aged single mother who arrived at my office, presenting with obsessive compulsive disorder.¹ The disorder manifested in a fixation on asbestos contamination which was adversely impacting her life: she avoided going into her garden which had an old shed in it; she avoided visiting her sister who lived in an old house; she removed her youngest son from multiple preschools due to fears of contamination; etc. We processed many of her emotions relating back to her attachments in childhood. She described her father as critical and overbearing and her mother as absent and shut down. Many tears were shed as we processed various questions: Who comforted her when she felt scared or overwhelmed? Who was reliably there for her when she needed help? Who gave her permission to be her full self? In between sessions, the client wrote many poems related to these questions. Much of the therapeutic work was focused around helping her self-regulate when she felt overwhelmed. She often reported that in her most overwhelmed times between sessions, she would recall her therapist’s voice as she engaged in gentle self-talk: “It’s going to be ok . . . I will be fine, my boys will be fine.” The more the therapeutic relationship developed, the more the client’s sense of self changed and her ability to regulate her anxiety improved.

During the 15th session, the client said: “Through you I have come to see that I am valuable . . . that I have choices in how I think and react when I feel anxious.” As Wallin (2007) explained, this relational, emotional, reflective process at the heart of attachment-focused therapy can “provide a context for accessing disavowed or dissociated experiences . . . [and facilitating their] integration, thus fostering a more coherent and secure sense of self” (pp. 2-3).

Thus, when the counsellor-client relationship is experienced as warm and non-judgmental, it elicits in-depth, reflective narratives that result in healing (Wampold, as cited in Lewis, 2008). Hall and Maltby (2014) have posited that in attachment-based counselling “the client’s attachment to the therapist is foundational in the change process” (p. 195). This is based on Bowlby’s (1988) conviction that the *real relationships* of early childhood (unlike Freud’s notion of internal fantasies about them) and the client’s *real relationship* with the therapist, fundamentally shape personality and produce neuronal change in therapy.

Therefore, it is important that the therapist provides a safe relational space as a secure-enough, base for the client. Firestone (as cited in Farber & Metzger, 2009, p. 4). believes that “real therapy is about creating a brand-new experience of safety, a kind of safety never before experienced in the [client’s] life. This kind of safety provides the atmosphere for inspired guidance and the courage to attempt new behaviour” (as cited in Farber & Metzger, 2009, p. 4). When this emotional safety is present, it can lead to profound healing and growth.

The courage to attempt new behaviour, or experience a more coherent sense of self, are among the outcomes we long for in our client’s lives. However, many of our clients may present as emotionally “stuck”. How do we help them become emotionally unstuck, or process “stuck” emotions? Much of my work has been influenced by Gordon Neufeld, a developmental clinical psychologist. Neufeld’s developmental, attachment-informed approach has been integrated into my work with parents

whose children are experiencing emotional and behavioural difficulties. Moreover, this approach informs my work with adult clients who struggle with anxiety or depression due to early attachment injuries or neglect in childhood.

What follows is an adaptation of Neufeld's five-step model of working with emotions, which he developed for parents, teachers and therapists to use with children who experience emotional and behavioural difficulties. Insights from neuroscience and attachment theory have been integrated to form a framework for working with emotions experienced by adult clients. It must be noted that this model is a simple approach that is most appropriately used with mild to moderate clinical symptomatology, and has not been used, and is not recommended for use, with clients suffering from complex trauma, bipolar or schizophrenic symptomatology.

Neufeld's five-step model for working with emotions

'That which was discarded [emotion] has become the key to the unfolding of human potential; that which moves us, grows us up.' (Neufeld, 2015).

The word "emotion" comes from the Latin word *immovere*: to move. The function of emotion is to move us toward a response. Greenberg (2006) postulated that emotion is primarily a signalling system, which, if ignored, remains unregulated or underdeveloped. A basic assumption of both neuroscience and counselling is that "optimal functioning and mental health are related to increasingly advanced levels of growth, integration, and complexity" in emotion regulation (Cozolino, 2016, p. 25).

Step one: express the emotion

The first step in working with emotions is to help our clients express the emotion they are feeling. Neufeld (2015) has posited a key principle that emotions seek expression to do their work; suppressed emotion cannot do its work. Lack of expression of emotion may mean there is a lack of internal emotional movement; the client presents as "unmoved", cold, expressionless and shut down (Neufeld, 2015). If emotional expression is thwarted it can lead to devastating effects, such as depression (flattened affect); distorted or displaced emotional expression (impulsivity or aggression); failure to adapt to life circumstances and feelings of "stuckness" (Neufeld, 2015).

We can only feel an emotion when it is "stirred up" inside us. The primary defence of the limbic system is to retreat from feeling or to "numb out" (Neufeld, 2015). The Social Engagement System (SES) of the brain, according to Porges' Polyvagal theory, regulates the expression, detection and subjective experience of emotion; if this system is shut down it has significant consequences resulting in "poor affect regulation, poor affect recognition and poor physiological state regulation" (Porges, 2009).

The expression of emotion is viewed as crucial to a positive therapeutic experience and to the change process (Wampold, as cited in Lewis, 2008, p. 64). The role of the therapist is to help clients express the emotion they may be experiencing, but may not be aware of: making the implicit explicit. Therefore, the first thing a therapist needs to do is come alongside the client to help them express the emotion in order to be able to accept it, invite it or assist it in coming to consciousness, so that it can be managed or processed healthily (Neufeld, 2015).

It can be difficult for "stuck" or emotionally shut-down clients to express the emotion they are feeling. When such is the case, consider having the client focus on felt sensations in their body. Mindfulness practices can help to access this felt sensation. According to Baum (2013, p. 38), awareness of physical sensations forms the very foundation of human consciousness; body-centred therapeutic approaches help clients come into the present moment and shift out of fear, numbing and hyper-arousal.

Porges (2009) has argued that "all emotional states require specific physiological shifts to facilitate their expression and to reach their implicit goals" (p. 30) (e.g. fight/flight/freeze, proximity-seeking/

attachment instincts). The importance of engaging the body in therapeutic work is further emphasised by Van der Kolk (2014) who has suggested that clients take up yoga, drama, theatre and music to help process emotions that may have been shut down due to trauma: “in order to find our voice, we have to be in our bodies ... the opposite of dissociation ... acting is an experience of using your body to take your place in life” (p. 331). Psychodrama techniques can be helpful for clients who find it difficult to express bodily sensed emotion. Art therapy, Interactive Drawing Therapy (Withers, 2006), music therapy or any other expressive therapy is a good place to start with clients who may struggle to identify their emotions.

Step two: name the emotion

One reason a client may be unable to express their emotion may be due to a lack of appropriate words for the feelings. Once a feeling can be expressed, it then needs to be named (Neufeld, 2015). The role of the therapist is to coach, explore and help name the emotions that match the client's inner experience. This is the psycho-educational component of working with emotion. Many of our clients did not have early attachment figures who coached them in pairing words with emotions due to lack of contingent, attuned attachment.

Thus, the therapist needs to coach and match words to feelings, similar to the safe attachment role the caregiver plays for young children who are emotionally dysregulated. According to Porges (2009) “psycho-therapeutic treatments may change the neural regulation of physiological states” (p. 29), especially those involved in anxiety, fear, panic and pain. Southam-Gerow (2013) has stated that “children with mental health problems have emotion-related gaps in their understanding that might not be adequately treated by a focus on behaviours and thoughts” (p. 5). Those trained to work with children from a CBT model may have intuited that emotion is the vital missing ingredient in this approach. Research suggests that children with anxiety problems struggle to understand and name emotions (Southam-Gerow, 2013, p. 5). On a practical note, it can be very helpful for clients who do not have a wide ranging emotional vocabulary to be able to see a chart with facial expressions and emotions attached to them (see: http://www.freeprintablebehaviorcharts.com/feeling_charts.htm).

Step three: feel the emotion

‘If you can’t feel it, you can’t heal it,’ says the adage. Thus, the third step in processing emotions is to help the client feel their emotions. Many of our clients seem unable to access their feelings; when asked what they are feeling, they often respond by telling us what they are thinking. One reason a client may not feel an emotion may be due to a perceived lack of safety from wounding (Neufeld, 2015). For many of our clients, to express and experience their full emotional reactions in childhood may not have felt safe. We have a complex brain, vulnerable to a variety of factors that can “disrupt the growth and integration of important neural networks” (Cozolino, 2016, p. 10). The field of counselling has emerged because of the brain’s vulnerability to these developmental and environmental risks (Cozolino, 2016, p. 10).

The role of the therapist is to provide safety for the client to feel their feelings, without shame, censorship or fear of punishment. For this to happen the counsellor must be a safe attachment figure. For a young child, Neufeld (2008) has suggested three things which contribute to feeling emotionally safe in the presence of their caregiver (at least some of the time): delight, enjoyment and emotional warmth; or “an invitation to exist in our presence”. Research on children who have experienced abuse, or extreme neglect (lack of emotional and physical contact) points to the need for children to have both stable emotional attachment with, and safe, emotionally soothing touch from, their primary adult caregivers (Perry, 2002, p. 79). If these ingredients were missing in our client’s childhoods, then they may experience difficulty accessing and regulating their emotional responses.

The client needs to be emotionally “held” by a safe attachment while processing early attachment wounds (active/abuse or passive/neglect). There needs to be a deep empathic connection with the

therapist, limbic resonance (e.g. mirroring the emotion in facial expressions and body language) and building capacity for the emotion to be fully felt. According to Lyons-Ruth and colleagues (1998) “clients remember ‘special moments’ of authentic person-to-person connection with their therapists, moments that altered their relationship with him or her and thereby their sense of themselves ... these moments of inter-subjective meeting constitute a pivotal part of the change process” (p. 283). This is the crucial role of a corrective emotional experience leading to change in counselling.

Step four: mix the emotions

The fourth step involves helping our clients mix, or integrate, the emotions that have already been expressed, named and felt. The role of the therapist is to draw out the range of emotions present in the client, finding the “answer” or the antithesis to the troublesome impulses, helping the client develop their capacity to feel the opposite and complementary emotion in order not to “lose their temper” (Neufeld, 2015). The term “temper” originated in the early 1800s from the Latin word *temperare* and means “to mix correctly”; thus, to lose one’s temper means to lose self-control or to dysregulate emotionally. Getting the right “temper” or mix of emotions is crucial for healthy emotional regulation and integration (Rodriguez, 2013).

The integrative process, according to Neufeld (2015), involves dealing with inner conflict or mixed emotions which is a sign of emotional maturity; it involves the capacity to attend to conflicting signals and integrate or mix them to the right balance. All virtues consist of mixed emotions; for example, self-control is made up of impulses to react tempered by caring about the impact of one’s reactions. Patience is a mix of feeling frustrated but loving the other or the outcome too much to sabotage it with impulsivity. Courage is not the absence of fear, but “fear of the dragon mixed with love for the treasure” (Neufeld, 2015).

Many of our clients come to therapy because of a lack of “mix” or integration: that is, lack of emotional regulation, for example, erupting in aggression towards self (self-harm, negative self-talk, depression or suicidal ideation) or aggression towards others (verbal or physical attack/bullying). According to Neufeld (2015), one factor which may affect our client’s ability to integrate or mix competing emotions is that vulnerable emotions are more likely to be defended against, and therefore not felt. The word vulnerability comes from the Latin *vulnera* which means “to wound”. Examples of vulnerable feelings include: feelings of woundedness (anguish, pain, rejection abandonment); feelings of dependence (neediness, longing, loneliness, insecurity, emptiness); feelings of shyness or timidity; feelings of embarrassment; feelings of shame (‘something is wrong with me,’ I am not enough’ [Brown, 2010]); feelings of futility (sadness, disappointment, grief, sorrow); feelings of alarm (anxiety, apprehension, unsafety, fear); feelings of caring (compassion, empathy, devotion, concern, emotional investment); feelings of responsibility (regret, remorse). If our clients were shamed or had their feelings disavowed during infancy, they may find it too vulnerable to experience their full range of emotions. Emotions can only mix when they are felt (*step three*) and can only be felt if they are named (*step two*) and expressed (*step one*).

A second factor impeding the mixing of emotions is that the person’s prefrontal cortex may not be fully developed. Neufeld (2015) has nicknamed the prefrontal cortex the “mixing bowl” of the brain. Impulsivity is a classic sign of non-integrative functioning in the prefrontal cortex; this occurs when the limbic brain is unable to process more than one emotion at a time or has limited capacity for mixed emotions (Schore, 2003). The development of the prefrontal cortex’s capacity to process two or more competing emotions begins, under optimal conditions, between the ages of 5 and 7 (Neufeld, 2015). Optimal sculpting of the prefrontal cortex through secure (enough) attachment allows us to trust others, think well of ourselves, regulate our emotions, maintain positive expectations, and utilise our intellectual and emotional intelligence for problem solving (Cozolino, 2006).

In order for the client to be able to mix their emotions, they must have capacity in their prefrontal cortex to integrate competing emotions (Neufeld, 2015). According to Ogden (2009), the counsellor’s role is to help the client expand their windows of tolerance of emotionally triggering states. This

involves developing the client's capacity in the prefrontal cortex to manage two competing or conflicting emotions, that is, come to the right "mix", and thus demonstrate self-control or self-regulation (Neufeld, 2015). To use an example from the CBT model, the cognitive distortion of "all or nothing thinking" or black and white thinking is a sign of an unintegrated prefrontal cortex, where only one feeling or perspective can be held at a time, rather than the more "mature" or nuanced perspective of holding two emotions or perspectives in balance.

The third factor which keeps emotions from mixing is that inner conflict is not embraced, or there is no room for mixed feelings in the client's narrative (Neufeld, 2015). Here the therapist has to "tread carefully" using deep empathy and active listening skills when painful experiences are being explored in a session (Lewis, 2008). Without a supportive response from the therapist, the flow of narrative may abruptly stop followed by intense emotional responses which may disrupt the client's sense of self. Thompson (2015) has attributed this abrupt disruption in the client's experience due to the effect shame has on the limbic brain. At this point the client may "dis-integrate" and swing back to all-or-nothing/black-and-white intense emotional responses, possibly followed by "shutting down" or "numbing out".

Therefore, it is vitally important that the therapist is able to self-regulate in these circumstances and stay present to the client's emotional reactions. As Van der Kolk (as cited in Ogden, 2009, p. 204) says, "you're only as good of a therapist as you are an affect regulator". According to Coombs, Coleman, and Jones (2002), clinicians, "whatever their theoretical background, must forge a path in therapy through a welter of client affect ... as well as their own emotional reactions to the client" (p. 233). This emphasises the vital necessity for therapists to have regular supervision, and ideally our own ongoing therapy.

Step 5: reflecting on emotions

The fifth and final step in processing emotions is to help the client reflect on the emotion or range of emotions they are experiencing. In the attachment research literature, Tronick (2003) noted that:

Mother and infant, as well as client and therapist, co-create dyadic states of consciousness, making implicit and explicit sense of the world out of their normally messy exchanges ... These co-creative processes lead to change in the child's, and client's state of knowing the world, and also changes the way the client makes sense of the world and ways of being with others (p. 473).

The process of reflecting on emotions is what Neufeld (2015) has called "taking up a relationship with our emotions." This implies moving from implicit or unconscious emotional regulation to awareness of emotions and what may be happening in the body; possibly displayed in the client's behaviour and choices, as well as in their narratives. With reflection, the client is able to move from impulsive reacting, to empowered responding. The client is able to see that they have a choice in terms of how they process an event or an emotional reaction: as the victim, or as an empowered agent. Glasser's Choice Theory-based counselling focuses on helping clients learn to make self-optimising choices (Glasser, 2010). Mindfulness based practices focus on helping the client to stay present with the experience, in a non-judgmental state (Kabat-Zinn, 2011). In an agentic focused therapeutic approach we offer opportunities to explore what emotions come up for the client, emphasising that their emotions are only "data, not directions" (David, 2016), therefore they can make choices about how to respond to those emotions and go through the steps outlined above.

'Taking up a relationship' with our emotions (Neufeld, 2015), can lead to "positive affect regulation, biological homeostasis and the quiet internal milieu allowing for the consolidation of the experience of subjectivity and a positive sense of self" (Cozolino, 2016, p. 25). What Cozolino means by "quiet internal milieu" may be similar to Neufeld's term "psychological rest". Neufeld (2008, 2009, 2012, 2015) has posited that the end goal in working with emotions is to bring the client to "psychological

rest". His point is that all growth, physical and psychological, comes from rest. In the Christian contemplative tradition, this would be described as coming to a place of deep peace, or surrender.

Thus, the ability to reflect on emotions is the crown jewel mounted on the foundation of all the other steps in processing emotions. Without the earlier steps it is unlikely a client would reach this deep integrated, reflective, peaceful place. This is why an emotionally safe, attuned therapeutic relationship is key to deep, emotional work.

Conclusion

In conclusion, in this paper I have presented an adaptation of Neufeld's (2015) five-step model of working with emotions in children, integrating attachment research and neuroscience findings, to more fully understand the dynamics of emotional regulation in adult clients. I have argued that safe emotional connection in the therapeutic relationship is vital for the processing of emotion. Relationships have come to take centre stage in all clinical fields with attachment now considered the key element in emotional well-being across the lifespan (Schoore, 2012). We have also seen that the communication of emotions in the first years of life ultimately leads to the child's ability to self-regulate in later years (Schoore & Schoore, 2008).

Even if early experiences of care were not optimal, there is hope for healing in adult relationships, thus gaining "earned security". According to Wallin (2007), "if early relationships promoted an insecure or preoccupied attachment pattern then subsequent relationships can offer us second chances, perhaps affording us the potential to love, feel and reflect with the freedom that flows from secure attachment" (p. 133). Therein lies the hope of therapy: emotions experienced within the safe, relational context of our attachment with our clients can lead to maturation in their self-regulation, enhancing their emotional wellbeing. Emotional regulation and safe attachment relationships are at the heart of emotional wellbeing in adults. It is hoped that this five-step model – expressing, naming, feeling, mixing and reflecting on emotional experiences – will serve counsellors as a guideline to more confidently work with emotions in therapy.

Note

1. Care has been taken to hide any identifying information of the client, and written consent to include her in this publication has been obtained.

Disclosure statement

No potential conflict of interest was reported by the authors.

Notes on contributor

Ruth Lawson-McConnell is Senior Lecturer in Counselling in the School of Social Practice at Laidlaw College, New Zealand, and has a private practice. She did her MA in Psychology at Aberdeen University, Scotland, followed by her PhD in Counselling Psychology from Robert Gordon University, Scotland. Over the past 26 years, Ruth has worked as a counsellor in Scotland, Canada and New Zealand. Her areas of research include: attachment-based psychotherapy, counselling children of divorce, research methods in counselling, culturally-sensitive counselling, and the neuroscience of therapeutic relationships.

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