When a Family Begins Anew

Core Concepts of Family Therapy

Saša Poljak Lukek

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To Lara, Ines and Julija.

It is because of you
that I continue to learn.

About the author

Saša Poljak Lukek, PhD, is a family therapist whose work bridges the gap between clinical practice and academic research. She has extensive experience in psychotherapy with couples and families, focusing on relationship dynamics and mental health issues such as addiction, violence and parenting. In her academic career, she has contributed to the advancement of family therapy through teaching, supervision, interdisciplinary and international collaboration. Her research explores the intersection of family processes, intergenerational patterns and the process of identification and change in psychotherapy. She has published widely in the fields of psychotherapy and family studies and is actively involved in professional networks to promote evidence-based practice in family therapy.

Contents

Foreword by Prof. Dr. Christian Gostečnik

(the author of Relational Family Therapy: The Systemic, Interpersonal and Intrapsychic Experience)

The monograph When a Family Begins Anew by Assoc. Prof. Dr. Saša Poljak Lukek – consisting of an Introduction, six chapters with subsections, and a Conclusion – is analytically – methodologically, professionally, therapeutically and educationally well conceived.

Already in the Introduction, the author articulates with great clarity the purpose of her work, which, in her own words, is to present and define the therapeutic relationship based on her own long-standing, deeply emotional and intellectual therapeutic process. She identifies this process as the most significant dynamic, marked by the dimensions of a process in which the therapist persistently seeks answers to the fundamental question of what takes place in a therapeutic session, or, as she puts it, why this dynamic process occurs precisely to her, alongside her, and with her. In the following chapters, the author provides answers to the fundamental questions posed at the outset, namely: what constitutes the core of family therapy, what makes it recognizable, and how it differs from other therapeutic approaches. She thoroughly defines and concretely describes how to initiate the therapeutic process, which lends the entire work particular value. Importantly, she does not remain solely on a theoretical level, but instead demonstrates concretely

how, at the beginning of therapy, one must observe the participant and, above all, to which aspects special attention must be paid. She dedicates particular attention to the therapeutic process itself, which she throughout the work illustrates by means of concrete questions, answers, and transcripts that represent not only the initial but also subsequent therapeutic encounters.

In continuation, the author articulates with great specificity – thus lending the monograph notable practical and applicative value – the characteristics of the therapeutic process to which it is necessary to pay special attention, while also demonstrating how to establish a professional therapeutic relationship that can be evaluated. The author devotes considerable attention to the dynamics that occur beyond the spoken word, with a special emphasis on content that is consciously or unconsciously present both within and outside the therapeutic relationship or process. She further stresses the definition of therapeutic interventions and their mechanisms, explicitly underlining that empathy, embodiment, and particularly the processing of the therapist's own psycho-organic material constitute essential therapeutic tasks. Moreover, the author addresses and defines the dynamics of change in family therapy and devotes significant attention to issues related to the conclusion of the therapeutic relationship.

It may therefore be said that the entire monograph is distinguished and recognizable above all by virtue of its appropriate scientific and professional framework, which provides the work with the required scholarly structure, as well as with clarity and coherence – making it an excellent textbook. To this one must add the specificity of the thematic units, which follow the therapeutic process sequentially, are logically organized, and demonstrate the author's mastery of the methodology of educational-scientific work, as well as her skill in selecting and citing appropriate literature. The references are well chosen, and above all, she demonstrates the ability to articulate content in a compelling manner. Particularly worthy of mention are the extraordinary value of the concrete therapeutic transcripts and the principles underlying the

therapeutic process, which simultaneously constitute its essential elements. It is equally important to emphasize that the author presents the entire therapeutic process in line with the guidelines of contemporary research in therapeutic work, situating it in both a theoretical and a practical framework, and demonstrating its applicability for educational and therapeutic purposes. The work displays originality of thought, a distinctive integration of therapeutic theories and practices, and a connection with new perspectives, which she presents convincingly. All of this provides a fresh insight into the subject matter, while also testifying to the author's capacity for critical reflection, integrated with theoretical and educational considerations.

I therefore highly recommended the book to both those at the beginning of their journey in therapeutic practice and education, and to therapists with experience who wish to deepen particularly their scholarly and educational approach – an approach of particular importance in all forms of supervision.

Foreword by Assoc. Prof. Dr. Sebastjan Kristovič

(director of the International Institute for Psychotherapy and Applied Psychology, ECM)

The scholarly monograph When a Family Begins Anew. Core Concepts of Family Therapy offers a thorough, extensive, and comprehensive treatment of the processes of family therapy. The monograph is systematically and concisely structured. Its author, Dr. Saša Poljak Lukek, presents the fundamental concepts of family therapy on the basis of clinical experience as well as scientific research. In an academically rigorous manner, she independently examines and addresses highly relevant areas of both professional practice and scholarship. The monograph provides an in-depth overview of the history of family therapy and situates the discipline among other forms of assistance in the field of mental health. This framework enables the reader to gain a deeper understanding of the discipline and to apply its findings more effectively. A central feature of the book is its systematic analysis of the individual phases of family therapy. The author divides the process into five basic phases: planning and assessment, the therapeutic relationship, change-oriented interventions, maintenance of change, and conclusion of family therapy. Within each phase she discusses essential psychotherapeutic concepts such as: therapeutic goals, motivation, therapeutic diagnostics, the therapeutic alliance, empathy, attunement in therapy, transference, countertransference,

identification, affective awareness, implementation, the definition of change in therapy, implicit relational awareness, integration, and the conclusion of the therapeutic process. Each concept is supported by an extensive body of literature and research, reflecting the depth of the author's scholarly work. One of the principal strengths of this monograph lies in its clarity and accessibility. Despite the complexity of the subject, the author succeeds in explaining the core concepts of family therapy in a way that is understandable even to readers without prior expertise in the field. The text is enriched with clinical case studies that illustrate the application of theoretical foundations in practice. These examples accurately present individual concepts and constitute a significant scientific and practical contribution to the discipline of family therapy. Through a straightforward and logical style of writing, the author succeeds in elucidating the key concepts necessary for understanding the therapeutic process. Furthermore, the monograph provides insight into contemporary research and achievements in family therapy, defining its core concepts on the basis of the most recent studies and leading theoretical frameworks in the field. It also opens up a number of directions that point toward the promising future development of family therapy.

Taken as a whole, the scholarly monograph When a Family Begins Anew. Core Concepts of Family Therapy represents a valuable contribution to the discipline. Dr. Saša Poljak Lukek has succeeded in presenting complex themes in an accessible and engaging manner, thereby stimulating discussion, reflection, and further research in the field of family therapy. I would recommend this monograph to all those working clinically in family therapy or related psychotherapeutic modalities, as well as to researchers in the field and to readers interested in the course of family therapy.

Instead of an Introduction – A Personal Take on Family Therapy

I am a family therapist, and for the past fifteen years I have been practicing and researching family therapy.

When I first entered a therapy room – and then for the tenth, twentieth, and even the hundredth time – I firmly believed that my mission was to help people get rid of painful emotions. With this conviction I welcomed my first client and began building my experience as a therapist.

Today, after fifteen years of experience, I begin therapy sessions with a very different approach – no longer aiming to take away my clients' painful emotions, but instead to help them discover how even their deepest struggles can lead to better self-understanding, stronger relationships, and a safer and more welcoming world that inspires curiosity, creativity, and a genuine sense of belonging.

Taking responsibility for other people's feelings is an overwhelming burden and responsibility that no one can carry. Some of us, however, learned early in life that our value in relationships depended on doing just that, and perhaps chose a profession often described as demanding and emotionally taxing. Even in our first social smiles at just a few weeks old, we show a natural pull toward caring for others. Somewhere deep inside we carry the belief that people around us should feel good – and we unconsciously assume the *task of protecting others from their painful emotions*. Although we are often quite unsuccessful in this regard, some of us find it very difficult to relinquish

this task. However, I would argue that this very insight is essential for the practice of psychotherapy. We should come to understand that the feelings experienced by those who enter therapy are not dependent on us, and we are not responsible for them. We should grow beyond the child's instinct to fix the pain of those who, in truth, are capable of caring for themselves. Only then can we create a reciprocal, collaborative therapeutic relationship where therapists are not »fixers« of emotional suffering, but companions in the search for new ways of experiencing, feeling, and behaving. Only then can we open ourselves to the vulnerability required to form true, healing connections. A child cannot collaborate with an adult parent; the child only wants the pain to disappear. And if we as therapists aim primarily to remove painful feelings, we are acting from the powerless position of that child who cannot bear emotional pain because it feels unfamiliar or overwhelming. No matter how well-intentioned we are, this starting point loads us with a burden too heavy to bear – and, worse, it hinders our clients' growth toward greater emotional resilience and autonomy. Moreover, believing we can spare someone their pain positions us above the deep, intimate relationships they have already formed. If their closest relationships could not protect them from suffering, how can we presume that we can? Just as a child might believe that being perfectly behaved could ease a mother's anxiety, or that anger could draw a father closer to the family, we may unconsciously believe we can save our clients from pain.

In a therapeutic career, we should mature. Sooner or later, we have to allow ourselves to relinquish the responsibility we carry for others and, first and foremost, take care of ourselves. Only when we are able to take that risk do we gain the opportunity to enter into adult, reciprocal relationships. As a therapist – and also as a daughter and wife – once I began to care for myself, I was ready to step into another person's pain and to learn and grow within that space. This insight has also shaped the way I raise my own children. Truly recognizing that I cannot take away their pain and suffering – and that,

inevitably, I contribute to some of it – has allowed me to be more relaxed, more authentic, more present, and ultimately more fulfilled in my relationship with my daughters. When I stop trying to take painful emotions away from them and instead choose to remain with them in those emotions, I, too, am learning.

In my therapeutic practice, I no longer fear the difficult stories and painful emotions that people bring into my office. I know that their stories will continue to move me, time and again. But I also know that I can trust the therapeutic relationship, and that I am not responsible for feelings that originated in other relationships or even in different times. All I need to do is to be willing to experience those emotions alongside my clients. What grounds me is the awareness that these individuals have already survived their trauma – and if their bodies were able to endure it, then I can endure hearing about it and being present with the pain they are revisiting. I know that my office is a safe space. I know I work in a professional collective where I can always find support and understanding. And I know I have secure emotional grounding in my personal relationships. From this position of safety – a position I have worked hard to achieve – I no longer feel the need to »rescue« clients from their pain. *Instead, I strive to feel with them and to accompany them in discovering how even their most painful emotions can be used to deepen their self-awareness, foster secure relationships, and cultivate a sense of the world as an inviting space – one that stimulates curiosity, creativity, and a desire to remain engaged.*

I often return to a metaphor that illustrates the difference between compassion and empathy. Imagine a person trapped in a dark pit. Compassion might prompt us to want to help – we understand what the person is going through because we know what such dark places feel like, and with the best of intentions, we look for ways to help them climb out. However, we remain outside the pit, unsure or unable to descend into the unknown. The person should find their way out on their own. Empathy, on the other hand, does not

allow us to remain outside. In empathy, we descend into the dark pit – even if we've never been in that specific one and even if we don't know exactly what to expect. We might recall our own dark places, which offer some resemblance but are never quite the same. Still, we are willing to descend, to find the person, to begin a dialogue, to search for the right words, and to sit with them for as long as it takes until they themselves are ready to begin the climb out. In therapy, I do not revisit my own dark places simply to understand those who come to me – none of my experiences are identical to theirs. But I am willing to enter their darkness, to sit with them there until fear, anger, sadness, shame, and disgust no longer inhibit me but instead help me stay grounded and attuned. My own experiences of suffering give me the courage and confidence to believe that there is always a path back to the light. In therapy, I search for words and meanings that implicitly convey this message: that despite the pain, the relationship feels manageable and even comforting. Together, we can find ways to face these difficult emotions, process them, and use them as a foundation for new life experiences.

This book has been in the making for several years. Each therapeutic process I have undertaken with the individuals who entrusted me with their struggles and life challenges has surprised and taught me something. I would like to take this opportunity to express my sincere gratitude to all who chose to work with me. I deeply respect the courage of anyone who decides to enter therapy, and I am often very proud of the changes people are able to make through the therapeutic process.

My clinical experiences are presented here through sample cases: individual therapy with Monica, family therapy with a four-member household, couples therapy with Thomas and Sabina dealing with infidelity, Bogdan and Erica facing addiction-related issues as well as others. All excerpts are anonymized – personal details have been changed or are entirely fictional – and are intended to illustrate clinical applications of the theoretical concepts discussed.

My curiosity has continually compelled me to explore the therapeutic process, with a particular focus on understanding not only what unfolds in the therapy room but also why it manifests in precisely the way it does within my own clinical setting. This book offers answers to questions such as: *What exactly is family therapy? How does it differ from other forms of support for individuals in emotional or psychological distress? How does one begin the therapeutic process? How should a therapist observe clients and what warning signs should be closely monitored? What happens within the therapeutic relationship? How is a professional process established? What occurs beyond what is explicitly said in therapy? How can we define interventions in family therapy? How do we recognize and describe change? And finally, how do we bring the therapeutic process to a close?*

These are just a few of the ongoing questions I continually ask – and in this book, I offer several starting points for addressing them.

1

What Is Family Therapy – From I to We

1.1 Founders of Family Therapy

Family therapy first emerged in the 1960s in the United States as a new form of support for psychiatric, emotional, and relational challenges. Until then, individuals facing such difficulties were typically treated through individual psychiatric care, often separated from their families and social environments. The focus was primarily on the individual, rather than on the family or other significant relationships. The pioneers of family therapy faced a considerable challenge for their time: shifting attention away from the individual and toward relationships – moving from an individually oriented treatment of mental health difficulties to a systemic, relational approach. Family therapy emerged in the second half of the twentieth century as one of the new psychotherapeutic approaches, carving out its place alongside the then-dominant and highly esteemed psychoanalytic tradition.

The origins of family therapy are closely tied to a paradigm shift within psychiatry. Harry Stack Sullivan (Sullivan, 1954) offered an alternative definition of psychiatry, describing it as the study of processes between people, asserting that an individual's personality cannot be separated from the interpersonal relationships in which one lives and exists. The books *The*

Family in Psychotherapy (1957) by Christian Midelfort and *The Psychodynamics of Family Life* (1958) by Nathan Ackerman foreshadowed the development of family therapy. By studying the families of symptomatic individuals, both authors highlighted that taking relational and family experiences into account could offer a new and different understanding of psychopathology.

The development of family therapy originated from several key groups of mental health professionals who were particularly focused on understanding schizophrenia and the role of family relationships in the emergence of its symptoms. One of the first such groups formed around Gregory Bateson, joined by Jay Haley, John Weakland, William Fry, and Don Jackson. Their collaborative research and theoretical contributions significantly influenced the evolution of family therapy. Although they did not practice this therapeutic approach themselves, they placed great importance on the family as a central factor in understanding symptomatic behavior.

In addition to research focused on mental illness – especially schizophrenia – the foundations of family therapy were also shaped by psychoanalytically trained therapists who worked directly with families in clinical settings. Key figures associated with the development of multigenerational family therapy include Ivan Boszormenyi-Nagy, Carl Whitaker, James Framo, David Rubinstein, and Geraldine Spark. This form of therapy emphasized not only the significance of current family relationships but also the transmission of emotional content across generations. Despite the dissolution of some of the early professional groups after 1960, certain members – most notably Jay Haley – continued their work and played a central role in guiding the further development of the family therapy field.

> In his book *Uncommon Therapy* (1973), Jay Haley describes strategic therapy as an approach in which the therapist takes responsibility for directly influencing the clients in therapy. In strategic therapy, the therapist takes the initiative in guiding the therapeutic process and designs specific strategies tailored to the problem presented. Symptoms

> are viewed as solutions to problems within the family system, and are explored accordingly. Strategic therapy is short-term and solution-focused, requiring the therapist to clearly define the therapeutic goal, design interventions aimed at achieving that goal, monitor clients' responses, and reflect on the outcomes of therapy.

Murray Bowen also continued is work, laying the foundation for key concepts in family therapy through the study of family systems. Among his theoretical contributions is the concept of triangulation, or the formation of emotional triangles within families, which remains a foundational framework for many family therapists in understanding emotional dynamics within the family system.

> Bowen (1978), through his definition of the triangulation process in families, prompts reflection on the idea that stress arising within a relationship does not originate solely from that dyadic interaction. Instead, unresolved conflict between two family members is often unintentionally regulated by a third person. In families, heightened and unresolved conflict between parents is most commonly resolved by a child, whose symptomatic behavior serves to diffuse emotional tension. Because of their deep need for belonging, children are particularly vulnerable to being drawn into this regulatory role within the family system.

Virginia Satir is another pivotal figure in the development of family therapy. Her understanding of communication, emotional interconnectedness among family members, and the impact of family dynamics on individual personality development has profoundly shaped how the individual is conceptualized within the therapeutic context.

> Virginia Satir (1964) introduced the *Process of Change Model* as both a framework for individual transformation and a means of coping with change. The model outlines change in four stages: the *initial status quo, chaos, practice and integration,* and the *new status quo*.

> The individual begins with a familiar routine and established perceptions of relationships and the world, which provide a sense of predictability and familiarity. The next stage, *chaos*, arises when life changes disrupt these patterns, rendering old frameworks ineffective. During this phase, individuals experience intense and painful emotions such as confusion, helplessness, anger, and fear. At this point, the therapist intervenes to help the family manage and regulate these emotions. This phase is essential for transformation, as it opens up space for creativity and perspectives beyond existing frameworks.
>
> The third stage, *practice and integration*, involves family members exploring and applying new ideas and skills, a process that requires patience and repetition.
>
> Through repeated application, what was once »new« becomes familiar and forms the *new status quo*. Individuals and families internalize the change to the extent that it becomes part of their new sense of predictability and normalcy.

Another prominent figure from this period is Salvador Minuchin. An Argentinian-born psychoanalytic psychiatrist, he made significant contributions to the development of family therapy, particularly through his work with delinquent youth in New York. In the course of his clinical practice, Minuchin developed a new therapeutic approach to families, which he termed structural therapy. He also introduced innovative training methods for future therapists, including the use of one-way mirrors and the recording of therapy sessions – methods that remain standard in psychotherapeutic education today. His supervisory work focused particularly on collaboration with organizations supporting families affected by poverty, racism, and discrimination based on gender or sexual orientation.

> Salvador Minuchin (1974) emphasized that Structural Family Therapy addresses problems within the family system itself, highlighting the importance of the therapist recognizing and influencing the patterns

of relationships among family members as well as between different family subsystems. Through structural interventions, the therapist aims to disrupt dysfunctional family patterns and replace them with more functional ones. Most families attempt to solve their problems through first-order changes (changes in specific behaviors), but Minuchin proposed that true transformation of the family structure can only occur through second-order changes (changes in the underlying family rules).

Family therapy experienced its true emergence after 1970, when the American Association for Marriage and Family Therapy (AAMFT) published the first educational standards for family therapy training programs. This marked the beginning of the professional standardization of the field, which was subsequently recognized by national health organizations. While the core development of family therapy occurred in the United States, European psychotherapeutic practices gradually began to embrace systemic treatment of the entire family unit.

In Europe, the main centers of development were Italy and the United Kingdom. In Italy, under the auspices of the Institute for Family Studies, the renowned »Milan Group« was formed, comprising Gianfranco Cecchin, Giuliana Prata, and Luigi Boscolo. A key contribution of this group was the recognition that many families seeking therapy often resist change. They turned this paradox into a therapeutic technique, using circular questioning or triadic interviewing, wherein one family member is asked to describe the relationship between two others. In the United Kingdom, family therapy became closely aligned with social work, carving out a space within the field of family and individual care services.

By the 1980s, various schools of family therapy began to take shape, moving away from the dominance of individual founders. Under the broader umbrella of family therapy, models such as systemic family therapy, narrative therapy, solution-focused brief therapy, and transgenerational therapy developed. At the turn of the new millennium, family therapy faced new challenges brought

about by the evolving understanding of family structures and relationships, as well as broader sociological transformations. Family therapists had to come to terms with the fact that no universal solution exists for individuals or families; rather, meaningful change emerges uniquely and distinctively from within each person. In addition to the diverse approaches to understanding symptomatology in family therapy, new therapeutic frameworks emerged in response to the sociological changes of the time. Guidelines were developed for working with a variety of family structures, including single-parent families, same-sex parent families, blended families, as well as families from different ethnic backgrounds and religious traditions. These adaptations reflected a growing recognition of the complexity and diversity of modern family life, requiring therapists to adopt culturally responsive and context-sensitive approaches in their practice.

> **Definition of Family and Systemic Psychotherapy – Association for Family Therapy and Systemic Practice (AFT, 2023)**
>
> Family and Systemic Psychotherapy – also known as Family Therapy – can help people in close relationships better understand and support each other. It provides family members with a safe space to express and explore difficult thoughts and emotions, to understand each other's experiences and perspectives, to appreciate each other's needs, to build on family strengths, and to work together toward making changes in relationships and in life in general.

Family therapy has also developed significantly in Slovenia.The evolution of family therapy has been marked by the introduction of systemic family therapy into psychiatric and psychological treatment, the advancement of cybernetics in psychotherapy and the systemic approach (Možina and Rus Makovec, 2010), and the development of the innovative model of relational family therapy (Gostečnik, 2017, 2022).

> Relational Family Therapy (RFT), developed by Dr. Christian Gostečnik, is an innovative therapeutic model for treating families and couples. It integrates three basic relational theories – interpersonal analysis, object

relations theory, and ego psychology (Gostečnik, 2017) – and is further enriched by key findings from neuroscience (Gostečnik, 2022). At its core lies the concept of the relation, or therapeutic relationship. From the perspective of the relational family model, the therapeutic relationship has the unique capacity to reenact and bring to awareness dissociated, denied, and hidden aspects of the client's inner world (Schore, 2012; Siegel & Solomon, 2013; Stern et al., 2010). This allows the client to identify and give meaning to previously unconscious experiences that have shaped their systemic and interpersonal interactions. The primary goal of therapeutic intervention in RFT is to connect present experiences with past events, fostering awareness of the past and empowering the client to gain control over current relational patterns. This is achieved through a transformation of the individual's emotional experience and perception (Gostečnik, 2017).

Affect regulation represents a cornerstone intervention within Relational Family Therapy. Interventions focus on the integration of early memories and the correction of affective experiences through therapeutic engagement, which promotes changes in implicit relational awareness (Poljak Lukek, 2011; Stern et al., 2010). This results in a shift in the symbolic internal experience of both self and other. In the therapeutic relationship, the therapist utilizes the compulsive repetition of dysregulated affective responses to offer a new experience of safety, acceptance, and understanding (Gostečnik, 2017).

1.2 Modern Family Therapy

In contemporary approaches, family therapy complements the systemic view of the individual with psychodynamic and neurobiological theoretical foundations. Systemic interventions, which focus on the present, are thus enriched by modern modalities of family therapy with interventions aimed

at understanding an individual's inner psychological experience and, to some extent, their past experiences.

The Internal Family Systems – IFS (Schwartz, 2001)

The IFS posits that consciousness is composed of multiple internal parts, all of which exist around a core, a true Self. These internal parts develop in response to life experiences and may adopt extreme roles. Each part has its own perspective, interests, memories, and viewpoints. A foundational principle of IFS is that every part serves a positive purpose – even when its actions appear counterproductive or dysfunctional. Rather than being combated, suppressed, or eliminated, these parts should be acknowledged and engaged with compassion. The IFS approach encourages internal harmony and integration in order to restore psychological balance.

The IFS model is based on three primary categories:

- Exiles represent psychological trauma, often stemming from childhood, and carry emotional pain and fear. These parts are typically suppressed or isolated from the rest of the system, yet their presence can polarize internal dynamics.
- Managers adopt a protective, preventive role. They regulate how a person engages with the external world and attempt to prevent emotional pain or trauma from surfacing into conscious awareness.
- Firefighters emerge when exiles break through suppression and demand attention. Their role is to distract the individual from the pain and shame of the exiles, often through impulsive or maladaptive behaviors such as substance use, overeating, or aggression. In some cases, they may redirect attention toward more socially acceptable but still excessive behaviors such as overworking or compulsive exercising.

Managers and firefighters work to shield the individual from consciously experiencing the pain carried by exiles. The goal of IFS therapy is to heal these wounded parts and reestablish internal equilibrium. The therapeutic

process begins by accessing the core Self and, subsequently, facilitating understanding and healing of each part.

Although the importance of the therapist's personal qualities was already emphasized by some early pioneers of family therapy (Bowen, 1978; Satir, 1964), the role of the therapist in shaping the therapeutic process and outcome has gained increasing at the beginning of the third millenium (Rober, 2021). In earlier models, the family therapist was primarily expected to master various techniques and skills, which could then be applied to help families achieve change. However, with the emergence of a new paradigm, the family therapist is expected not only to utilize professional knowledge but also to establish a relational context that co-creates the conditions for change. In this paradigm, the family therapist is no longer seen as a neutral, objective, and technically dominant expert, but rather as someone who actively works to co-create a collaborative therapeutic relationship. The therapist initiates processes that enable new forms of narration, interpretation, and understanding to emerge within the therapeutic relationship. Central to this view is also the recognition of the therapist's personal history: professional competence is no longer equated with emotional detachment, but with the ability to transform one's own life experiences into empathy, affective attunement, and the creation of conditions for implicit change in the client's inner experience.

Consequently, introspective and retrospective self-work is becoming an increasingly vital component of training and professional development in family therapy (Rober, 2021). Therapists should cultivate self-awareness regarding their emotional responses and belief systems, including how their personal history shapes reactions in current relationships and under stress. Theoretical knowledge and technical proficiency, while important, are not the decisive factors in determining the quality of the therapeutic process. Rather, it is the so-called relational quality – the therapist's capacity to adapt within the relationship and co-create an interpersonal space – that lies at the heart of effective therapeutic work.

This concept of interpersonal influence and the co-constructed nature of the therapeutic relationship is also central to Dynamic Systems Theory. The theory maintains that: (1) the therapeutic process is governed by an inherent drive toward relational organization between therapist and client; (2) both therapist and client contribute to the process with their individual characteristics; (3) patterns of interaction within the therapeutic relationship are inherently unpredictable; and (4) the therapeutic relationship is shaped by the personal histories that both therapist and client bring into their relationship (Stern et al., 2010).

Intuitive Responsiveness and Reflective Inner Dialogue in Family Therapy – Peter Rober (2017, 2021)

Family therapists should trust their intuition in responding to family members. The therapist's presence is a key factor in empathic listening – what Rober describes as »listening with the heart«.

In family therapy, the therapist engages in two cognitive processes:

- **Fast thinking** refers to intuitive or bodily responsiveness to the context. This knowledge is acquired through experience and the development of patterns that allow for immediate, implicit decision-making. The therapist responds intuitively and remains attuned to the shared experience unfolding in the therapeutic dialogue.
- **Slow thinking** involves deliberate, effortful mental activity. This process corrects the fast-thinking system, which is not always reliable. Through slow thinking, the therapist creates plans, monitors their own behavior, and adjusts actions to align with therapeutic goals.

The therapist constantly moves back and forth between intuitive responsiveness and reflective internal dialogue. Intuitive responsiveness is essential for establishing interpersonal connection between the therapist and family members, and for cultivating a safe intersubjective space in which clients feel secure enough to share their personal stories. However, intuition can also be risky if the therapist does not monitor the effects of their intuitive

responses. Therefore, therapists should remain reflective and open to feedback from family members. While the therapist initially enters the therapeutic relationship guided by intuition, this intuition should be continuously reflected upon and subjected to supervision throughout the process.

Maintaining equilibrium between intuitive responsiveness and reflective, goal-directed action in family therapy requires the development of deliberate practice. This practice is systematic, seeks out weaknesses and areas for improvement, draws on expert support, and is continuously focused on self-improvement (Ericsson & Lehmann, 1996; Rousmaniere, 2017). By integrating deliberate practice into family therapy, the therapist is placed in a position of ongoing learning and self-refinement, engaging in a continuous, cyclical process aimed at enhancing clinical effectiveness. A key element of this process is the systematic use of methods that support the evaluation and improvement of therapeutic practice. The therapist should be willing to critically examine their own work, move beyond the comfort of routine, and seriously reflect on feedback from clients, colleagues, mentors, and supervisors. This investigation goes beyond simply proving the effectiveness of interventions; it also focuses on enhancing student competencies and therapist expertise (Rousmaniere et al., 2017).

Client feedback has become an essential element of modern therapeutic practice – not only to tailor therapy to the individual, but also to promote the ongoing professional development of the psychotherapist (Rober, 2017; Rousmaniere et al., 2017). The study of the therapeutic process itself (as distinct from therapy outcomes) and the inclusion of clients in the ongoing adjustment and development of the therapeutic work are now standard features of contemporary family therapy. These applied research approaches typically take place through iterative cycles of observation, planning, implementation, and feedback, which actively guide the therapeutic process. In such a collaborative, change-oriented research model, the gap between research and practice is significantly reduced (Mendenhall & Doherty, 2005).

A notable innovation in this area is real-time monitoring, a paradigm based on the assumption that the psychotherapeutic process functions as a complex dynamic system with nonlinear patterns (Schiepek, 2009). Drawing on common factors theory (Wampold, 2017) and the principles of nonlinear dynamics, Gunter Schiepek and colleagues (2016, 2017) developed a real-time monitoring system to track and understand processes of change in therapy. This nonlinear dynamic approach represents a new meta-theoretical paradigm in psychotherapy research (Gelo & Salvatore, 2016; Schiepek, Aas et al., 2016). It emphasizes client-centered research focused on identifying common factors that drive psychotherapeutic change (Schiepek et al., 2017). Empirical application of this approach has led to the adoption of high-frequency feedback loops, in which data is collected daily – even between therapy sessions – to track client progress. This approach seeks to explain the complexity of both empirical and practical psychotherapy questions through self-organizing processes, as articulated in theories of synergetics and chaos theory (Schiepek et al., 2017). Phases of critical instability, detectable through sufficiently frequent measurement, can predict the potential for therapeutic change (Schiepek et al., 2014; Schiepek, Aichhorn et al., 2016; Schiepek, Stöger-Schmidinger et al., 2016), and are directly linked to therapy outcomes.

This model of researching family therapy represents the cutting edge of new trends, emphasizing routine process and outcome monitoring, personalization of therapeutic approaches to the client's needs, preferences, and traits, and a strong commitment to collaborative planning and delivery of therapeutic work. Such developments are poised to profoundly shape the future of family therapy.

In addition to transforming the therapeutic relationship, recognizing the therapist's influence on the process, and tailoring therapy to users, contemporary family therapy is also marked by new understandings of individual symptoms and the functioning of the broader family system.

The Myth of Normal in a Toxic Society (Mate & Mate, 2022)

Experience determines how genetic potential is expressed.

While acknowledging the genetic and biological components of disease, Maté emphasizes that it is primarily environment and upbringing that significantly influence how these biological predispositions actually manifest in an individual's development. Trauma is a central source of many modern psychological and chronic physical illnesses. Illness, therefore, should not be viewed as a personal deviation or dysfunction, but rather as a symptom of a dysfunctional society. What we recognize today as normal in society is neither natural nor healthy for the individual. Conforming to societal standards often means adapting to demands and expectations that are misaligned with our natural human needs, and can be harmful on physiological, psychological, and even spiritual levels. From this perspective, illness can be understood as an expected and even normal consequence of abnormal or unnatural environmental and societal conditions. Consequently, bodily illness can no longer be viewed solely as a manifestation of individual pathology but should be recognized as a clear reflection of environmental conditions – conditions laden with trauma and unfavorable to the authentic development of the individual.

Principles of Healing (The Four A's – Authenticity, Agency, Anger, Acceptance)

- **Authenticity:** Authenticity is most readily achieved by paying attention to the moments when we are not being true to ourselves. With honest curiosity, we should explore the limiting beliefs within us that prevent us from living authentically. A lack of authenticity may manifest as tension, anxiety, irritability, regret, depression, or fatigue.
- **Agency:** Agency refers to the capacity to take responsibility for our existence freely and to engage meaningfully with the key decisions that shape our lives. The absence of agency is a significant source of stress.

- **Anger:** Healthy anger is a natural and necessary response that allows us to establish boundaries. In our brains, this response is activated when our life or our physical or emotional integrity is under threat.
- **Acceptance:** Acceptance means allowing things to be as they are – regardless of how we feel about them.

The future development of health care should therefore be rooted in biopsychosocial medicine, in acknowledging the educational role of illness, in recognizing the importance of attachment and authenticity, and – above all – in fearlessly exploring the self, both on an individual and societal level. Most importantly, we should strive for collective awareness of trauma as the fundamental source of dysfunction and disease.

The conceptual foundations of inner experience (Schwartz, 2001), authenticity (Maté & Maté, 2022), and neurobiological perspectives (Gostečnik, 2022; Schore, 2019; Siegel, 2020) significantly shape our understanding of the individual, their development, present functioning, and the role of the environment in human growth – thereby offering new directions for the field of family therapy.

1.3 Structure of Family Therapy

The early theorists of family therapy (Haley, 1973; Minuchin, 1974) underscored the critical importance of structure within the therapeutic process, a responsibility that rests solely with the therapist. From the very outset of therapy, the therapist should establish fundamental rules and present a clear therapeutic framework within which the sessions will be conducted. This operational framework enables clients to experience the therapeutic relationship as distinct from other social relationships – ideally, less subjective than intimate relationships and more engaged than non-familial social connections. A precisely defined framework allows

clients to develop a realistic understanding of the boundaries and scope of the therapeutic relationship (for example, by setting time limits, clients understand that the therapist is not continually available). As with any structured system, the therapeutic framework is designed not only to provide stability but also to accommodate deviations. Departures from the established framework offer opportunities for additional therapeutic interpretations of both the dynamics within the therapeutic relationship and the client's subjective experiences.

In this chapter, we will address two fundamental frameworks within which family therapists are expected to operate:

- Objective Framework (time, space, and ethical conduct)
- Subjective Framework (orderliness and professionalism)

Objective Framework of the Family Therapist's Work

The objective framework of therapeutic practice is defined by time, space, and ethics.

Time, or the scheduling and duration of therapeutic sessions, should be determined in advance. A typical session lasts 50 minutes, while the length of a therapy cycle varies depending on the modality – in relational family therapy, for example, a cycle consists of three months or twelve sessions. A safe therapeutic framework is established through uninterrupted therapy, punctuality in starting and ending sessions, and the consistency of appointments.

Space for family therapy should support a professional approach, confidentiality, uninterrupted work, and discretion. The therapist is responsible for ensuring that the therapy setting meets these criteria through intentional attention to the physical environment. The space should reflect professionalism, clearly distinguishing it from a personal or familial environment. While a welcoming atmosphere is beneficial, the furnishing of the therapy office should adhere to professional standards. The space is

primarily intended for the clients, so it is essential that decorative elements do not draw undue attention to the therapist. Caution and moderation should be exercised when introducing personal items into the therapeutic environment. Both the ambiance and furnishings should support the therapeutic purpose. The setting should ensure confidentiality for clients. Wherever possible, it is advisable to organize discreet entry and exit routes to minimize encounters between clients. The therapy room should also be soundproofed. Therapy sessions should not be interrupted by unexpected entries, knocking, phone calls, computer notifications, or other distractions. Since the space reflects the therapist's internal state, even the most »inventive« therapists should strive for a tidy and orderly environment, thereby demonstrating respect for those attending therapy.

Ethical conduct constitutes another external framework guiding the work of family therapists. Therapists are bound by various ethical codes that ensure the professional and safe delivery of therapeutic services.

Revised AAMFT Code of Ethics (AAMFT, 2015)

The Code of Ethics of the American Association for Marriage and Family Therapy (AAMFT) serves as a foundational document for the professional behaviour of marriage and family therapists. Its primary purpose is to articulate the profession's core values, establish enforceable standards for ethical behaviour, and protect the public by promoting responsible practise in therapy, research, supervision, and education.

This Code outlines both aspirational principles and specific obligations that marriage and family therapists must adhere to. It is intended to enhance ethical decision-making, promote high standards of competence and integrity, and ensure accountability in complex therapeutic relationships. The Code applies to all AAMFT members and Approved Supervisors, regardless of their professional setting or geographic location.

The AAMFT Code of Ethics is organised into the following nine main sections:

STANDARD I - Responsibility to clients

- Respect for client autonomy, informed consent, non-discrimination, confidentiality, and the avoidance of dual relationships.

STANDARD II - Confidentiality

- Standards for maintaining, disclosing, and protecting client confidentiality in clinical and non-clinical settings.

STANDARD III - Professional competence and integrity

- Expectations for continuing professional development, avoidance of harm, honesty, and proper record keeping.

STANDARD IV - Responsibility to students and supervisors

- Ethical commitments in educational and supervisory relationships, including fairness, respect, and appropriate boundaries.

STANDARD V - Research and Publication

- Ethical behaviour in research activities, including informed consent, confidentiality, and truthful reporting.

STANDARD VI - Technology-enabled professional services

- Guidelines for ethical behaviour in the delivery of therapy by electronic means, including teletherapy and digital communication.

STANDARD VII - Professional judgements

- Standards for objectivity, accuracy, and informed consent when conducting assessments for legal or administrative purposes.

STANDARD VIII - Financial arrangements

- Ethical billing practises, transparency in financial matters, and the avoidance of exploitative arrangements.

STANDARD IX - Advertising

- Guidelines for truthful representation of services, credentials, and affiliations in all forms of public communication.

Let us now highlight the key ethical principles that define the objective framework of therapeutic practise, as outlined in the AAMFT Code of Ethics (2015). Marriage and family therapists are committed to promoting

the well-being of individuals, couples, and families, and to conducting their work in a professional, respectful, and responsible manner. Therapists must provide their services in a fair and ethical manner and must never exploit the therapeutic relationship for personal, professional, or financial gain. At the beginning of therapy, therapists must obtain the informed consent of all persons involved. This includes clear communication about the structure, goals, risks, and procedures of the therapy.

As systemic or family therapy often involves several people, therapists are subject to particularly strict confidentiality standards. According to the AAMFT Code, confidentiality must be maintained for each individual participant. Clients must be clearly informed of any legal or ethical restrictions on confidentiality before therapy begins. In cases where multiple family members are involved, therapists must continually weigh what information can be shared within the session and what must remain private. In addition, therapists must ensure the protection of confidential information outside of therapy, including in supervisory and counselling contexts, where identifying information must be withheld. Marriage and family therapists are also responsible for maintaining a high level of professional competence and integrity. They are expected to engage in ongoing education and clinical training to ensure the quality and effectiveness of their services. Therapists must not provide services that exceed their scope of competence, and they must avoid conflicts of interest that could compromise their objectivity or judgement.

In the context of research, therapists must protect the dignity and rights of all participants. Informed, voluntary consent must be obtained for all research participation, and participation should never be a prerequisite for receiving therapeutic services. Researchers are bound by all applicable ethical, legal, and institutional guidelines in their work.

Finally, therapists must make financial arrangements that are transparent and consistent with professional standards. Fees, billing practises, and

financial responsibilities must be clearly communicated to clients in advance. Therapists must not engage in fraudulent billing or take financial advantage of clients , and must comply with all relevant legal and regulatory requirements.

The European Family Therapy Association (EFTA) has adopted a Code of Ethics that defines the professional and moral obligations of family therapists across Europe (EFTA, 2012). While recognising national and institutional differences, this code provides a common ethical framework for EFTA members, including individual therapists, training institutes, and national family therapy organisations.

The most important sections of the EFTA Code of Ethics (EFTA, 2012)

1. Professional competence and development

Therapists should work within the limits of their competence and continually strive for professional growth and reflective practise.

2. Respect for clients

The therapeutic relationship should be based on respect, autonomy, and non-discrimination. Therapists must recognise the complexity of family systems and avoid imposing their own values.

3. Informed consent and voluntariness

All participants must be informed about the nature of the therapy and participate voluntarily. Particular care should be taken when working with children or vulnerable people.

4. Confidentiality

Therapists are obliged to maintain the confidentiality of their clients, bearing in mind the particular challenges of working with multiple clients in a systemic setting.

5. Responsibility and integrity in practise

Therapists should act with honesty and integrity, avoid dual relationships and conflicts of interest, and be transparent about fees, roles, and boundaries of intervention.

6. Supervision and training

Ethical responsibility also extends to training and supervision relationships. This includes respect, competence, and the avoidance of exploitative dynamics.

7. Research ethics

All research must be conducted with informed consent, with respect for participants, and in compliance with applicable national and international standards.

8. Cultural and social sensitivity

Practitioners should be aware of and sensitive to the socio-cultural, political, and economic context. They should avoid practises that reinforce social injustice or marginalisation

In contrast to the AAMFT Code of Ethics, which is regulatory and contains enforceable standards, the EFTA Code is more aspirational and dialogue-based. It does not prescribe detailed rules, but rather encourages reflective ethical decision-making that is tailored to the relational and systemic dimensions of practise. The Code emphasises the cultural competence of the therapist, the complexity of multi-person systems, and the broader responsibility of therapists to promote social justice within and beyond the therapeutic setting. The EFTA Code of Ethics is characterised by its systemic-relational orientation, emphasis on cultural and contextual awareness, and a flexible, principles-based approach that emphasises ethical reflection over rule enforcement. It serves as a guiding framework for ethical maturity and professional integrity within the diverse European landscape of family therapy.

As members of the psychotherapy profession working within a European framework, family therapists are equally bound by the core ethical commitments outlined by the European Association of Psychotherapy (EAP). Although the EAP's ethical Guidelines (EAP, 2018) are modality-independent and apply to the whole field of psychotherapy, they are of

great importance to family therapists and systemic therapists, particularly with regard to respect for human dignity, informed consent, protection of confidentiality, and avoidance of harm. The Ethical Guidelines of the EAP provide a comprehensive and Europe-wide framework for ethical behaviour in psychotherapy. Based on respect for human dignity, autonomy, and the integrity of the therapeutic relationship, these guidelines aim to protect both clients and professionals, while promoting high standards of competence, responsibility, and accountability in member associations and countries. They apply to all recognised modalities of psychotherapy and aim to harmonise the different national traditions within a common European ethical space. Importantly, the guidelines are complemented by the Strasbourg Declaration on Psychotherapy (EAP, 1990), which recognises psychotherapy as an independent, scientific discipline with its own theory and practise, which should be carried out by appropriately trained professionals.

Summary of the core ethical standards of the EAP (EAP, 2018)

PRINCIPLE 1: Professional competence

Psychotherapists must have recognised qualifications, work within their area of competence, and undergo continuous professional development.

PRINCIPLE 2: Well-being and dignity of the client

The therapist's primary responsibility is to protect and promote the psychological, emotional, and physical well-being of the client, while respecting the dignity, autonomy, and rights of each individual.

PRINCIPLE 3: Informed consent

Clients must be fully informed about the nature, aims, methods, and limitations of therapy. Consent must be given voluntarily and can be withdrawn at any time.

PRINCIPLE 4: Confidentiality and data protection

All personal information must be treated confidentially. Therapists must comply with data protection laws (e.g., GDPR) and inform their clients of the limits of confidentiality.

PRINCIPLE 5: Therapeutic boundaries and non-exploitation

Therapists must maintain appropriate boundaries, and avoid dual relationships and any behaviour that could be exploitative, abusive, or coercive.

PRINCIPLE 6: Integrity and professional responsibility

Therapists must act with honesty, transparency, and accountability in all professional matters, including advertising, public presentation, and collegial behaviour.

PRINCIPLE 7: Research ethics

In research contexts, therapists must obtain informed consent, minimise harm, ensure anonymity, of participants and follow ethical research standards.

PRINCIPLE 8: Cultural and social sensitivity

Therapists are expected to be aware of the socio-cultural context and power dynamics, avoid discrimination and promote equality and inclusion.

PRINCIPLE 9: Ethical complaints and accountability

Member associations must have fair and transparent procedures for dealing with complaints of ethical misconduct or professional offences.

The EAP guidelines reflect a broader European perspective, that includes cultural diversity and subsidiarity. While the AAMFT provides detailed and codified standards, the EAP guidelines offer a principles-based orientation that allows for adaptation to different national contexts and psychotherapeutic traditions. In contrast to the EFTA Code of Ethics, which is specifically tailored to systemic and family therapy and focuses on relational ethics and cultural sensitivity, the EAP Guidelines take a cross-modality stance, that is relevant to all recognised psychotherapy approaches in Europe. Their strength lies in their universality and compliance with European human rights frameworks, such as the European Convention on Human Rights and the General Data Protection Regulation.

Subjective Framework of Family Therapist Practice

The subjective framework of a family therapist's work is defined by the therapist's professionalism and personal conduct.

A therapist's external appearance should reflect their professional attitude toward their vocation. As therapy constitutes a professional service, the therapist's attire should be appropriate to this role, projecting professionalism and neatness. However, equally – if not more – important than outward appearance is the therapist's internal stance: the attitude and approach they bring to their work. Therapists are expected to maintain their professional competence diligently and pursue conscious, ongoing professional development. Continuous self-reflection and self-critique are critical to professional growth. Importantly, therapists undergo personal therapy as part of their training, providing a foundation for self-awareness and self-criticism, which should be sustained throughout their therapeutic careers.

One recurring dilemma in therapeutic practice concerns the appropriate degree of therapist self-disclosure within the psychotherapeutic process. Research has shown that approximately 90% of therapists report using some form of self-disclosure during therapy, most often related to their professional experiences (Edwards & Murdock, 1994). This suggests that complete avoidance of self-disclosure is unrealistic in intensive therapeutic work. Therefore, it is crucial for therapists to understand the significance and potential pitfalls of self-disclosure.

Typically, therapists use self-disclosure to encourage client openness, strengthen the therapeutic alliance, validate the client's experiences, and normalize their feelings (Henretty & Levitt, 2010). Henretty and Levitt (2010) provide several guidelines for therapist self-disclosure:

- Self-disclosure should be infrequent.
- Self-disclosure should be deliberate rather than impulsive (often, clients' questions inviting self-disclosure are statements rather than genuine requests for information).

- Sharing less intimate inform
- ation, without excessive detail, can strengthen the therapeutic alliance.
- After self-disclosure, it is important to assess its impact on the client.
- Attention should quickly shift back to the client following any self-disclosure.

Thus, it is essential that therapists continually reflect on their own motives for self-disclosure and remain attentive to its effects on clients. Therapists should also recognize that self-disclosure is not essential for building a strong therapeutic alliance. Therapists always retain the right to withhold personal information during therapy to preserve their own sense of security and maintain the professional boundaries critical to effective therapeutic work.

2

Planning and Assessment in Therapy

2.1 Before the First Therapy Session

The therapeutic process does not begin with the first session or the clients' inquiry about therapy, but within therapists' expectations, abilities, and professional competence. It originates in their subjective experience.

It is therefore essential for therapists to be aware that learning this profession requires a lot of time and personal commitment; that their professional performance can be influenced by external stressors; that maintaining healthy personal relationships and one's own mental well-being is vital in this field; that self-doubt is normal in this profession; and that the learning of therapeutic skills is a lifelong endeavor (Patterson et al., 2009).

Therapists actively shape their therapeutic space through both their professional expertise and their personal approach. Consequently, it is essential that therapists – even before the first contact with clients – reflect on their experiences and possible barriers to establishing a high-quality therapeutic relationship. Early in their career, anxiety and fear of failure often present significant challenges. Later, an overreliance on clinical experience may pose an obstacle to establishing a unique therapeutic

relationship with each client. These feelings are not only common but expected. What matters is therapists ability to be aware of them, reflect on them, and use that awareness constructively within the therapeutic relationship.

Another key factor at the beginning of the therapeutic process is the client. Especially in adult psychotherapy, clients actively construct the therapeutic process together with the therapist. Clients enter therapy with their own expectations, reservations, and fears. They bring with them expectations, hesitations, fears, and unique personal motivations. Understanding what prompted a client to seek therapy and what catalyzed their decision to reach out is essential. When working with multiple family members, therapists should be attuned to the different motivational dynamics at play, and to each individual's subjective experience of distress.

Therapists should also be mindful that the desire to maintain the status quo can be just as strong as the desire for change – even when this means individuals may harm themselves or their relationships (Maroda, 2004). It is precisely this ambivalence toward change that often prevents individuals from resolving their distress without psychotherapeutic support. In many cases, clients are aware of the actions that could alleviate their situation, yet they struggle to recognize the deeper psychological mechanisms that inhibit their ability to act – o r that make preserving the current state feel safer. As a result, they may repeatedly revert to old, familiar patterns – patterns that are perhaps dysfunctional, but also predictable and emotionally safer.

Meaningful change in therapy becomes possible when clients are motivated not just to end a particular situation or to change others and their circumstances, but when they develop a desire to understand themselves more deeply.

2.2 Initial Contact with Clients

Guidelines for Therapists During Initial Contact with Clients (Patterson et al., 2009)

- Listen attentively and reflect clients' narrative: Within approximately five minutes, gather essential information regarding the reason for seeking therapy and provide a brief reflection of what has been shared, thereby signaling that you understand their concerns and are capable of offering support.
- Assess the urgency of the situation: Be prepared to initiate a rapid response protocol if an immediate intervention is necessary.
- Evaluate your competence for the case presented and consider whether it falls within your scope of expertise.
- Respond promptly.
- Consider who initiated contact (e.g., a parent, child, or partner) and remember to take into account the broader family system.
- Clearly communicate practical information such as the structure of the therapy (duration, frequency, cost, location, etc.).
- Limit the initial contact to essential information: required for scheduling the initial session, avoiding premature therapeutic discussions.

Before organizing the initial therapeutic session, the therapist determines who will be included in the therapeutic process, what information will be provided to the clients, and what information, if any, may be communicated to individuals outside the therapeutic setting. In doing so, the therapist should be guided by the needs and wishes of the clients, while keeping in mind that the entire social system of the family is crucial for establishing a sense of safety and the potential for therapeutic progress (Carr, 2006). Following established practice (Patterson et al., 2009), the therapist should aim to invite all individuals involved in the presented issue – at least for the initial session. In family

therapy, it is standard to invite the partner of the person seeking therapy. If the issue involves children, all siblings in the family should be invited as well. Over time, members of the extended family, family of origin, or other significant individuals may also be involved, based on the therapist's professional judgment or at the request of the therapy clients.

Prior to the first session, the therapist also prepares all necessary documentation for managing the therapeutic process.

Sample of Informed Consent[1]

Name and Surname: _____
Address: _____
Phone Number: _____
Email Address: _____

By signing this document, I confirm that I have been informed of and agree to the following:

- ▷ that the therapeutic process s will be conducted according to the method _____;
- ▷ that the therapeutic cycle consists of _____ sessions, held in continuous succession; and that the cycle may be repeated upon mutual agreement with the therapist;
- ▷ that a prerequisite for entering the therapeutic process is the ability to attend sessions regularly and in appropriate psychophysical condition (if the client arrives under the influence of strong medication, alcohol, drugs, etc., the session will be terminated and considered completed);
- ▷ that participation in the therapeutic process is voluntary and may be discontinued at any time;

1 This document is intended as an example and starting point for the development of a standardized form. It must be reviewed, adapted, and supplemented in accordance with current national legislation, professional regulations, and institutional guidelines in effect at the time of use.

▹ that I will notify the therapist of any absence at least 24 hours prior to the scheduled session by email at _____
or by phone at _____.

▹ that the therapist alone cannot guarantee the successful outcome of the therapy;

▹ that the therapist keeps records of clients and protects my personal data in accordance with the Personal Data Protection Act and the General Data Protection Regulation;

▹ that all information disclosed during the therapeutic process is confidential, except in cases where the therapist is legally obligated to report;

▹ that I am assured of high-quality therapeutic care, including the possibility of the therapist consulting with a supervisor (individually or in a group setting) and taking all necessary measures to protect my identity;

▹ that I will not call upon the therapist to serve as a witness in legal or administrative proceedings, nor request written statements or expert opinions from him or her;

▹ that the therapeutic process conducted by method _____ does not replace medical treatment; and that I may always contact psychiatric emergency services, general emergency services (or 911), or my primary care physician;

▹ that the therapist may occasionally invite me to complete evaluation questionnaires, with my participation being entirely voluntary and having no bearing on the therapeutic process;

▹ that the agreement is drawn up in two identical copies, of which each signatory receives one.

Date:

Signature of the therapist:

Signature of the client:

Sample of a Personal Data Protection Statement[2]

I hereby consent to the collection and processing of my personal data in accordance with the European General Data Protection Regulation (GDPR). I further agree to:

- ▷ The entry of my data into the user records;
- ▷ The use of my email address for communication and occasional updates;
- ▷ The statistical processing of my data.

This consent is valid for as long as is necessary to fulfill the purpose for which the data were collected or further processed. Consent may be withdrawn at any time by submitting a written request to the address: _____

Your personal data are processed in accordance with the provisions of the General Data Protection Regulation (GDPR), the applicable national Personal Data Protection Act, and all relevant internal regulations on data protection. Any additional questions may be directed to the appointed Data Protection Officer at: _____.

Date: _____ Signature: _____

2 This document is intended as an example and starting point for the development of a standardized form. It must be reviewed, adapted, and supplemented in accordance with current national legislation, professional regulations, and institutional guidelines in effect at the time of use.

Research Collaboration Agreement[3]

between _____ and _____

_____

(Contact Email and/or Phone Number)

Participants in the research acknowledge and agree to the following:

- ▷ Participation in the study is voluntary;
- ▷ The individual will only participate if willing to provide accurate and truthful information;
- ▷ The researcher should treat participants courteously, respectfully, and in accordance with professional ethical standards;
- ▷ The participant may withdraw from the research at any time;
- ▷ The researcher should treat all collected data as confidential and protect it in accordance with legal regulations;
- ▷ Therapeutic sessions will be audio recorded and used solely for the specified research;
- ▷ The participant may be asked to complete questionnaires;
- ▷ Collected data will be used exclusively for research purposes;
- ▷ Participants will be informed about the research findings and outcomes upon completion of the therapeutic process;
- ▷ If the participant experiences distress during the study, they may access free therapeutic support via email _____ or telephone _____;
- ▷ This agreement is issued in two identical copies, one of which will be given to each signatory.

By signing this consent form, the research participant confirms their voluntary agreement to participate in the study.

Date:

Signature of Researcher:

Signature of Research Participant:

3 This document is intended as an example and starting point for the development of a standardized form. It must be reviewed, adapted, and supplemented in accordance with current national legislation, professional regulations, and institutional guidelines in effect at the time of use.

Informed Consent for Audio Recording of Therapy Sessions[4]

I, _____

born _____

hereby acknowledge and agree to the following:

- ▷ That therapy sessions may be audio recorded;
- ▷ That the audio recordings may be used in clinical supervision;
- ▷ That all data will be used and stored in a way that ensures my anonymity;
- ▷ That my participation is entirely voluntary;
- ▷ That I may withdraw my consent for audio recording at any time;
- ▷ That in case of emotional distress during the research period, I may seek free therapeutic support via email _____ or telephone _____;
- ▷ That this agreement is issued in two identical copies, one of which will be provided to each signatory.

Date:

Signature of Therapist:

Signature of Participant:

4 This document is intended as an example and starting point for the development of a standardized form. It must be reviewed, adapted, and supplemented in accordance with current national legislation, professional regulations, and institutional guidelines in effect at the time of use.

Sample Questionnaire for Measuring Symptoms and Change in Systemic Therapy: STIC – Systemic Therapy Inventory of Change (Pinsof et al., 2018)

The STIC is an assessment tool designed to evaluate functioning across various domains, including individual problems and strengths, the partner relationship, the current family, child problems, and characteristics of the family of origin (Pinsof et al., 2009). It is specifically developed to monitor therapeutic change within family, couple, and individual therapy from a multisystemic and multidimensional perspective.

The questionnaire is available in two distinct forms:

- Initial STIC – Administered at the beginning of the therapeutic process. This version is longer, as it also includes items related to demographic and background information concerning the client's family of origin.
- Intersession/Final STIC – A shorter form completed during the course of therapy (between sessions) or at the conclusion of treatment.
- The Initial STIC includes five scales that assess six domains of the client's systems:
- Scale of individual problems and strengths,
- Scale of family of origin,
- Scale of the partner relationship,
- Scale of the current family,
- Scale of the child's problems and strengths, and
- Scale of the parent–child relationship.
- The Intersession or Final STIC includes only four of these scales:
- Scale of individual problems and strengths,
- Scale of the partner relationship,
- Scale of the current family, and
- Scale of the child's problems and strengths.
- The scales included in the Intersession and Final STIC are conceptually and methodologically consistent with those in the Initial STIC, allowing for ongoing assessment of therapeutic change.

2.3 The First Therapy Session

The therapeutic relationship begins to take shape during the very first session. While we explore this topic more extensively in the following chapter, here we highlight some key challenges that therapists may encounter during the initial direct contact with clients: the first encounter, establishing a new kind of dialogue, actively influencing the emotional climate of the session, offering a different perspective on the problem through assessment, and collaboratively setting basic goals and outlining the therapeutic process (Taibbi, 2015).

The initial interaction with clients should reflect the structured nature of therapy. This means the therapist should maintain an appropriate professional distance that communicates the opportunities and boundaries of the therapeutic relationship. Simultaneously, the therapist should establish a professional connection while also creating a sufficiently intimate space that allows for the vulnerability of those involved. These two dimensions – professional structure and emotional intimacy – may at first appear to be in conflict, as if enhancing one diminishes the other. However, from a safety-oriented perspective, it becomes clear that a structured setting and relationship can actually bring the client's experiences and emotionally significant relationships to the forefront. By creating a distinct and secure space, the therapist enables storytelling, reflection, and ultimately a new experience of a safe and structured relationship in which the client's needs are prioritized. The therapist's courtesy – expressed through simple gestures such as addressing clients by name, offering a glass of water before the session begins, and maintaining eye contact – along with active listening, forms the foundation of a professional yet safe therapeutic relationship (Taibbi, 2015).

In addition to building the therapeutic relationship, it is crucial at this stage to identify therapy goals and carry out the process of assessment or

diagnosis. The therapist should gather sufficient information to allow for the continuation of the therapeutic process. The type of information needed largely depends on the therapeutic approach and the goals set at the beginning, based on the clients' expectations.

Scholars emphasize the importance of defining goals from the perspective of clients (Finlay, 2016; Lemma, 2003; Patterson et al., 2009). Based on this premise, client goals can be grouped into three main categories:

- **Symptom Relief**: The client seeks therapy to alleviate specific psychological distress. The symptoms may severely impair daily functioning and call for crisis intervention, often requiring collaboration with a psychiatris.
- **Support**: The client seeks help in achieving a desired change. Although the symptoms are manageable, they still impact the individual and their relationships. Support may involve psychoeducation and guidance on resolving existential concerns.
- **Insight**: Clients recognize patterns in their behaviors and relationships and seek to deepen their understanding of themselves and their relational dynamics. They expect therapy to facilitate self-exploration and reflection.

The therapy goals are collaboratively established by the therapist and the clients. In family therapy, therapists often face the challenge of reconciling differing goals among family members. However, the very act of discussing and negotiating these goals may already serve as a significant therapeutic intervention – one that unites family members in a shared effort and also aligns the therapist with the clients in a collaborative relationship (Patterson et al., 2009). In line with the hierarchy of therapy goals presented above, the therapist should also assess the feasibility of achieving those goals. First, it is necessary to evaluate whether all clients

are functioning and stable. Then, the therapist should determine the type of support each individual may need. Finally, the therapist should assess the clients' readiness for deeper introspection. Ideally, the therapeutic process would address all three levels of goals, but this is not always feasible and does not necessarily guarantee a successful outcome. Therefore, therapy should be adapted to the client's needs, desires, and capacities, which in turn shapes the therapy goals and interventions. Clients' goals tend to focus on the problems they wish to resolve, whereas the therapist's goals are more concerned with how to help them achieve these outcomes (Patterson et al., 2009).

During the first session, the therapist works to establish a collaborative relationship centered around the client's narrative, offering a sense of safety and containment (Finlay, 2016). Through the client's storytelling, the relationship is developed, therapy goals are set, and a basic assessment of functioning is conducted. The therapist's focus is not on diagnosing mental disorders per se but rather on identifying risky behavior, emotional responses, and patterns of thinking. They gather basic information on the client's functioning (which may align with diagnostic criteria), while also attending closely to all implicit communications that illuminate the client's distress. Much of this information emerges through the way the therapeutic relationship is formed – offering the therapist insight into how the client experiences and engages with others. The importance of this relationship for assessment and intervention planning will be explored in greater depth in the following chapter.

The First Therapy Session

The therapy involved a family of four (parents, a 12-year-old daughter, and a 15-year-old son). Prior to the first session, the therapist had spoken with the mother over the phone.[5]

Ts (Thomas, father): I don't know. We really are trying.

T: Your wife mentioned that you've already tried couples therapy. What do you expect from this therapy?

Ts: Maybe it would be good if we talked more. But I don't see it as such a big problem.

T: Alright. If you both agree, I'd now like to give Maya and Robbie a chance to share their perspective. Robbie, if I understand correctly, you're finishing elementary school this year?

R (Robbie, son): Yeah.

T: And you'll be enrolling in high school?

R: Yeah.

T: Why do you think your mom arranged this session today?

R: I don't know. She keeps asking me things and I don't know what she wants from me.

T: What does she mostly »nag« you about?

R: (Looks down) About the computer and video games.

T: She probably wants you to spend less time on the computer?

R: I guess so.

T: Do you also think you might be spending too much time on it?

R: Maybe sometimes. But otherwise, I'm just bored.

T: I understand. How would it be for you if you all came to see me every week and we talked here together and tried to find ways to change some

5 The presented therapeutic case is based on real clinical experiences. However, certain details have been modified, fictionalized, added, or omitted to ensure the anonymity and confidentiality of the individuals involved.

things so they work better for everyone? It's probably also hard for you now, with elementary school ending and starting a new school with new classmates.

R: That's okay. Just as long as my computer won't be the only problem...

T: No, I want us to talk about the things that are important to you, too. And how are you, Maya?

M (Maya, daughter): I'm fine.

T: Would you also like to say something? Is there anything you're worried about?

M: I don't know.

S: She's very well-behaved.

T: That's great. I imagine your grades are very good?

M: Nods.

T: Would it also be okay with you if we met here weekly and talked together as a family?

M: Nods.

T: Great! That doesn't mean you have to talk about anything you don't want to, only what you feel like sharing. So in the next sessions, we'll try to talk more about what has been happening and what is still going on.

2.4 Assessment in Family Therapy

In the course of the therapeutic process, the family therapist evaluates the following areas:

- Family system assessment,
- Psychological assessment:
  - Risk assessment,
  - Assessment of capacity for psychotherapeutic engagement,
  - Assessment of motivation.

Family System Assessment

Three-Level Model of Family System Assessment (Carr, 2006, pp. 254-255)

CONTEXS	BELIEF SYSTEMS	BEHAVIOUR PATTERNS
Historical	Denial of the problem	The problem person's symptoms and problem behaviour
Major family-of-origin stresses 1. Bereavements 2. Separations 3. Child abuse 4. Social disadvantage 5. Institutional upbringing **Family-of-origin parent–child problems** 1. Insecure attachment 2. Authoritarian parenting 3. Permissive parenting 4. Neglectful parenting 5. Inconsistent parental discipline 6. Lack of stimulation 7. Scapegoating 8. Triangulation **Family of origin parental problems** 1. Parental psychological problems 2. Parental drug or alcohol abuse	Rejection of a systemic framing of the problem in favour of an individualistic framing Constraining beliefs and narratives about personal competence to solve the problem Constraining beliefs about problems and solutions relevant to the presenting problem Constraining beliefs and narratives about the negative consequences of change and the negative events that may be avoided by maintaining the status quo Constraining beliefs and narratives about marital, parental and other family relationships	The sequence of events that typically precede and follow an episode of the symptoms or problem behaviour The feelings and emotions that accompany these behaviours, particularly positive feelings or pay-offs Patterns involving ineffective attempted solutions Patterns involving confused communication Symmetrical and complementary behaviour patterns Enmeshed and disengaged behaviour patterns Rigid and chaotic behaviour patterns

3. Parental criminality
4. Marital discord or violence
5. Family disorganisation

Contextual

Constraining cultural norms and values

Current lifecycle transitions

Home–work role strain

Lack of social support

Recent loss experiences

Bereavement

Parental separation

Recent illness or injury

Unemployment

Moving house or schools

Recent bullying

Recent child abuse

Poverty

Secret romantic affairs

Constitutional

Genetic vulnerabilities

Debilitating somatic states

Early illness or injury

Learning diffi culty

Difficult temperament

Constraining beliefs and narratives about the characteristics or intentions of other family members or network members

Constraining attributional style (internal, global, stable, attributions for problem behaviour)

Constraining cognitive distortions
1. Maximising negatives
2. Minimising positives

Constraining defence mechanisms
1. Denial
2. Passive aggression
3. Rationalisation
4. Reaction formation
5. Displacement
6. Splitting
7. Projection

Authoritarian and permissive parenting patterns

Neglectful and punitive parenting patterns

Inconsistent parenting patterns

Coercive interaction patterns

Patterns involving inadvertent reinforcement

Pathological triangles and triangulation

Patterns involving lack of marital intimacy

Patterns involving a significant marital power imbalance

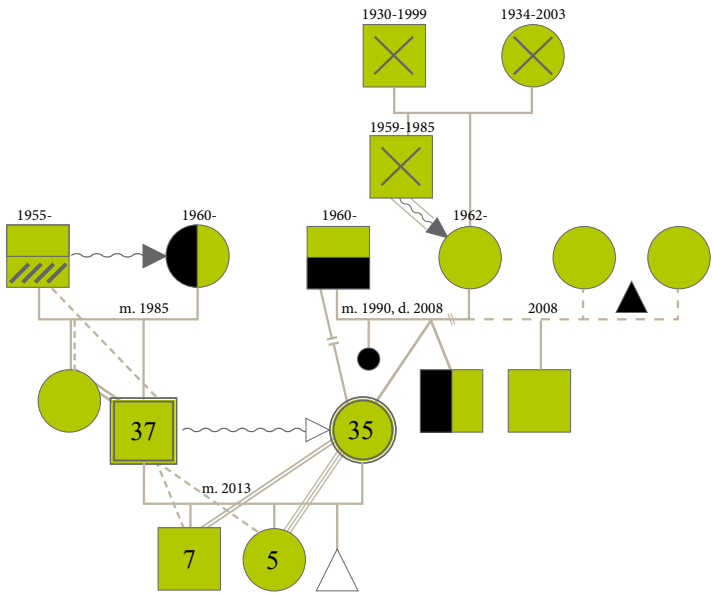
Patterns including lack of coordination among involved professionals and family members

Assessment of the family system should encompass current relational dynamics, family history, individual cognitive frameworks, and the broader social and cultural context in which the family is embedded (Carr, 2006). The therapist is responsible for conducting a comprehensive and clinically appropriate evaluation of the family's symptomatology, while maintaining sensitivity to all contextual and systemic factors that may influence family dynamics. These factors should inform the development of an effective therapeutic treatment plan. Such an assessment should include the identification of family structure, intrafamilial dynamics, developmental tasks, and the functioning of the marital and/or parental subsystem (Patterson et al., 2009). In family therapy, family structure is commonly assessed and documented through the use of a genogram (McGoldrick et al., 2020). McGoldrick characterizes the genogram as a contemporary version of the traditional family tree, integrating essential information about family composition, the quality of relationships among members, and salient characteristics of individuals across at least three generations. The genogram is a critical diagnostic tool in family therapy, as it supports the identification of behavioral and emotional patterns transmitted across generations. In addition to its diagnostic function, the genogram can also serve as a therapeutic intervention. Its visual depiction of family dynamics allows clients to externalize and reflect on complex or disorganized internal experiences, or to infuse rigid family narratives with emotional nuance and personal meaning. In the context of family therapy, genograms are typically employed in three principal ways:

- During initial sessions, to assess family structure. The therapist may either draw the genogram independently and include it in the clinical notes, or co-construct it with the family, thereby eliciting essential information in a more non-intrusive and collaborative manner.
- As a therapeutic intervention in response to disorganized narratives presented by the client. In this case, the therapist and client collaboratively create the genogram to facilitate the integration of fragmented storytelling and memory recall.

- As a therapeutic intervention in the context of rigid narratives. When the therapist encounters difficulty obtaining information about the family system due to the client's constrained or limited narrative, the genogram can offer a sense of safety and structure, encouraging the client to recall and share significant family events.

Basic genogram symbols (McGoldrick et al., 2020)



Kinship Relationships: The genogram depicts a nuclear family of four. The husband, Peter, is 37 years old, and the wife, Sabina, is 35 years old. They have two children: a 7-year-old son and a 5-year-old daughter. Sabina is currently pregnant. Peter has an older sister who is adopted. Sabina has a twin brother and a half-brother. Prior to Sabina's birth, her mother experienced a miscarriage. Sabina's parents were married in 1990 and divorced in 2008. Since 2008, her father has been in a cohabiting relationship and is also involved in a secret affair. Sabina's maternal grandparents and maternal uncle are deceased.

Symptomatology: Sabina's brother has a chronic illness. Peter's father is a covert alcoholic. Peter's mother suffers from depression. Sabina's father also struggles with

alcohol dependence. Sabina's maternal uncle (her mother's brother) died by suicide at the age of 26.

Emotional Dynamics: Peter is emotionally abusive toward Sabina and maintains a distant relationship with both of his children. Sabina is emotionally connected to her son and has an enmeshed relationship with her daughter. Peter has a close bond with his older sister and a distant relationship with his father. Peter's father is physically abusive toward Peter's mother. Sabina has cut off all contact with her father. Sabina's mother was sexually abused by her older brother.

The assessment of the family system should also include the identification of the family's core developmental tasks. These tasks are defined within the specific developmental stages of the family, each of which is characterized by the entry or exit of family members from the family system (Poljak Lukek, 2017). The arrival or departure of a family member typically generates stress within the family, which members regulate through the execution of appropriate developmental tasks.

Developmental Stages and Tasks of the Family (Poljak Lukek, 2017)

1. Leaving Home: Becoming an Adult

Assuming emotional and functional responsibility:

- Emotional separation from the family of origin and transformation of the parent-child relationship
- Formation of a personal identity and autonomy
- Development of intimate peer relationships
- Establishment of effective stress management strategies

2. Establishing a Couple Relationship

Formation of the couple relationship and respective partner roles

- Establishment of emotional bonds within the relationship
- Development of a shared couple identity
- Definition of internal and external boundaries in the relationship
- Maintenance of a healthy emotional climate within the partnership

3. Family with Children

3.1 Family with Young Children

Integration of new family members:

- Development of parental roles
- Shifting focus toward the child subsystem
- Managing vulnerability within the family system
- Fulfilling parenting responsibilities

3.2 Family with Adolescents

Increasing family flexibility to support the development of children's autonomy:

- Maintaining connection despite the growing autonomy of children
- Flexible emotional regulation
- Parenting adolescents – facilitating autonomy while maintaining boundaries and emotional closeness
- Supporting adolescents' peer relationships

4. Launching Children and Moving On

Refocusing on the couple relationship:

- Acceptance of children's departure and emotional separation
- Attaining maturity and investing in the marital relationship

5. Couple in Later Life

Acceptance of aging and transfer of authority to the next generation:

- Coping with retirement and age-related physical changes
- Development of the grandparent role
- Delegating authority to younger generations
- Confronting and processing personal and relational losses

Based on the structure of therapy, the therapist identifies the family's key developmental tasks and, during the assessment process, evaluates how family members are coping with these tasks – particularly identifying the areas in which they are experiencing difficulties. Successfully accomplishing developmental tasks supports the growth of both the family system and the

individual development of each family member. Through the completion of these tasks, the family system's differentiation develops – its ability to maintain a functional hierarchy while maintaining emotional connectedness among members – as does individual differentiation, which refers to a person's capacity to maintain autonomy and uniqueness while remaining emotionally connected to other family members (Poljak Lukek, 2017). In the assessment process, the therapist determines how the identified developmental tasks affect each family member's ability to achieve autonomy, and how their individuality is supported within the family system in forming and maintaining relationships. Furthermore, knowledge of the family's developmental stages and associated tasks enhances the therapist's ability to identify key stressors within the family system, including those that family members may not yet recognize or consciously acknowledge.

Psychological Assessment

In family therapy, the therapist should, in addition to assessing overall family dynamics, pay particular attention to each individual family member by evaluating their level of risk, capabilities, and motivation for participating in the therapeutic process.

Assessment of Individual Risk

When assessing individual risk, the therapist should consider both the stability of the individual client and potential threats such as suicidality, substance dependence, or other undiagnosed mental health disorders. Additionally, the therapist should evaluate the possibility that others in the individual's relational system may be at risk, particularly in cases involving violence, abuse, or neglect.

> **Therapeutic Questions for Assessing Suicide Risk** (Patterson et al., 2009): »Do you ever feel or think that life isn't worth living?« (If the answer is yes): »Do you currently have thoughts that it might be better to die?«

(If the answer is yes): »Are these just thoughts, or do you also think about how you might end your life?«

(If the answer is yes) »What specific method have you considered? How would you take your own life?«

(If methods are specified) »Have you taken any steps toward planning this? Have you visited a place where you might jump? Do you have pills? Have you bought a rope? Have you written a suicide note? Have you written a will?«

The suicidal process typically progresses from ideation to behavior and is often the result of prolonged psychological distress. A sense of helplessness and a passive wish to die may, if the underlying distress remains unresolved, develop into persistent suicidal thoughts. These may eventually evolve into actions such as planning and executing a suicide attempt, which may result in either a failed attempt or death (Poštuvan, 2020). When a client is at risk, the therapist should identify the level of the suicidal process: thoughts about death, suicidal ideation, suicidal intent, suicidal plans, or a suicide attempt. Each level represents an escalating degree of risk, and when intent, planning, or an attempt is identified, immediate intervention is essential. If the therapist identifies thoughts about death or suicidal ideation in the client, these should be incorporated into the therapeutic plan. Targeted interventions should aim to address and evaluate such thoughts to prevent escalation to the higher levels of suicidal risk. If the client is already at the stage of intent, planning, or has attempted suicide, the therapist should, upon obtaining this information, immediately establish a so-called »contract for life«. This is an agreement between the at-risk individual and a trusted person (in this context, the therapist), in which the client commits not to harm themselves until the next session (Poštuvan, 2020). This contract should be made within the context of a strong therapeutic alliance; without a sufficiently trusting relationship, the contract is unlikely to be effective. The therapist should also provide the client with clear, concrete information about where to seek help in moments of acute crisis – especially since therapists are

typically not available outside scheduled sessions and most communication occurs via email. The client should have access to emergency contacts and crisis support services, (such as confidential helplines, Children and Youth Helpline, Psychological Crisis Line, Women's Counseling Center, etc.). If the client is unable to commit to the contract for life, and the therapist assesses that the individual's life is at risk, the therapist should inform the client's family or significant others – specifically someone with whom the individual is willing to make such a commitment. In extreme cases, the therapist is obliged to call emergency medical services.

When a therapist identifies a client in family therapy as being at risk, they should quickly decide how and when to include or exclude other family members from the risk assessment conversation. Suicidality is often a taboo topic within families and can provoke further distress or conflict. However, opening space for dialogue may also provide significant relief to the family system (Patterson et al., 2009). To ensure the safety of the at-risk client, the therapist may need to conduct individual sessions separate from the rest of the family. These sessions should prioritize establishing a confidential and safe therapeutic environment, enabling the client to engage in a contract for life as the first step toward safety. Long-term safety, however, depends on the presence of a supportive social and familial network. Therefore, once immediate risk is addressed, it is essential to include the rest of the family in therapy to foster safe and open communication. Beyond reducing suicidal behavior, therapy should aim to create conditions that restore the individual's desire to live (Freedenthal, 2018).

In addition to suicidality, the therapist should remain alert to signs of substance dependency or undiagnosed mental illness, both of which are significant risk factors. If a family enters therapy with a known diagnosis or acknowledged addiction, a multidisciplinary approach is required. With the symptomatic client's consent, the family therapist should collaborate with their physician, clinical psychologist, or psychiatrist. If direct collaboration is not feasible, the therapist may request that clients share medical records,

discharge summaries, or other relevant documentation. This information enables the therapist to more accurately assess the level of risk and evaluate the potential of the family system to either mitigate or reinforce the symptoms. From a systemic perspective, any change within the family – especially the absence of symptoms – disrupts the existing balance, requiring adaptation by the entire system (Pinsof et al., 2018). Therefore, during the assessment phase, the therapist should evaluate the family's ability to adapt to a new, symptom-free dynamic and identify core tasks that will promote flexibility and resilience.

Even when a family does not enter therapy due to a recognized addiction or another mental disorder affecting a specific family member, the therapist should assess all potential risk factors during the evaluation phase. This can be done using standardized questionnaires provided to clients at the outset (e.g., the STIC), or by giving particular attention to possible signs and symptoms of addiction or other mental disorders during the initial interview with family members. Although family therapy is not designed to diagnose psychiatric conditions, the assessment phase aims to identify potential risk factors. If the therapist determines that the risk is significant, the client should be referred to a clinical psychologist or psychiatrist for formal diagnosis, with whom the therapist will maintain collaborative involvement throughout the therapeutic process. As will be discussed later in this chapter, abstinence from addictive behaviors and the manageability of mental health symptoms are essential for the continuation of the psychotherapeutic process.

> Based on the research project *The Dynamics of Alcoholism and Addiction in the Family System and Relational Family Therapy* by Prof. Dr. Barbara Simonič and colleagues, the following key premises are emphasized for therapeutic work with addiction:
>
> - The first year of life can be a particularly critical period for the later development of various addictions. In this phase, illusory self-regulation

mechanisms may be formed to manage overwhelming internal organic states that the individual is unable to tolerate (Gostečnik, 2023).

- Unresolved and repressed early traumas, often accompanied by dysfunctional relationships, hinder the development of effective self-regulation, a healthy sense of self, basic differentiation, and impulse control – factors that are among the most common causes of later addictive behaviors (Repič Slavič, 2023).
- A key element in overcoming addiction is understanding its underlying causes, especially those rooted in past experiences and maladaptive stress regulation (S. Jerebic, 2023).
- Addiction affects not only the individual with the dependency but the entire family system, often generating dysfunctional behavioral patterns in other family members who may never engage in substance use themselves (D. Jerebic, 2023).
- Addiction may serve as a substitute for safety and comfort in moments of heightened stress, or as a surrogate relationship for individuals with insecure attachment styles who struggle to form authentic bonds with others (Šeremet, 2023).
- Parental addiction significantly impairs the ability to fulfill parental roles effectively (Rijavec Klobučar, 2023).
- Unresolved and traumatic experiences stemming from growing up with alcoholic parents shape adult functioning (Simonič, 2023).
- The legacy of addiction can be transmitted across generations (Valenta, 2023).
- Recovery from addiction may be described as a transformation in one's internal experience and interpersonal relationships, facilitating maturation into a more integrated sense of self, others, relationships, and the surrounding world (Poljak Lukek, 2023).
- Spirituality is also an important dimension in the recovery process from addiction (Pate, 2023).

In addition to assessing the immediate risk to the individual client, the therapist also evaluates behaviors that may pose a threat to others. The therapist remains attentive to indicators of violence, abuse, and neglect both within the family system and in external relationships.

According to the data from European states (e.g. SURS, 2020), 14.9 percent of women and 5.4 percent of men have experienced domestic violence at least once since the age of fifteen. Of these incidents, three-quarters involved physical violence accompanied by threats, while one-quarter involved sexual violence. Women were three times more likely than men to be victims of domestic violence. Slightly less than one-third of women (28 percent) and one-fifth of men (20 percent) with a current or former partner have experienced at least one form of violence – psychological, physical, sexual, economic, or threats – by their partner at some point. The most prevalent form of violence in intimate partnerships is psychological violence, experienced by 26.2 percent of women and 19.7 percent of men with a current or former partner. According to data from the United Nations Children's Fund (UNICEF, 2014), as many as 80% of children worldwide are subjected to corporal punishment. A more recent study on the use of physical punishment in European countries found that 91.1% of parents occasionally hit or slap their child in response to inappropriate behavior, and 8.9% do so frequently (DuRivage et al., 2015). A Slovenian study revealed that more than half of adults reported being physically punished by the age of ten. Of these, 25.5% of mothers and 20.2% of fathers used objects such as wooden spoons, belts, and similar items to administer punishment (Poljak Lukek, 2011). All of these data highlight the prevalence of violence within family environments and underscore the responsibility of family therapists to recognize signs of abuse, label violent behaviors, and intervene to prevent the perpetuation of such behaviors.

> Based on the research project *The Process of Resolving Physical and Sexual Violence and Relational Family Therapy*, Prof. Dr. Tanja Repič Slavič and colleagues, emphasized the following key principles for therapeutic work involving violence:

- Adolescence is a particularly vulnerable developmental period, as experiences of neglect and abuse during this time can lead to a tendency toward physical aggression, alcohol and drug abuse, and aggressive or often self-destructive behaviors (Gostečnik, 2021).
- In intimate partnerships, a so-called traumatic bond may develop, underpinned by a pattern of dysfunctional affect regulation, which makes it difficult to break free from a violent relationship (Simonič, 2021).
- Psychotherapeutic work that identifies the interconnection between violence and addiction in intimate relationships should focus on creating a sufficiently safe space, regulating intense affect, recognizing vulnerabilities, and transforming maladaptive coping mechanisms for dealing with negative emotional states (Rijavec Klobučar, 2021);.
- Recognizing transference through mechanisms such as compulsive repetition, projective-introjective identification, transference, and countertransference is essential for effective therapeutic intervention in cases involving violence (D. Jerebic, 2021).
- The early developmental period is particularly sensitive from the perspective of both brain maturation and attachment formation, and it plays a crucial role in the recognition of violent dynamics in adulthood (Lipovšek, 2021).

Although countertransference will be discussed in greater detail in the following chapter, it is important to address the therapist's emotional responses to the client at this point. When assessing the level of risk faced by clients, the therapist cannot rely solely on the clients' verbal accounts; important information is also gathered through the therapist's own emotional experiences within the therapeutic relationship. Furthermore, in working with at-risk individuals, the therapist should remain attuned to their own emotional responses, as this attunement is essential to establishing a safe therapeutic environment for both the therapist and all clients in the therapy process. In assessing suicide risk, the therapist should manage their own fear

(Poštuvan, 2020); in assessing addiction and other mental illnesses, they should be able to tolerate the shame and vulnerability that often arise in addressing these symptoms; and in evaluating violent behavior, the therapist should manage their own anger and remain aware of the fear generated by the family's violent atmosphere. Recognizing one's own emotional responses – responses that are often specific to different types of risk – alerts the therapist to pay closer attention and allows for the identification and addressing of risks that may not yet be consciously acknowledged by the client or other family members. Effective affect regulation, which requires the therapist to recognize these countertransference emotions, enables them to contain even the most threatening situations, de-escalate them through their therapeutic presence, and thereby reduce the overall level of risk.

Assessment of Suitability for Psychotherapeutic Treatment

As previously mentioned, certain essential conditions should be met in order for the therapeutic process to proceed. At this stage, it is therefore crucial to assess the client's capacity for psychotherapeutic engagement. From the outset, clients agree to specific conditions for therapy through the informed consent process (e.g., the client agrees not to attend therapy sessions under the influence of psychoactive substances). A client's inability to adhere to the therapeutic agreement or to maintain the basic structure of the therapeutic process may be grounds for discontinuation of therapy.

Participation in therapy should, first and foremost, be voluntary. In the case of children, both parents should consent to their inclusion in therapy, provided that neither has had their custodial rights revoked. In addition to voluntariness, attention should be paid to the personal characteristics of clients. These characteristics should be adequately assessed at the beginning of therapy, and therapeutic interventions should be tailored accordingly.

Several interrelated factors must be considered when deciding whether a client is suitable for psychotherapeutic treatment (Lemma, 2003). A key

consideration is the client's capacity for basic self-reflection, as this forms the basis for meaningful participation in the therapeutic process. Equally important is emotional resilience, particularly the ability to endure the inevitable frustrations of the therapeutic relationship and to self-analyze without resorting to impulsive or self-destructive behaviors. The clinician must also assess the likelihood of an outburst and, if such a risk exists, assess whether it can be safely managed within the therapeutic setting. Another essential criterion is the presence of adequate personal or professional support to enable the client to cope with the challenges of therapy.

In cases where a brief psychotherapeutic intervention is being considered, additional criteria become relevant (Lemma, 2003). The client's current difficulties should lend themselves to the focused exploration of a single theme or central conflict, and it is crucial that the client is receptive to interpretations related to the identified theme during the assessment phase. Finally, the client's motivation to pursue the defined therapeutic goal is a crucial factor in determining whether a short-term intervention is likely to be successful.

Although the criteria outlined above pertain specifically to analytic treatment, they are equally important in the context of family therapy. A safe environment is essential for any form of psychotherapeutic intervention. Therefore, based on the suitability assessment, the therapist should pay close attention to the personal characteristics of the clients – especially those required for sustained engagement in the therapeutic process. Psychotic experiences identified during therapy – such as distorted perceptions of the present (e.g., the client mistakes the therapist for another person, claims to have no memory of how they arrived at the session, loses touch with the present moment during the assessment process, or is unable to tolerate impulses and frustration during conversation) – pose a significant threat to the continuation of therapeutic work. Addressing sensitive topics under such conditions is likely to intensify the psychotic experience (Lemma, 2003). If the

therapist determines that such experiences are present, the psychotherapeutic process should be terminated, and the client should be referred to appropriate psychiatric care.

Assessment of Client Motivation

Client motivation is evaluated by observing indicators such as the desire for change, capacity for insight and self-understanding, active engagement in therapeutic work, willingness to alleviate psychological distress, ability to take personal responsibility, and positive expectations regarding therapy (Lemma, 2003). Based on the client's abilities and expectations, the therapist assesses whether motivation is present and, if so, what it is directed toward. Naturally, a client's motivation is closely tied to the goals with which individual family members enter therapy. When we connect the aforementioned abilities with the goals outlined in the previous chapter, we can conclude that specific client characteristics necessary for achieving each therapeutic goal come into focus:

- **Immediate symptom relief**: This primarily requires a desire to alleviate psychological pain, the ability to actively participate, and a willingness to take responsibility for oneself.
- **Support**: In addition to the above, self-understanding and positive expectations regarding therapy are essential.
- **Insight**: Finally, the individual should not only desire change but also demonstrate the capacity for insight and self-reflection.

Naturally, motivation is not a static experience; it fluctuates over time and therefore should be continuously monitored and evaluated throughout the therapeutic process. A decline in motivation during therapy may not only stem from unmet expectations but also from confronting painful material that demands additional psychological resilience.

Promoting Motivation for Therapy

A couple comes for therapy. They are between 25 and 30 years old, have no children, and have been in a relationship for four years. Barbara is highly motivated for therapy, having initiated the process herself, with the goal of resolving the couple's ongoing arguments. Ron, on the other hand, is not intrinsically motivated to participate in therapy; he attended only after Barbara issued him an ultimatum.[6]

T (Therapist): What are you hoping to gain from our sessions, Ron?

R (Ron): Nothing.

T: So why are you here today?

R: Because Barbara told me I had to come. I don't see the need for us to go to therapy. I think we can solve our problems on our own.

T: How do you understand the fact that this is so important to Barbara that she felt compelled to insist you come today?

R: I don't know. I think she's overreacting a bit.

T: And how would it be for you to consider that Barbara may be in genuine distress, and that she also needs your help so the two of you can get through this together? Seeking help wasn't an easy step for her either. But as she said, she no longer knows how to move forward on her own.

R: I can understand that. I'd like things to be different too, and for us to stop arguing.

T: The fact that you're here today isn't a failure on your part. It's simply another attempt to make things easier for both of you.

R: I don't know. I still think we could just talk it out ourselves.

T: Of course, and that option is still available to you. But we can also use the time here to talk and perhaps raise some issues that are harder to bring up on your own.

6 The presented therapeutic case is based on real clinical experiences. However, certain details have been modified, fictionalized, added, or omitted to ensure the anonymity and confidentiality of the individuals involved.

R: Okay.
T: What would you like to change in your relationship?
R: Nothing really.
T: And what would you need for things to feel even better for you?
R: I think it's fine.
T: It's just this situation here that's uncomfortable for you – having to sit down and talk.
R: Yeah, that's definitely uncomfortable.
T: So can we agree that we'll try to guide these conversations in a way that won't feel too uncomfortable for you? You probably feel like the focus is always on problems and mistakes, but maybe what you're looking for is more ease and relaxation. In our sessions here, we can look for ways to help you both feel more at ease with each other. To make the situations where Barbara starts a conversation also pleasant for you.
R: That's true. It would be nice if things could be more relaxed again. Like they were in the beginning.
T: And that's something we can work on recreating in your relationship.

2.5 Planning the Therapeutic Process through Action Research Steps

Action research in family therapy is used both as a methodology for process-based inquiry (Cvetek et al., 2011) and as a tool for designing the therapeutic process. It follows recurring cycles of four steps, which can be recognized in therapy as (Cvetek et al., 2011):

1. **Observation and Data Collection**

   In this phase, the therapist (or research team) gathers information and, typically after the therapy session, describes the family structure and functioning, and defines the current problem. The therapist may document what is known about the client system so far, which interventions have already been implemented, and what results have been achieved. To

improve the validity of these descriptions, the therapist may incorporate results from questionnaires that therapy clients voluntarily complete. Based on all these dimensions of assessment, the therapist forms a data set about the family that is crucial for planning therapeutic interventions.

2. Reflection (Conceptualization or Diagnosis)

During the reflection phase, the therapist (or research team) explores theories that align with the presented problem and collected data. This step includes evaluating the effectiveness of previously implemented interventions and always involves the therapist's process of self-reflection, as well as insights from peer consultation or supervision. Through this, the therapist evaluates their interventions and develops new understandings of the problem, with the aim of forming more effective interventions for future sessions. Ongoing assessment tools filled out by clients may also be included in this process. Hypotheses are formulated, which are then tested in subsequent steps of the research or therapeutic process.

3. Planning

This is a key moment for shaping the therapeutic plan. In accordance with the principles of action research, this step follows each therapy session or reflection. At this stage, based on gathered information and reflection, the therapist (or research team) defines the desired outcome of the next session and possible solutions to the presented problem, which are to be addressed through therapeutic interventions. The therapist outlines planned measures and interventions aimed at achieving these outcomes and identifies potential theoretical constructs or ideas that support the proposed measures and solutions. This results in a plan for therapeutic interventions that the therapist follows and evaluates in subsequent steps of the therapy process.

4. Action or Therapeutic Interventions

In this step, the therapist implements the planned interventions into the therapy process. It is important that the therapist, despite having planned interventions, remains responsive to the needs of the family

or therapy clients. Often, the planned interventions serve as a starting point, and in practice, they may serve as catalysts for change. However, they can also become a hindrance if the therapist, by rigidly adhering to the plan, loses touch with the issues that are currently most important to the clients.

Example of Action Research in Family Therapy[7]

Observation and Data Collection

A family of three came to therapy seeking help. The issues began when their four-year-old son, Nik, started preschool. Nik struggles with separation from his mother in the mornings. When she drops him off, the teachers often have to take him from her arms while he cries. He needs a significant amount of time to calm down and continues to have difficulty engaging in classroom activities. He interacts only minimally with other children. His mother frequently picks him up early, and he is often sick, resulting in frequent absences from preschool. The relationship between the parents is distant – they have little to no communication. In therapy, the mother does most of the talking, while the father remains mostly silent. He appears emotionally detached and disinterested.

Reflection

During the session, the therapist reflects on the family's dynamics. Through compassionate and empathetic engagement, she gains the parents' agreement that they both need to support Nik in his adjustment to preschool. She also addresses their relationship, and they acknowledge that they have grown distant from each other and that their relationship has changed significantly since their child was born.

7 The presented therapeutic case is based on real clinical experiences. However, certain details have been modified, fictionalized, added, or omitted to ensure the anonymity and confidentiality of the individuals involved.

Planning

Together, they develop a plan with two main changes: both parents will attend a parent-teacher meeting at the preschool to create a structured plan for Nik's gradual transition. The father will begin taking Nik to and from preschool. At the next therapy session, the parents will come without their child so that they can focus more directly on their relationship issues.

Action

The parents schedule a meeting with the preschool teacher. At the following session, they arrive without Nik.

The therapist follows a similar process at each therapy session: she reflects on the most pressing issues, collaboratively develops a plan for the upcoming week with the parents, and designs interventions for future sessions. The plan is then implemented and later evaluated.

3

The Therapeutic Relationship

Therapy is a relationship, and an increasing body of research confirms that the quality of the therapeutic relationship is a key determinant of success in psychotherapy (Baier et al., 2020). The therapeutic process can be likened to the construction of a house – where the therapeutic relationship forms the foundation. These foundations should be strong and stable; while they may not be visible in the finished structure, they are essential to the strength and safety of the entire project. The therapeutic relationship begins with the first contact between the client and the therapist. Its initial framework is established through a mutual agreement on the goals and structure of therapy (Patterson et al., 2009). It is crucial that the client feels heard in their individual needs and understood in their experience of the situation and relationships in which they are embedded. The client's active participation and sense of responsibility are also essential, as their engagement plays a vital role in shaping the conditions for the therapeutic process. Within the development of safety, attachment, and empathy in the therapeutic relationship, the role of the therapist and the client's responsibility are defined (Tudor, 2016). A mutual responsibility for the therapeutic process is established, with both client and therapist actively engaged and aware of their respective roles.

The central dynamic of the therapeutic relationship is the formation of the therapeutic working alliance. This alliance is established between two

relatively differentiated individuals who share a positive intention toward resolving a mutual task or concern (Praper, 2013). In therapy, the development of the alliance occurs in two phases: the first phase encompasses the initial five sessions, emphasizing the establishment of trust and the basic framework of the therapeutic process; the second phase involves the therapist adopting not only an empathic stance but also the role of an active facilitator of change (Horvath & Luborsky, 1993). The first phase is seen as crucial for initiating the therapeutic process, while the second phase is critical for determining therapeutic outcomes (Praper, 2013). An empathic and well-structured therapeutic relationship that includes a consensus on cooperation forms the basis upon which the therapist implements interventions to foster change in the client. It can be concluded that therapeutic change is not possible without an empathic, collaborative relationship established in the early phase of the working alliance. At the same time, empathy alone is not sufficient for achieving therapeutic outcomes. The working alliance should be enriched with a focus on the client's vulnerabilities, resistances, and defenses (Horvath & Luborsky, 1993; Praper, 2013). In this phase, the therapist carefully evokes the client's vulnerability and introduces a new relational experience into their intrapsychic experience of that vulnerability. Within the safe and empathic therapeutic relationship, the client accesses painful emotional content, which the therapist regulates through empathetic responses, emotional reprocessing, validation, and meaning-making. The working alliance thus enables a novel experience of an empathic relationship in which the therapist, through interventions at the systemic, interpersonal, and intrapsychic levels, transforms the client's internal experience (Gostečnik, 2017). By connecting the client's current experience within the therapeutic relationship to significant past relational experiences, the client gains greater self-awareness, self-confidence, and self-trust (Praper, 2013).

The importance of interpersonal influence and the unique relational space between therapist and client is also emphasized in Dynamic Systems

Theory. The Boston Change Process Study Group, based on research into the therapeutic process, posits the following: (1) the therapeutic process is guided by the tendency to organize the relationship between therapist and client, (2) both therapist and client contribute their individual characteristics to the course of therapy, (3) patterns of the therapeutic relationship are unpredictable, and (4) the relationship is influenced by the personal histories both therapist and client bring into the encounter (Stern et al., 2010). The therapeutic process represents a shifting, creative dynamics, through which therapist and client co-create a unique relationship shaped by their traits, perceptions, and expectations. In this creative space, the therapist respects fundamental systemic principles, as only through maintaining boundaries, safety, clearly defined roles, hierarchy, and distinct subsystems can therapy enable safe confrontation with painful intrapsychic content and its transformation. Forming an alliance in psychotherapy requires the therapist's willingness to experience feelings of incompetence, vulnerability, and uncertainty – because it is precisely in that space that a shared vulnerability begins to emerge between therapist and client (Cozolino, 2004). Within that vulnerable space, a new sense of safety can be established – one that is vital to the psychological stability of every individual.

3.1 Establishing Safety in the Therapeutic Relationship

Safety within the therapeutic relationship enables the therapist to act in accordance with ethical principles, fostering collaboration and mutuality between therapist and client. In this context, safety can be understood from three perspectives:

- the client's subjective experience of safety,
- the therapist's efforts to establish and maintain a sense of safety,
- the quality of the interpersonal therapeutic space.

The experience of safety is inherently subjective and varies from person to person. As such, the therapist should attune to and accommodate this individual perception in every therapeutic process. Throughout development, individuals tend to form patterns of loyal behavior, gravitating toward relationships that provide comfort and security, and toward people who offer connection, regardless of the actual content or quality of the relationship (Fairbairn, 1952). This means that a person's sense of safety is formed in relational contexts where some form of interpersonal contact was present, and the nature of that contact becomes part of their internal experience of safety. As a result, safety may stem from loving, nurturing relationships, but it may also derive from avoidant, anxious, or even abusive ones. In the latter case, the individual may continue to seek out familiar relational dynamics in adulthood, not necessarily because they are healthy or functional, but because they are the only ones that evoke a sense of safety. These relational patterns and attachment styles tend to be repetitive and enduring.

In the therapeutic context, a client's early attachment experiences often predict how they will relate to the therapist (Talia et al., 2017). Clients with a history of secure attachment may be more likely to seek closeness with the therapist, work to maintain the therapeutic relationship, and thus contribute to the creation of a safe environment. Conversely, clients with insecure attachment histories may – often unconsciously – introduce patterns of avoidance or resistance into the therapeutic relationship, thereby repeating familiar attachment dynamics.

Client's Subjective Experience of Safety[8]

Monica, a 35-year-old woman, began therapy shortly after ending a romantic relationship. The breakup caused her significant emotional

8 The presented therapeutic case is based on real clinical experiences. However, certain details have been modified, fictionalized, added, or omitted to ensure the anonymity and confidentiality of the individuals involved.

distress – she experienced sleep disturbances, persistent fatigue, and was unable to work for a period of time. Her primary care physician prescribed antidepressants, and she independently decided to pursue psychotherapy. From the initial session, Monica appeared highly disengaged. She spoke in a quiet voice and gave brief responses to questions. It was only after approximately five sessions that a therapeutic relationship gradually began to develop. At this point, Monica was able to speak more freely, and the therapist no longer felt she had to carefully manage the interaction or constantly strive to maintain the connection. Nonetheless, avoidant behavior persisted. When the therapist attempted to offer empathic attunment and validation, Monica would often fall silent and avert her gaze. She appeared emotionally numb and dissociated. She was unable to articulate her feelings and did not respond to the therapist's interpretations of her emotional state.
Monica is an only child. She speaks little about her family and retains only fragmented memories of her childhood. Her father was frequently absent due to work obligations, and she describes her mother as sad and emotionally distant. Monica spent a great deal of time alone and had to care for herself from an early age – she was often home alone, cooked her own meals, and her parents did not attend school meetings or events.
From this environment, she learned to be self-reliant and internalized the belief that she could not depend on others for support. This relational pattern repeated itself in therapy. Although she actively sought help, Monica was unable to allow herself to become emotionally attached to the therapist. Moments of vulnerability were consistently followed by emotional withdrawal and dissociation.
The therapist had to remain consistently patient and attuned, recognizing that Monica's unresponsiveness was not a reflection of a lack of trust in the therapeutic relationship per se, but rather an expression of her early attachment experiences, in which emotional closeness had never felt safe.

A therapist's effort to establish safety within the therapeutic process is reflected in their ability to recognize the client's patterns of seeking safety, evaluate them, and use therapeutic interventions to transform dysfunctional safety-seeking behaviors. In doing so, the therapist should remain aware of the powerful influence of early attachment patterns formed in previous relationships and, above all, consistently offer the core components of psychological safety.

Establishing Safety in the Therapeutic Relationship according to the »three P-s« (Crossman, 1966)

The key components of a therapist's work are:

- Permission
- Protection
- Potency

In the therapeutic context, permission refers to the therapist's creation of conditions that enable behavioral or relational changes the individual has been unable to achieve outside of therapy (Crossman, 1966). The therapist provides a space in which the client can explore their emotions, gain insight into their beliefs, and analyze their behavior from a new perspective. Furthermore, through both explicit and implicit actions, the therapist conveys permission for change – instilling the sense that transformation is possible, that distress is resolvable, and that psychological pain can be managed. Crossman (1966) associates permission in therapy with the role of a parent. The therapist should play the role of a nurturing figure who encourages and cares for the client. The process of granting permission in therapy begins at the moment of helplessness, when the client, despite all insights and experiences, is unable to manage their distress, emotions, or behaviors. At this point, the therapist, through parental encouragement and expression of care, guides the client toward the desired change. This does not simply involve offering behavioral and cognitive options for change, but also providing new relational experiences from which the client can draw positive

experiences about themselves and their relationships on their path toward greater self-control and confidence. It is important to consider how the client is able to accept new experiences. In this process, both the verbal and non-verbal granting of permission by the therapist and the verbal and non-verbal acceptance of permission by the client are crucial (Tudor, 2016). The client should be able to accept permission for a new way of thinking, behaving, or feeling and should also grant this permission to themselves, feeling strong, significant, and capable enough to follow the desired change.

Permission in Therapy with Monica

»Talking about your life, relationships and difficulties likely stirs up in you a lot of emotions like helplessness, guilt, fear, sadness, and perhaps even some anger. All of these are expected and completely valid. Your stories carry many emotions that you may never have had the chance to speak about, and that no one ever explained to you or discussed with you. That's why they've remained in your body, and even now, you and I may struggle to properly describe them. But that doesn't mean you can just suppress them. What we have now is an opportunity to finally understand them – and together, we can begin to find the words they've always needed.«

Another essential »P« in the therapist's approach to ensuring safety in the therapeutic process is protection. In transactional analysis, protection is described as a maternal function – a mother's protection of her child as they explore the world around them (Crossman, 1966). From a relational perspective, when a client begins to experience new emotional states made possible through therapeutic permission, a relational fear may emerge – specifically, the fear of losing the therapeutic bond. This relational fear is rooted in early experiences of separation anxiety (Mahler et al., 1975), during which the implicit memory of relational loss becomes encoded in the body. As the child begins to experience differentiation and separateness, they risk

the loss of the bond with the mother. This experience evokes relational fear, which, according to Winnicott's (1965) theory of the »good-enough mother,« is regulated by the caregiver's emotional responsiveness. Through such regulation, the child internalizes a sense of emotional safety and the ability to manage relational stimuli. This experience of protection helps transform fear (and other affects) into tolerable bodily states and allows the relationship to become a safe haven. In therapy, the therapist plays a similar role, supporting the client through the fear and vulnerability that often accompany change. The therapist creates a secure therapeutic space that offers sufficient protection for the client to risk internal changes – such as new ways of understanding the self, others, and relationships – as well as interpersonal changes, including experimenting with new emotional and behavioral strategies.

Protection in therapy with Monica

»Whenever we begin talking about emotions, I can see fear appear on your face. It's as if your body feels this is too dangerous. The idea that someone might try to understand what you're feeling keeps triggering a sense of threat. Your mind wants to go there, but your body says no. And that fear comes from the unknown – it's unfamiliar. There's nothing wrong with your feelings being seen, and nothing bad will happen if someone understands what you feel. It's just that this experience is new, and that's why it's hard. So we'll explore your emotions very slowly, and you can stop me at any time if it becomes too much. «

In addition to offering permission and protection, therapists should also convey a sense of capacity and competence, both in themselves and in the clients. A therapist's capacity is demonstrated through authenticity, credibility, truthfulness, and responsiveness. These qualities stem from the therapist's own experience of self-awareness, self-analysis, and capacity for personal change (James, 1977). Therapeutic competence is not merely a matter of

technical expertise or education, but arises primarily from the therapist's ability to engage in self-exploration, self-critique, and self-reflection. Such experiences give the therapist the psychological strength necessary to work with and transform the client's deeply rooted emotional experiences. The therapist's ability to contain and tolerate the client's psychological pain is grounded in empathy – more specifically, in the therapist's capacity for empathic attunement and responsiveness. This relational responsiveness supports both therapist and client in a shared process of making sense of the client's internal experience and psychic structure (Tudor, 2016).

Potency in therapy with Monica

»We can go through even the toughest feelings together. Although for a moment we might not know what the right path is, I won't give up. I will always try to find explanations for your feelings, and together we will find ways to make those feelings manageable. «

As previously noted, the sense of safety in the therapeutic relationship is shaped not only by the client's subjective experience of safety and the therapist's efforts to foster it, but also by the quality of the interpersonal therapeutic space. Safety in therapy should not be understood as a unidirectional process from therapist to client; rather, it emerges as a relational process within the therapeutic dyad (Tudor, 2016). The organization of the therapeutic relationship is guided by a mutual effort to co-create this space. Given the unique personal histories and individual characteristics of both therapist and client, the process and outcomes of therapy are inherently distinct and unpredictable (Stern et al., 2010). Therapeutic safety develops through what Stern and colleagues (2010) describe as relational quality, which includes the ability to adapt within the relationship and to co-construct a shared interpersonal space. This perspective moves away from the traditional view of the therapist as a detached expert and instead emphasizes the

importance of the therapeutic relationship as one formed not only between professional and client, but between two human beings. Within this human-to-human connection, safety is established: the therapist offers permission, protection, and capacity, while the client, through their lived experience in the relationship, is able to receive and enact this support through behavior, cognition, emotional expression, and implicit self-perception in relation to others. In practice, family therapy represents a dynamic and creative therapeutic process, shaped by the therapist's and client's individual traits, perceptions, and expectations, resulting in a unique relationship. Within this creative space, the therapist honors the foundational principles of systemic functioning – recognizing that only through the maintenance of clear boundaries, emotional safety, defined roles, appropriate hierarchy, and distinct subsystems can the therapeutic process safely address and transform deeply painful intrapsychic material.

3.2 Empathy in the Therapeutic Relationship

Empathy in the therapeutic relationship is a goal-directed interactive process aimed at understanding the client's inner experience. Traditionally, empathy has been defined not only as the cognitive understanding of another person, but also as the felt sense of the other – the ability to emotionally attune to another, making empathy a relational and embodied process between two individuals (Rogers, 1975). In the context of therapy, empathy involves attending to what is spoken, with the therapist paying close attention not only to the explicit content of the client's life narrative, but also to the implicit dynamics within the therapeutic relationship itself (Finlay, 2016). Through this focused attention, the therapist explores the meaning of the client's experience within the therapeutic context, facilitating an empathic exchange of affect. An empathic relationship enables the client to better regulate feelings of threat and fear, which in turn fosters trust – both in themselves

and in the therapeutic relationship. This trust then allows the client to follow the therapist's guidance more openly and enhances the constructive elements of communication (Finlay, 2016). To build an empathic relationship, the therapist should be capable of experiencing the client's key emotional states and viewing both the therapeutic process and the world through the client's perspective (Yalom, 2002). It is essential, however, that empathy remains a temporary merging with the client's experience – a repetition of primary affective identification – which should then be followed by cognitive understanding and awareness of the therapist's own emotional responses during the process of identification (Praper, 2013).

Five Levels of Empathy (Mate and Mate, 2022)

1. Basic Human Empathy

Basic empathy refers to the fundamental human capacity to be present with suffering. It means allowing ourselves to be touched by the awareness that someone is struggling.

2. Empathy of Curiosity and Understanding

This level of empathy is grounded in the principle that everything exists for a reason – and that this reason matters. Without judgment, we inquire into why a person or group is the way they are and acts the way they do, especially when it challenges or unsettles us. This is also referred to as contextual empathy. No matter how sincere our desire to help ourselves or others may be, we cannot do so effectively unless we acknowledge the suffering being experienced, and – wherever possible – its origins.

3. Empathy of Recognition

This level allows us to see and appreciate that we are all »in the same boat,« shaken by similar struggles and contradictions. Until we recognize our shared humanity, we inadvertently create more suffering – for ourselves, by distancing from our own humanness and becoming entangled in physiological states of judgment and resistance; and for others, by evoking their shame and deepening their sense of isolation.

4. Empathy of Truth

Truth often brings more pain before it brings relief. True empathy does not protect people from the inevitable disappointments, failures, and pain that life brings from early childhood onward. When a therapist shields a client from such truths, it is often an avoidance of their own woundedness. Empathy and truth are reciprocal processes; authentic care involves the courage to acknowledge reality, even when it hurts.

5. Empathy of the Possible

Each of us is more than the conditioned personality we present to the world, more than the untamed emotions we express, and more than the behaviors we enact. Possibility is connected to some of humanity's greatest capacities: wonder, awe, mystery, and imagination. This deepest level of empathy holds the belief that what we most deeply need and yearn for is always within reach.

Through empathic responsiveness, the therapist enables the correction of the client's emotional experience (Kohut, 1984), transformation of implicit relational awareness (Stern et al., 2010), and the reparative fulfillment of relational needs (Erskine, 2011). This means that by engaging empathically, the therapist addresses the individual's core psychological needs and offers a model for alternative ways of satisfying those needs, as well as a new model for experiencing oneself, others, and relationships. From the perspective of ego psychology, the processes of mirroring, idealization, and twinship are essential to empathic responsiveness (Kohut, 1984). In the therapeutic process, these processes are re-enacted: the client seeks affirmation of their uniqueness and worth (facilitated through the therapist's mirroring), a need for idealization and a sense of safety (supported by the therapist's competence), and the desire to share similarities with another (enabled through the therapist's encouragement of collaboration). In this way, fundamental relational experiences are revisited, and through empathic responses, opportunities for emotional correction and growth are created. The moment of empathy in

the therapeutic relationship is understood as the »present moment« (Stern et al., 2010), marked by affective attunement between therapist and client. This moment reactivates familiar emotional atmospheres and habitual ways of establishing and maintaining relationships. Repetition of dysfunctional patterns provides a chance for new experiences, through which emotional regulation fosters the development of new internal models for relating to self, others, and the world.

An empathic therapeutic relationship thus requires attunement between therapist and client. Interpersonal attunement refers to the creation of a shared affective space (Stern et al., 2010), where the relationship influences the biological architecture of the interactive brain (Schore, 2001) and reflects the universality of human experience. It involves kinesthetic and emotional perception of the other, sensitivity to the other's rhythm, impact, and lived experience, and the formation of a continuous emotional bond between two individuals through mutual influence and/or resonant responsiveness (Erskine, 1998).While empathy is directed toward the client with the aim of compassion, cognitive understanding, and emotional resonance, attunement is oriented toward the therapeutic relationship itself, with an emphasis on relational synchrony and facilitating the expression of intrapsychic content through the relationship (Finlay, 2016). It is crucial to recognize that we are not present in relationships only with our minds and consciousness, but with our entire bodies. Thus, empathy manifests through embodied presence. Empathic attunement can be defined as a moment of contact in the relationship while maintaining contact with oneself – when one can feel the other through awareness of one's own body. Empathy is not unconditional emotional merging with another person; rather, it is a directed relational process that combines perception of the other's state, intuitive understanding of their position, and a forward-looking orientation toward growth (Praper, 2013). The key to empathy lies in directing attention to one's own internal experience. Only through an established connection with one's own body

can an empathic response to the other be cultivated. In addition to cognitive understanding, empathy also involves the embodied or implicit experience of psychological content and the somatic regulation of emotional material. Therefore, empathy is expressed in the relationship through the whole body – we convey empathy not only through words but primarily through bodily and implicit regulation.

Through levels of attunement, the therapist becomes attuned to the client's relational needs, meaning they are able to identify and respond to unmet relational needs (Modic & Žvelc, 2021).

Levels of Attunement (Erskine et al., 1999)

Affective attunement involves observing the expressed affect, internalizing it, and responding through emotional regulation.

Cognitive attunement refers to understanding the client's way of thinking and the meanings they assign to their experiences.

Developmental attunement entails recognizing developmental needs, tracking the client's regressions, and meeting these needs accordingly.

Rhythmic attunement involves adjusting the pace of therapy to the client's capacity for processing information.

3.3 Establishing Attachment in the Therapeutic Relationship

Attachment theory provides a foundational framework for understanding the therapeutic relationship. The patterns of forming attachment in relationships – both on the part of the client and the therapist – are closely linked to how the therapeutic relationship itself is established (Talia et al., 2019).

Attachment Theory (Ainsworth, 1978; Bowlby, 1969)

John Bowlby defines attachment behavior as behavior aimed at maintaining proximity to another person and seeking comfort in stressful situations. Throughout development, humans form emotional bonds

with others because connection, closeness, and the experience of safety represent fundamental human needs that are essential for growth. A child's attachment to a caregiver ensures survival while also shaping lifelong patterns of forming and maintaining relationships. Attachment not only determines how individuals establish contact with others but also how they experience and respond to separation. The development of internal working models is significantly influenced by how the environment responds to disruptions in contact. When a child experiences safety, intimacy, and relational continuity – even amidst separation or distress – a foundation is laid for the development of functional internal attachment models. In this context, the other person can be perceived as a secure base from which to explore the world and as a reliable source of comfort and regulation when needed.

Through her empirical research using the »Strange Situation« procedure, Mary Ainsworth identified three primary attachment styles:

- Secure Attachment: A securely attached child seeks closeness with the caregiver, expresses distress when separated, and is soothed upon reunion. Caregivers of securely attached children tend to be responsive and consistent in their emotional availability. As adults, securely attached individuals trust themselves and others, do not perceive closeness or separation as threatening, and typically experience relationships as positive and fulfilling.
- Avoidant Attachment: An avoidantly attached child does not actively seek proximity to the caregiver, shows little visible distress during separation, and appears emotionally unaffected by reunion. Caregivers of these children are often emotionally unavailable or dismissive of the child's needs. Adults with avoidant attachment tend to experience discomfort with intimacy, struggle with trust, and have difficulty depending on others or seeking support.

- Anxious-Ambivalent Attachment: A child with an anxious-ambivalent attachment style exhibits anxiety even while in the presence of the caregiver, is highly distressed by separation, and is not easily comforted upon reunion. These children typically experience inconsistent caregiver responsiveness. In adulthood, individuals with this attachment style often feel that others are not as close as they desire, experience chronic worry about whether they are truly loved, and fear abandonment.

Marrone (2014) outlines several theoretical dimensions of attachment: (1) a developmental theory of both normative and pathological functioning, (2) a theory of sensitive responsiveness as a psychological organizer, (3) a theory of internalization and representation, (4) a theory of anxiety, (5) a theory of reflective functioning, (6) a theory of emotional regulation, and (7) a theory of interpersonal transmission of attachment patterns. These theoretical perspectives will serve as the foundation for understanding the significance of attachment formation within the therapeutic relationship.

Attachment as a Developmental Theory and Its Significance for the Therapeutic Relationship

The foundation of developmental paths is marked by the interaction between the child and the parent, with Bowlby (1969) emphasizing that it is primarily the parental style that determines whether the developmental path is normal or pathological. A child who grows up in an emotionally responsive and stable environment, where parents provide secure interactions, is more likely to follow a functional developmental path. In contrast, a child growing up in an emotionally unstable environment is more likely to follow a pathological developmental path. Psychological resilience in difficult life situations also develops based on the experience of a secure and satisfying attachment in early development or through the experience of a secondary attachment outside the parent-child relationship that offers support and stability (Marrone, 2014). In the therapeutic process, the therapist explores

the developmental experiences of the therapy client and simultaneously takes these experiences into account when establishing the therapeutic relationship and therapy goals. The exploration of developmental experiences in therapy takes place on both an explicit and implicit level of memory.

Explicit and Implicit Memory (Dew and Cabeza, 2011)

Explicit memory typically refers to the conscious, intentional recall of past information or events through recognition or free recall. Explicit memory represents conscious information about events. The hippocampus in the limbic system plays a key role in storing information in explicit memory, as it processes information that relies on verbal understanding.

In contrast, implicit memory usually refers to an unconscious, unintentional form of memory that enables repeated experiences in response to new stimuli. Implicit memory stores information about emotional and bodily experiences without the actual recall of those experiences. It is responsible for recalling information that represents automatic responses, which are the result of learning through classical and operant conditioning. The amygdala in the limbic system is responsible for storing information in implicit memory.

In psychotherapy, exploring explicit memory allows for the collection of essential biographical information, which is critical for setting therapeutic goals and informs the therapist's choice of appropriate interventions for each client. Additionally, reflecting on developmental experiences provides the client with an opportunity to develop trust in the therapist, while offering the therapist the information needed to formulate more accurate interpretations. The therapeutic relationship may itself offer a corrective emotional experience of support and stability (Cozolino, 2010). However, it is crucial that the therapist remains aware of the client's limited capacity to modify deeply ingrained attachment patterns. While individual developmental trajectories can shift toward more or less functional forms throughout the lifespan, early relational experiences place constraints on the potential for change (Marrone, 2014).

The longer a maladaptive developmental path has persisted, the less likely it is that the individual will be able to fully redirect this trajectory in an optimal direction later in life. Thus, therapeutic access to this level of information does not occur solely through the exploration of explicit memory, but more importantly through the focus on implicit memory processes. Understanding a client's developmental attachment requires attention not only to their declarative experiences but also to their bodily responses to key relational experiences, as well as to the ongoing transference and countertransference dynamics within the therapeutic relationship.

Exploring Implicit and Explicit Memory (in therapy with Monica)

T: How do you feel when we talk about your relationship? Can you describe what you feel in your body?

M (Monica): I just feel my head.

IMPLICIT MEMORY

T: Is there a feeling of tension or emptiness in it?

M: Tension.

T: Can you identify where in your head this tension is?

M: In the front (*points to forehead*).

T: Is it a feeling that you need to understand something, that you need to explain something but you don't know what?

M: Maybe.

T: When something starts happening around you that you don't understand, and then you feel like you have to understand it, even though no one explains to you what's going on or what exactly they want from you ...

INTERPRETATION

M: Yes, and then I always have the feeling that I'm the most stupid person in the world, that I don't understand anything.

T: And the same thing happens here. I'm asking you, you don't understand what I want from you, and you feel like you have to explain something,

say something, but you don't know what, and then all that remains is the tension in your head and the feeling that you're the most incapable person in the world.

M: Yes.

T: You don't need to explain anything here. Today, you can ask, and I will explain it to you...

M: I know. I can here, but not elsewhere...

T: Where does this memory come from, that you can't ask?

M: I don't even remember ever daring to ask my parents anything. Everything in our house was self-explanatory, everything was clear without explanation. I never dared to ask anything.

EXPLICIT MEMORY

M: I know. I can do it here, but I can't do it anywhere else...

T: Where does this memory come from that you can't ask?

M: I don't think I even remember when I dared to ask my parents anything. With us, everything was self-evident, everything was clear without explanation. I didn't dare to ask anything.

EXPLICIT MEMORY

Sensitive Response Theory and its Importance for the Therapeutic Relationship

Parents are considered sensitively responsive when they are able to notice their child's signals promptly, interpret them appropriately, and respond in a timely and attuned manner. This implies that the parents are psychologically available, capable of recognizing the child's emotional state, and able to assign meaning to the child's experience within their own internal process. In contrast, a lack of sensitivity is reflected in neglectful parental behavior – when parents fail to notice the child's internal state, misinterpret it, or respond in ways that are wholly inappropriate. Sensitive responsiveness allows parents to perceive the child's needs as distinct from their own and from those of others. This

enables them to adequately address both the child's need for closeness and their need for exploration and autonomy (Marrone, 2014). In psychotherapy, sensitivity is most often associated with the therapist's empathic attunement to the client's experience. Empathic responsiveness involves the therapist's sensitivity to the emotional content expressed by the client (Rogers, 1975), the capacity to perceive implicitly expressed needs (Erskine et al., 1999; Finlay, 2016), and the ability to facilitate new relational-affective experiences (Kohut, 1984; Stern et al., 2010). It also requires the therapist to remain self-reflective and actively engaged in the process of co-constructing meaning (Praper, 2013). Through empathic responses, the therapist offers a corrective experience of primary sensitivity, approximating the role of a caregiver who is emotionally available, attuned, and prepared to help regulate even the most painful and difficult internal experiences of the client.

In life, sensitive responsiveness plays a crucial role in the development of self-awareness and self-confidence, as well as in the formation of loving, cooperative, and reciprocal relationships (Marrone, 2014). A collaborative relationship between therapist and client is the foundation of the therapeutic working alliance, which serves as the basis for all therapeutic interventions. In psychotherapy, it is precisely the therapist's sensitivity during the initial phase of alliance formation that enables the transition to later stages of the process, where even the most vulnerable aspects of psychological experience can be accessed and transformed (Horvath & Luborsky, 1993).

Sensitive responding (in therapy with Monica)

Therapist (T): You likely feel quite helpless as we talk about these memories. It's difficult to speak about experiences where your needs were not adequately met.

M: Yes, I don't know why this feels so hard. I didn't do anything wrong as a child.

T: And yet, the feeling of guilt is so strong. Talking about our parents is always challenging. Deep down, we carry an enduring sense that we should protect them. Sometimes we even suppress certain memories, simply to preserve our connection with them.

M: It really is hard for me to talk about this.

Theory of Internalization and Representation and its Significance for the Therapeutic Relationship

The theory of internalization is an analytic concept that Bowlby expands upon with the theory of representation, more precisely through his definition of internal working models (Marrone, 2014). The experience of relational interactions in early development – particularly in situations where the child is exposed to fear or threat and seeks comfort from an attachment figure – facilitates the process of representation and the formation of internal working models (Bowlby, 1969). Initially, these two experiences – fear and the presence of a protective figure – are not integrated. However, in the context of a secure relationship, the child becomes capable of connecting them, which allows the attachment figure to be experienced as a source of safety in the face of danger. This integration leads to the development of an internal working model of safety and self-worth (Bowlby, 1988). Stern (2010) emphasizes that internal experience is not shaped solely through conscious relational encounters. Rather, foundational experiential patterns are formed in early development, when the child, on a nonverbal level, absorbs messages about what to expect from others, how to behave, and how to feel toward them.

The process of internalization. and the addressing and transformation of internal representations, also take place within the therapeutic relationship. The experience of being-with represents a crucial step in the therapeutic process. It allows the therapist to attune to the client's inner experience and to expand and generalize this experience throughout the client's broader

relational and emotional world (Stern et al., 2010). The therapist uses the therapeutic relationship as a tool for gaining both explicit and implicit insights into the client's modes of internalization and representation. Acknowledging the critical role of early experiences in shaping subjective experience, the therapist co-creates a new interpersonal space that supports the emergence of new relational experiences.

Addressing representations (in therapy with Monica)

M: I don't think I have any memory of ever daring to ask my parents anything. In our home, everything was just assumed – everything was clear without explanation. I never dared to ask.

Therapist (T): How old were you? What image comes to mind when you speak about this?

M: Elementary school.

T: Around ten years old? Can you picture yourself at that age – can you bring up an image of ten-year-old you? What did she look like?

M: *Lifts her gaze.*

T: Do you see her in front of you?

M: *Nods.*

T: When you look into her eyes, what do you see there? What is that girl experiencing?

M: She's lost. She doesn't know what's going on around her – completely confused...

T: Is she expecting someone to come? Or is she afraid someone might?

M: No, no one's coming. She's alone.

Anxiety Theory And Its Importance for the Therapeutic Relationship

Attachment theory not only proposes models for the formation of interpersonal relationships but also emphasizes the disruption of contact as

a crucial factor in shaping an individual's emotional experience. Anxiety is understood as a response to the threat of losing a loved one, distinguishing it from fear, which is a reaction to actual physical danger. Thus, anxiety in insecure attachment forms does not arise from threats to biological survival but from threats to psychological survival (Marrone, 2014). When a child experiences inadequate responses to relational disruptions – such as a caregiver being emotionally unavailable or responding inappropriately to the child's needs – the child fails to develop a sense of internal safety that supports psychological stability. Disruptions in contact, which in early development may represent real danger if not adequately regulated through secure and comforting responses, become a source of anxiety or a constant threat of loss. According to Mahler et al. (1975), the so-called psychological birth of the individual occurs between the fourth and fifth month of life. During this time, emotional stimuli are processed through the mechanisms of emotional regulation (Gross, 2008), and the individual begins to experience separation from others. This realization is closely tied to the emergence of contact disruptions and the accompanying anxiety. Parents serve a key role as external regulators of emotional states, providing support in managing unfamiliar and intense emotional experiences (Cummings et al., 2003). In this context, anxiety is referred to as relational fear, defined as an organic response to a relational stimulus when facing the threat of contact loss – essentially the feeling of »I will be left alone« (Poljak Lukek, 2017). Relational fear or anxiety, when met with experiences of emotional soothing in relationships, becomes a manageable physiological state. A secure relationship thus becomes a safe haven rather than a source of fear and anxiety.

Even in adult relationships, individuals experience physiological responses rooted in early relational fears (Rothschild, 2000; Schore, 2009). Relational stimuli in early adulthood may evoke arousal responses that the individual is, to varying degrees, able to recognize, contain, process, and respond to effectively through internalized mechanisms of regulation. When stress

arises from fear of contact disruption or loneliness, it is often unrecognized, leading individuals to adopt ineffective or unexpected coping strategies. These maladaptive responses can manifest as feelings of helplessness, guilt, anger, sadness, or other forms of emotional distress. Despite cognitive and emotional intelligence, adults under stress may revert to regulation strategies formed during pre-verbal developmental stages, before the emergence of symbolic thinking and language. The fear of »being left alone« is embedded in organic responses to relational cues and significantly influences how individuals manage stress in adulthood. This fear also deeply shapes the therapeutic relationship. The therapeutic relationship is not a context in which anxiety and fear are absent; rather, it is a space that should be capable of containing, accepting, processing, and rendering such emotional experiences manageable.

Addressing relational fear (in therapy with Monica)

M: No, no one will come. She is alone.

T: Even then, she had already learned not to expect anyone to come and help her.

M: Probably, since that's how it always was.

T: That was the only way she could maintain a relationship with her parents – by expecting nothing from them. She had to give up the hope of ever being understood. Only by doing so could she preserve the relationship. If she had allowed herself to expect understanding, every renewed disappointment would have hurt even more. She would have lost the relationship with them over and over again and would have repeatedly experienced being alone. And that is the most painful thing a child can go through. A child will do anything – adapt in any way – just to avoid feeling completely alone.

M: My mother was there. But I always preferred to be alone when things were hard.

T: Because at that time, you were most afraid that your distress would be too much for your mother to handle – that you would burden her, that she wouldn't be able to manage it...

M: It's true, she already had enough problems of her own.

Reflective Functioning or Mentalization Theory and its Role in the Therapeutic Relationship

Reflective functioning, also known as mentalization, refers to an individual's capacity to understand their own and others' mental states, intentions, and emotional experiences. The development of internal representations of self and others is closely linked to the formation of attachment and the regulation of affect throughout development (Fonagy et al., 2002). The ability to reflect – meaning the capacity to evaluate behavior through the lens of mental states – constitutes a key mechanism of an individual's psychological organization and is shaped through early relational experiences. Reflective functioning also plays a vital role for parents in forming secure attachment bonds with their children, as it enables them to attune to the child's internal mental states and respond appropriately to the child's developmental needs at any given moment (Marrone, 2014).

In therapy, a core element that extends the process of reflection is interpretation. Interpretation in psychotherapy serves not merely to demonstrate active listening or to summarize what has been said; rather, its principal value lies in uncovering the intrapsychic truth and underlying dynamics of the client (Praper, 2013). Through interpretation, the therapist addresses the here-and-now dynamics, thereby fostering the development of a trusting therapeutic relationship. At the same time, interpretation engages with key developmental factors and early experiences, allowing the client to reassess their subjective experiences, gain deeper insight into their own and others' emotions, behaviors, and intentions, and ultimately reshape their internal representations of self, others, and relationships.

Mentalization (in therapy with Monica)

M: It's true – my mother already had enough of her own problems.

T: Of course, that's true. She faced many challenges, and it probably wasn't easy for her. But you were just a child. And even though she did the best she could, your needs weren't met, because you often had to manage on your own. That's too great a task for a child – one they are usually not equipped to handle. The child adapts, but ideally, it shouldn't be the child who has to find solutions. Adults should at least provide a basic sense of safety.

M: I would never treat my child that way, if I had one. I would do everything to make sure they never had to feel alone...

T: Just like little Monica deserved to have someone by her side to help her understand what was happening around her and why she felt the way she did.

M: Yes, that never happened. No one ever talked to me.

T: And even now, that kind of presence is still missing – someone taking the time to really talk with you, to genuinely care. The feeling that you're alone and that no one can truly understand what's going on inside you still lingers.

M: Most of the time, I don't even understand what's happening inside me.

T: And it becomes hard to believe that someone else could understand it.

M: [*smiles*]

T: Because that internal experience of the little Monica is still present – the experience of needing to shut down and retreat from others because no one understood, because no one was there. And since truly no one was there back then, the only way to make sense of it was to withdraw. Over time, you develop a belief that you're too much for others or protect yourself from further disappointment by no longer believing that anyone can understand you.

M: That's true. I still don't believe it… [*begins to cry*]

The Theory of Emotion Regulation and Its Relevance for the Therapeutic Relationship

Emotion regulation is the ability to manage, maintain, and modulate emotional states, and it develops through a child's emotional, social, and cognitive maturation (Henderson et al., 2017). In human development, parents play a crucial role in a child's emotional regulation as an external support system that helps the child manage novel affective states (Cummings et al., 2003). Regulated affect refers to the capacity to cope with a current stressor in the environment or the body by recognizing the emotion associated with that stress and deliberately influencing how the emotion is expressed – this constitutes goal-directed behavior aimed at modifying the subjective emotional experience (Gross, 2015).

According to Gross (2015), affect regulation occurs in two directions: (1) decreasing emotional responses (both positive and negative), and (2) increasing emotional responses (both positive and negative). From this foundation, Gross (2015) outlines three fundamental steps of emotion regulation: (1) Identification – deciding (even implicitly) whether or not to respond to a particular stimulus, (2) Selection – choosing a method of regulation, and (3) Implementation – applying the chosen emotional regulation strategy to the present situation. Affect regulation is recognized as a core dynamic in therapeutic interventions within relational family therapy (Gostečnik, 2017), where the therapist assumes the role of an external regulator of the client's affect (Schore, 2012). The therapeutic relationship is capable of evoking the client's deepest, dissociated, denied, or hidden psychological experiences (Schore, 2012; Siegel & Solomon, 2013; Stern et al., 2010). This allows the client to name and evaluate aspects of their inner experience that were previously unconscious but have significantly shaped their systemic and interpersonal interactions. Therapeutic interventions thus aim at the integration of early memories and the facilitation of a reparative emotional experience. These interventions align with shifts in the client's

implicit relational awareness (Stern et al., 2010), meaning that the client's symbolic, internalized understanding of self and other is transformed. In the therapeutic relationship, the therapist makes use of the compulsive repetition of dysregulated affective responses by offering a new experience of safety, acceptance, and understanding (Gostečnik, 2017).

Emotion Regulation (in therapy with Monica)

M: It's true. I still can't believe it. *(begins to cry)*

*T (feeling sadness in h*er own body – teary eyes, a lump in her throat): So much longing. Someone should have been there, but they weren't. And there's so much sadness in that – so much that you can't even hope anymore, because it just hurts too much.

M: *(weeps)*

T: There's nothing wrong with those tears. Let them come. These are just the tears of longing and the pain of saying goodbye to everything that should have been, but wasn't. Someone should have noticed that sadness a long time ago, should have come to Monica and found the right words to soothe her.

M: *(lifts her gaze)*

*T: It's just sadness, a*nd it's okay. There's nothing wrong with these feelings, even if the right words aren't there yet. Today, we can speak about this sadness and find ways to say goodbye to those old wounds and beliefs. We can sit with this sadness for as long as it takes, until all the tears are cried out.

M: (*calms down*) Okay.

Theory of Interpersonal Transmission of Attachment and Its Importance for the Therapeutic Relationship

The therapeutic relationship is shaped not only by present-day interactions but also by emotionally significant past relationships of both the client and the therapist, due to the intergenerational transmission of emotional content.

An individual's functioning and experience are influenced by emotional patterns transmitted across generations (Bowen, 1978). Parents' ability to form secure attachments with their children is closely linked to their own early attachment experiences (Bowlby, 1988), and early attachment patterns strongly influence subsequent relational functioning (Marrone, 2014). This implies that attachment patterns are transmitted from generation to generation and have a significant impact on the formation and quality of the therapeutic relationship. Importantly, it is not only the client's attachment history and family background that matter, but also the therapist's own attachment experiences and family history. Ideally, the therapist, grounded in a personal experience of secure attachment, can offer the client a secure base – a safe haven where emotional patterns can be transformed and new relational experiences can emerge (Goodman, 2010). Central to this process is the therapist's capacity for self-reflection (Rober et al., 2008) and their ability to interpret and work with countertransference (Lemma, 2003).

3.4 Identifying and Addressing Relational Needs in the Therapeutic Relationship

Relational needs are fundamental psychological elements rooted in the basic human need for intimate connection (Erskine, 2011). They shape an individual's sense of psychological connection to others, emotional relatedness, and secure attachment in relationships (Bowlby, 1988). Unmet relational needs in early relationships constitute relational stress, which stems from traumatic relational experiences or dysfunctional attachment patterns between child and caregiver (Schore, 2001). These experiences give rise to an organic response to relational stimuli, associated either with relational fear (»I will be left alone«) or relational trauma (»Something terrible will happen to me in a relationship«) (Poljak Lukek, 2017). In adult intimate relationships, unmet relational needs can lead to attachment injuries (Johnson et al.,

2001), which profoundly affect ongoing relational experiences. In therapy, the mechanism of compulsive repetition (Gostečnik, 2015) allows for the reactivation of conditions under which these needs may finally be met. Within the safety of the therapeutic relationship, the client has the opportunity to experience and express their relational needs and allows the therapist the chance to meet them in a reparative manner.

Basic relational needs include: (1) the need for safety, (2) acknowledgment of one's importance in the relationship, (3) acceptance from a stable, reliable, and protective other, (4) validation of one's personal experience, (5) self-awareness, (6) the ability to influence another person, (7) initiation from the other person, and (8) the expression of love (Erskine et al., 1999). Subsequent empirical research has consolidated these into five core dimensions of relational needs: (1) authenticity, (2) support and protection, (3) influence, (4) shared experience, and (5) initiative from the other person (Žvelc et al., 2020).

Authenticity – the need for safety, acknowledgment, and self-awareness

The need for safety is fulfilled through experiences of protection from physical and emotional vulnerability. A person feels safe when they can be vulnerable while remaining in harmonious connection with another (Erskine, 1998). In early life, this need is typically met by caregivers who facilitate secure attachment through appropriate regulation of relational breaks and the ability to reestablish contact after a stressful event (Ainsworth, 1978; Bowlby, 1969). In adult relationships, safety supports the development of intimacy, characterized by trust, acceptance, compassion, and mutual interest and awareness (Poljak Lukek, 207).

In the therapeutic relationship, the therapist recognizes the client's need for safety through expressions of vulnerability and fear of the new or unknown. The therapist should continually assess their own expressions of respect toward the client, fostering an environment where the client can experience their needs as understandable and valid. This, in turn, allows the therapeutic space to

become a secure setting in which these needs can be re-explored and met. The therapist should remain attuned to the importance of this need, responding with emotional and behavioral sensitivity in a way that ensures the relationship remains safe, consistent, and sustaining (Erskine, 1998).

Meeting the Need for Safety in the Therapeutic Relationship

»There is nothing wrong with the feelings of helplessness you are experiencing. They are a completely normal response to a situation where you don't know how to move forward. And even though you feel completely helpless right now and wish this would pass as quickly as possible, I want you to know that there is nothing wrong with feeling this way. We will try to understand it together, and by doing so, it won't be as disruptive anymore.«

Acknowledging relational significance means that a person feels recognized by another as emotionally and intrapsychically valid (Erskine, 1998). In early relationships, this recognition occurs through the emotional regulation of the child's bodily arousal. Caregivers satisfy a child's need for emotional validation and significance by accepting, internalizing, naming, and transforming the child's physiological and emotional arousal (Gross, 2013). This process provides the child with a sense that their emotional experiences are both valid and manageable.In adult intimate relationships, the experience of emotional significance emerges through cognitive intimacy – a process in which both partners demonstrate mutual interest, develop self-awareness, retain memory of that awareness, become aware of the other's presence, and ultimately affirm mutual understanding (e.g., »I want to be sure you believe that I know what you're going through«) (Poljak Lukek, 2017).

Within the therapeutic relationship, the therapist responds to the client's need for significance by attuning to their emotional experience and responses. Central to this process is the therapist's affective attunement (Finlay, 2016)

and emotional co-regulation (Gostečnik, 2017). Through acceptance, internalization, and the verbalization and transformation of the client's bodily-emotional arousal, the therapist communicates that the client's experience is both significant and appropriate. In addition to offering a new experience of affect regulation, the therapist also facilitates mutual awareness. The client's need for significance is met when they feel and understand that the therapist is truly present in the relationship and acknowledges their internal experience.

Meeting the Need for Significance in the Therapeutic Relationship

»All your feelings are valid. Even though they are currently very disruptive, they are trying to tell you something. That's why it's important that we try to understand them as fully as possible. It matters that you have the opportunity to reflect on your experiences and try to make sense of them – because by doing so, you give both yourself and others the chance to truly understand you.«

Self-awareness is a relational need for the experience of personal uniqueness and the sense of being acknowledged and accepted by another person, while being able to express one's identity without fear of humiliation or rejection (Erskine, 1998). The sense of personal uniqueness develops through progressive phases of awareness: (1) I know, (2) I know that I know, (3) I know that you know, and (4) I know that you know that I know (Lewis, 2003). Awareness of the self, awareness of the other, and mutual recognition of that awareness form the foundation of individual identity. At the core of the need for self-awareness is the individual's striving to recognize their own capacities and the meaning attributed to those capacities (Caprara & Cervone, 2000). Within the therapeutic relationship, all phases of awareness are essential: (1) both the client and the therapist should be self-aware, (2) they should be able to recognize and verbalize that awareness, (3) they should be willing to share this awareness with one another, and (4) they should be open to allowing

the other to understand their subjective experience, including the risk that it may be evaluated. In this process, the therapist should take responsibility for allowing the client to express their experiences and self-awareness without resorting to humiliation, rejection, or any form of negative judgment.

Meeting the Need for Self-Awareness in the Therapeutic Relationship

»Your story is very painful. It should be difficult, with everything that is happening, to shift your focus onto your own experiences, and even harder to think about how you perceive others. However, this is very important. I suggest that we redirect our attention to the here and now. How do you think I perceive you at this moment?«

The dimension of authenticity reflects an individual's need to be accepted by others while being able to express authenticity in relationships. This need is fulfilled through the experience of safety, acceptance, and the capacity for self-definition within interpersonal connections (Žvelc et al., 2020).

Support and Protection – The Need for Acceptance by a Stable, Reliable, and Protective Other

To develop a sense of connectedness, an individual also requires the experience of being accepted by a stable, reliable, and protective figure. This involves a degree of idealization – perceiving the other as important and experiencing them as capable of providing protection, encouragement, and necessary guidance (Erskine, 1998). This experience fosters an internal sense that one can rely on the other for support and protection in times of distress (Žvelc et al., 2020). Attachment theory emphasizes the significance of a secure base in a child's development, where the child's behavioral responses are shaped by the caregiver's responsiveness during relational disconnection and reconnection (Ainsworth, 1978). From the outset, perceiving the other as important is essential for human development. As Fairbairn (1952) notes, individuals do not adapt solely to those who offer comfort and security, but to any relationship that facilitates contact

– regardless of its quality. Idealization enables the growing person to explore and engage with the world; admiration, in turn, facilitates the internalization of behaviors, emotional responses, and values (Kohut, 1984).

In therapy, the therapist is expected to serve as a moral and ethical authority, allowing the client to engage in the mechanism of idealization. Through their credibility and grounded sense of self, the therapist can be perceived as a stable, reliable, and protective presence, thereby meeting the client's need for acceptance (Erskine, 1998).

Satisfying the Need for Acceptance in the Therapeutic Relationship

»You may feel that you are misunderstood or too demanding. But that's okay. I'm here to create a space where you can speak and reflect on your experiences. Whatever comes up, we will try to find meaning in it together – to understand and, if needed, to accept it or to leave it behind, because the responsibility for those feelings may not be yours to carry.«

Influencing – The Need to Influence Another Person

Meeting the need to influence others and to be met with initiative in a relationship helps individuals develop a sense of agency and competence (Erskine, 1998). When people feel that their opinions matter and that they can impact others, they begin to experience themselves as effective and significant (Žvelc et al., 2020).

In therapy, it is essential for the client to be able to capture the therapist's attention and evoke genuine interest. The therapist should, in turn, be willing to be influenced by the client – acknowledging the client's uniqueness and valuing their contribution to the therapeutic process. This mutuality creates a sense of competence in both therapist and client. At the heart of this dynamic is the therapeutic relationship itself – not centered around the therapist, but rather built upon reciprocity and the creation of a unique interpersonal space co-constructed by both clients.

Meeting the Need to Influence in the Therapeutic Relationship

»I clearly remember what you shared last week about your relationship with your brother. The way you described your experience and the compassion you developed toward him was truly moving.«

Shared Experience – The Need for Validation of Personal Experience

Validation of personal experience refers to the establishment of mutuality in a relationship, where an individual seeks to be understood and affirmed (Erskine, 1998). It reflects the need for a relationship in which one can share interests, experiences, feelings, and perspectives (Žvelc et al., 2020).

In therapy, the sense of connection and reciprocity between client and therapist is essential – only within such a relational space can clients safely share their subjective experiences. The therapist should remain attuned to their own emotional responses and communicate an attitude of unconditional acceptance, signaling that any client experience is welcome and comprehensible. Through moderate self-disclosure or even subtle, implicit signals of attunement, the therapist can foster a relational space in which the client's experience is seen, valued, and accepted.

Meeting the Need for Validation in the Therapeutic Relationship

»I understand what you're feeling. The pain you describe is deeply familiar – that kind of pain that comes with realizing it might never be different.«

Initiative from the Other – The Need to Receive Initiative

Relationships become more personal and fulfilling when one receives initiative from another person to establish or maintain the relationship, thereby signaling the importance of the individual within that bond (Erskine, 1998). The sense of being valued is shaped by the responses of others – particularly in early childhood, where frequent and consistent initiative

from caregivers fosters a stronger sense of personal significance. This early experience forms the foundation for the individual's later ability to take initiative in relationships. Responsiveness in interpersonal connections is thus key to meeting relational needs.

While the client's motivation is essential in the therapeutic relationship, the therapist's continuous effort to engage and maintain the relationship is equally vital. This becomes particularly important when the client is overwhelmed by fear, helplessness, or other affective psychological constructs that hinder their capacity to maintain the therapeutic connection (e.g., withdrawal, passivity, desire to end therapy). At such times, the therapist's initiative and commitment to maintain the relationship and continue therapeutic process becomes a crucial therapeutic moment. As Christian Gostečnik stated, the therapist should »believe in people even when they no longer believe in themselves.« This requires the therapist to remain actively engaged and continually reflect on questions like, »What kind of relationship does this client still need?« or »How can I further support and encourage the therapeutic process?« A key experience in fulfilling this relational need is the sense of being cared for without having to ask – when others take initiative on our behalf without being prompted (Žvelc et al., 2020).

Meeting the Need to Receive Initiative in the Therapeutic Relationship

»Even if you're unsure of what you need right now, we'll keep going. I'll be here for as long as it takes for that tension to ease – tension we may not yet fully understand or know how to resolve.«

The Need To Express Love

The need to express love is fulfilled through subtle expressions of gratitude and affection (Erskine, 1998). While empirical findings do not clearly distinguish this need from others – showing only a weak correlation with the expression of authenticity (Žvelc et al., 2020) – the creation of a

space where gratitude can be expressed remains a meaningful element of the therapeutic relationship.

To meet this need, the therapist should be open to receiving the client's expressions of gratitude and affection, while simultaneously maintaining a functional and professional therapeutic relationship.

Meeting the Need to Express Love in the Therapeutic Relationship

»I am truly grateful for the trust you've shown by continuing to come to therapy. I'm proud of you and thankful that I've had the chance to be part of your journey – by your side through the changes you bravely made in your relationships.«

3.5 Defensive Experience in the Therapeutic Relationship

The affective psychological construct that manifests in therapy as the client's resistance or defense serves to protect the individual against psychological pain, the source of which is implicitly recognized in early attachment experiences within the family of origin (Gostečnik, 2017; Stern et al., 2010).

Affective Psychological Construct (Gostečnik, 2015)

An affective psychological construct comprises emotional, cognitive, and behavioral patterns that protect the individual from confronting painful experiences of rejection, neglect, or being replaced. On the emotional level, these constructs may include guilt, humiliation, and grandiosity; on the cognitive level, they may manifest as obsessive thoughts, feelings of inferiority, or neurotic beliefs; and on the behavioral level, as various forms of defense such as addiction, psychiatric symptomatology, infidelity, or persistent failure. These constructs provide a false sense of safety, as

they allow the individual to avoid direct engagement with core traumatic emotional experiences.

The affective psychological construct represents a strong attachment to past experiences; its persistence in future relationships perpetuates unresolved psychological material. The greater the early developmental injury, the more rigid and deeply rooted these constructs should be in order to shield the individual from further psychological pain. While dismantling such constructs can enable contact with core affect and provide a sense of control over one's emotions, thoughts, and behaviors, their defensive function should be acknowledged and respected. Destructive patterns rooted in these constructs can only be transcended through the experience of a new relational model that offers fundamental safety and helps uncover the original source of pain that the construct was designed to defend against.

The therapeutic relationship serves as a space where previously established defense mechanisms – shaped by early relational interactions and embedded in implicit experience – are reactivated. These internalized patterns often manifest in adult relationships through resistance and defensive behaviors. Through the therapist's empathic stance and attunement to the client's inner experience, a growing awareness of failed attempts at connection is facilitated. Over time, this fosters a sense of safety and stability within the therapeutic context. As a result, the client becomes increasingly able to recall and integrate childhood experiences with present emotional states (Erskine, 1998).

To achieve mutual responsibility in the therapeutic relationship, it is often necessary to overcome psychological constructs such as guilt and powerlessness – constructs that prevent the client from experiencing a sense of agency and control. The affective psychological construct functions as a defense mechanism for managing painful emotions, thoughts, or situations. These constructs are shaped by life experiences and activated by

internal or external stressors. From a developmental perspective, defensive functioning occurs across a continuum, from immature to mature defense mechanisms (Perry & Cooper, 1989). While immature defenses protect the person from distress or inner conflict, they are typically less adaptive, operate unconsciously, and often lead to maladaptive emotional and behavioral outcomes. These defenses tend to be rigid, limiting flexibility and decision-making capacity (Ambresin et al., 2007). In contrast, mature defenses are more adaptive, are typically employed consciously, and can lead to more positive outcomes. Although defense mechanisms originally serve an adaptive purpose, they may lose their protective function over time and become dysfunctional, distorting current perception and emotional experience (Barua et al., 2016). The individual may then experience threat where none exists or fail to respond appropriately to real danger. Immature defenses can persist even in situations where their protective role is no longer relevant. In the therapeutic process, these defenses often manifest as feelings of guilt and helplessness, preventing the client from achieving or maintaining desired change. Moreover, due to the process of compulsive repetition, experiences of guilt and helplessness frequently re-emerge within the therapeutic relationship. The therapist, by directing the process toward change, may inadvertently trigger immature defense mechanisms. The client may feel guilty for not meeting the therapist's expectations or helpless in their perceived inability to change despite the therapist's support. The therapeutic relationship, however, depends on the therapist's continued presence and empathy – especially when the client fails to achieve the desired change. When guilt and helplessness do not result in relational rupture, the client slowly learns that defensive behavior is no longer necessary within a safe relationship. At that point, a new space emerges in which the individual can begin to respond to internal and external stressors with greater flexibility and adaptability.

3.6 Transference in the Therapeutic Relationship

Transference refers to the transfer of emotionally significant experiences and content from an individual's most vulnerable developmental periods into present-day relationships with significant others (McCluskey & O'Toole, 2020; Praper, 2013). However, in contemporary psychotherapeutic practice, transference is no longer viewed merely as a repetition of the past or a distorted perception of current relationships. Rather, it is understood as a significant dimension of the interpersonal space between the therapist and the client (Lemma, 2003), being deeply embedded in the therapeutic relationship and difficult to separate from other relational dynamics (Praper, 2013).

Based on the nature of the projected object representations, transference can be categorized as either positive or negative (Lemma, 2003). Positive transference involves feelings of connection, trust, and safety within the therapeutic relationship, and is often a result of the therapist's empathic responsiveness. However, if the client does not consciously associate these feelings with the therapist's actual behavior, such emotions may serve as a defense against deeper, more painful feelings of anxiety, fear, and vulnerability. In such cases, the client's idealization of the therapist functions to avoid feelings of rejection and maintains the client in a position of a powerless child. Conversely, when an empathic and mutual relationship is genuinely established, the client experiences positive transference as a realistic perception of the therapeutic bond. The resulting feelings of safety and connection can then support more self-aware and confident functioning. Negative transference, on the other hand, manifests in the therapeutic relationship as feelings of rejection, resistance, hostility, and mistrust – emotions the client can often express only within the safety of a secure therapeutic alliance. Frequently, especially in the early stages of therapy, such negative feelings remain unconscious and/or unspoken. While positive transference forms the foundation for developing an empathic therapeutic

relationship, working through negative transference is essential for facilitating core change in the client's implicit experience. The expression of negative transference – such as criticism directed at the therapist – can be understood as a sign of a secure therapeutic environment and presents an opportunity for the therapist's professional growth (Rober, 2021). When interpreted skillfully, at the appropriate time and within a structured therapeutic context, negative transference allows for the transformation of the client's implicit relational perceptions. This process enables the client to experience themselves, others, and relationships in a new way, facilitating psychological reorganization. However, when interpreting negative transference, the therapist should consider the client's capacity for social engagement. For example, in individuals with borderline or psychotic personality organization, there may be relational difficulties that are not rooted in early attachment experiences and thus cannot be classified as transference in the traditional sense (Praper, 2013). In these cases, feelings of rejection, resistance, hostility, and mistrust may not stem from unresolved past dynamics but instead reflect an actual impairment in the client's ability to form and maintain interpersonal relationships.

Projective identification unfolds in three phases (Scharff, 2004):

- The sender seeks to rid themselves of unwanted aspects of the self by projecting them onto another person.
- The sender then exerts pressure on or unconsciously manipulates the recipient to accept and embody these projected feelings.
- The recipient, particularly if vulnerable, identifies with the projection and begins to feel and act in accordance with it.

Within the relational paradigm, transference represents the first step in projective-introjective identification (Gostečnik, 2017). This mechanism primarily serves as a defense against unwanted or unmanageable emotions, a means of feeling understood due to the recipient's emotional receptivity (valence), and a way to feel accepted (Poljak Lukek, 2017). In both therapeutic and intimate relationships, awareness of this mechanism – particularly

the processes of splitting and valence – can lead to resolution and healing. Understanding the transferential content activated in the client in relation to the therapist enables interpretation of previously unconscious psychological material. The client's transferential emotions are not necessarily a product of distorted perception, but rather an effort to resolve painful emotional states. Thus, transference is not merely a misperception of the present; it is a therapeutic process in which painful emotional states are split off and externalized into the therapeutic relationship as a form of defense against psychological pain (Lemma, 2003). Due to the therapist's emotional valence and capacity for psychological containment, they are able to receive these projected contents, process them – often through an awareness of countertransference reactions – and return them to the client in an interpreted form. This process facilitates emotional resolution and reintegration for the client.

Transference in the Therapeutic Process (with Monica)

Monica was never able to fully trust her therapist. Although she felt grateful for the therapy, she never truly expected that it could help her. In the therapist's presence, she often felt deeply helpless, and she found it easiest to retreat into her own inner world and respond to questions only briefly.

At one point in the therapeutic process, she even announced that she was ending therapy because she felt it was not beneficial. The therapist used this moment to help regulate Monica's fear, and as a result, Monica decided to continue.

Due to the loneliness she experienced in childhood and a profound relational fear of being abandoned, she did not form an emotional attachment to the therapist, even though she made progress in the therapeutic process. The recurring feeling of fear that was frequently activated within her continuously prevented her from developing deeper trust.

Attending to the client's emotional experience during the therapeutic process is essential for building an effective working alliance and fostering an empathic relationship. While the therapist may not recognize all transferential content that emerges during therapy, empathic responsiveness to the client's experience can significantly shape the therapeutic relationship and therapeutic progress (Praper, 2013). The therapist should interpret transference in a way that strengthens the therapeutic relationship. If mishandled, transference interpretation can evoke excessive discomfort in the client and even lead to premature termination of therapy. Transference interpretation is unlikely to contribute to a solid working alliance in the following cases: (1) When it overemphasizes the importance of the therapist–client relationship; (2) When it leads the client to feel overly exposed and vulnerable in the therapeutic relationship; (3) When it shifts the focus away from the client's actual issues and concerns; or (4) When working with transference is ineffective or even harmful in cases of severe mental disorders (Lemma, 2003).

3.7 Countertransference in the Therapeutic Relationship

Traditionally, countertransference was defined as the therapist's unconscious reaction to the client's transference material. Over time, however, this concept evolved to encompass countertransference as one of the most powerful therapeutic tools. Through their intrapsychic experience and awareness of their emotional responses to the client's transference, therapists can gain deeper insight into the client's psychological world (Lemma, 2003; Maroda, 2004). Interpretation in therapy is thus a hypothesis shaped by the therapist and inevitably includes a dimension of subjective perception (Praper, 2013). In the relational paradigm, two forms of countertransference – concordant and complementary – are recognized within the process of projective-introjective identification (Gostečnik, 2015). *The concordant process of projective-introjective identification* refers

to the therapist's countertransferential experience that reflects the client's experience of their own self. *The complementary process* represents the therapist's countertransferential feeling that corresponds to the affect linked to a significant other in the client's life. With appropriate interpretation of both transferential and countertransferential dynamics, it is possible to create new relational experiences for the client – experiences that can gradually generalize to relationships outside of therapy. The therapeutic relationship plays a crucial role in this process. The therapist's ability to attune to the client's experience creates a shared psychological space that allows for a deeper understanding of the client's emotional distress. Through their own emotional experience, the therapist establishes a unique relational dynamic with the client – one that is not based on authority but on a willingness to respond genuinely and emotionally to the content of the therapeutic relationship (Maroda, 2004).

Steps in Formulating a Countertransference Interpretation (Lemma, 2003)

Identification of the theme: Countertransference reflects recurring experiences of the client. In formulating an interpretation, it is therefore essential for the therapist to be aware of the client's core themes that repeatedly emerge throughout the therapeutic process.

1. Identification of the Trigger: Internalized representations of significant others are activated by internal or external triggers. These may include events outside therapy or occurrences within the therapeutic process. The trigger evokes familiar emotions that, due to their intensity or unmanageability, are projected into the therapeutic relationship. The therapist, through the experience of countertransference, is offered the opportunity to help the client develop a new emotional experience.

2. Identification of Countertransference: The therapist consciously registers the client's projected emotional experience or affect as it emerges in their own body and emotional state. Since these feelings are also part of the therapist's inner world, the therapist is able to attune to them, attribute

meaning to them, and seek the missing emotional elements that will make the experience manageable – first for the therapist and subsequently for the client.

3. Identification of the Client's Experience of Self: The first aspect of transference involves how the client experiences themselves. The therapist connects this self-perception to the client's previous and current intimate relationships, identifying how the client views and positions themselves within relational dynamics.

4. Identification of the Client's Experience of Others: The second aspect of transference involves the client's perception of others. Based on internalized representations, individuals unconsciously elicit familiar patterns of response from those around them. The therapist seeks to identify these patterns and their origins in past relational experiences.

5. Identification of Affect: Emotional experience is organized around affect. Identifying the core affective state is crucial to giving the experience meaning and enabling its transformation through therapeutic work.

6. Formulation of the Interpretation: The interpretation should be offered within the context of a safe therapeutic relationship and at the appropriate time – when the client is ready to receive, process, and integrate it. The therapist conveys the insights from the previous steps in a comprehensible and non-intrusive manner that facilitates emotional understanding and growth.

According to Praper (2013), interpretations in therapy can be classified based on their depth. Surface-level interpretations refer to insights related to current social interactions. These are generally less threatening to the client and more readily accepted. Deep-level interpretations, on the other hand, involve repressed conflicts and their manifestations in the present. These interpretations require greater care in delivery, as they should be received on both a cognitive and emotional level to be effective. Deep interpretation should occur in parallel with affect regulation. Both therapist and client should be able to tolerate the vulnerability that arises when uncovering

conflictual content. Through empathic internalization, the therapist processes and returns the affect in a safe and manageable form, allowing the client to integrate the new regulatory experience into their intrapsychic world.

Countertransference in the therapeutic process (with Monica)

The therapist often felt powerless in her work with Monica. She experienced deep anxiety as she persistently attempted to establish a therapeutic relationship. This anxiety was intensified by Monica's ongoing avoidance and devaluation of the relationship, particularly evident when Monica expressed a desire to terminate therapy. The therapist experienced her frustration as a sense of despair, which can be understood as a complementary countertransference – reflecting the desperation of a parent who is unable to connect with their child. At other times, she felt a deep sadness, a concordant countertransference reaction, mirroring Monica's own sorrow rooted in profound loneliness and a fundamental sense of relational loss.

The interpretation of countertransference in therapy enables the development of a sense of mutuality, which is crucial for affirming the personal emotional experience of the client. Through the therapist's emotional responsiveness, the client receives validation and gains a deeper understanding of their emotional world. A shared regression into painful feelings (e.g., shame, defeat, anger, rejection, abandonment), made possible by the therapist's capacity for authentic and conscious emotional responsiveness, is essential for establishing an empathic and collaborative therapeutic relationship (Maroda, 2004). However, it is not enough for the therapist to be capable of such regression – it should be experienced by the client as mutual, rather than as overexposure of the therapist's own emotional states. When mutuality is achieved, the client can entrust the therapist with the regulation of painful emotions. If, on the other hand, the client perceives the therapist as overly vulnerable, they may unconsciously take on the role

of emotional regulator, resorting to old emotional regulation strategies (e.g., taking on guilt, freezing, feeling helpless) in order to preserve the relationship. In the former case, the therapeutic relationship creates space for new relational experiences; in the latter, it leads to a repetition of familiar and maladaptive relational patterns. By co-creating a mutual interpersonal space, the therapist enables the introduction of new meaning into the client's repetitive emotional experience (Stern et al., 2010).

Typical Countertransference Responses in Therapists (Praper, 2013):

Hysterically structured therapists tend to respond quickly and excessively with positive countertransference; they are easily discouraged by difficulties and may lose interest in the long-term therapeutic process.

- *Obsessively structured therapists* tend to react with pressure and control, frequently repeating the therapeutic contract and maintaining an exaggerated »professional« distance.
- *Depressively structured therapists* strongly identify with the client, tend to overcare, inhibit the client's development of autonomy, and take on excessive responsibility.
- *Schizoid therapists* lean toward a scientific stance, make quick interpretations of transference, and rely heavily on intellectual explanations.
- *Narcissistic therapists* easily feel devalued and may manipulate the client to elicit idealization.
- *Borderline-dependent therapists* tend toward an endless therapeutic process without clear boundaries.

These countertransference reactions reflect the therapist's own unresolved infantile needs and are shaped by the nature of the client's transferential experience.

4

Change-Oriented Interventions

In the context of research into therapeutic interventions and the development of the *Therapy Affect Regulation Coding System* (TAR; Poljak Lukek, 2021a; Poljak Lukek & Valenta, 2021, 2022), a three-level model of therapeutic interventions was developed. Although the reliability of the coding system is still being researched, the current model provides a conceptual framework for describing basic therapeutic interventions within family therapy. The three-level model emerged from a content analysis of several research studies – primarily doctoral dissertations in the field of Marital and Family therapy at the Faculty of Theology, University of Ljubljana. Based on this analysis, an initial model of therapeutic interventions was created and later refined through the coding of therapy transcripts (Poljak Lukek, 2021a). Four researchers participated in the coding process, and the final model was developed through a consensus among them (Poljak Lukek & Valenta, 2021, 2022).

The foundational basis for the coding system and intervention model lies in Gross's (2008, 2015) model of emotion regulation, which conceptualizes the process in three phases: identification, selection, and modification.

During this process, an individual regulates emerging emotional states through support from an external, emotionally regulated adult (Cummings et al., 2003). Affect regulation in therapy proceeds in two primary directions: (1) downregulation of emotional responses (both positive and negative), and

(2) upregulation of emotional responses (both positive and negative), (Gross, 2015). These dynamics are also observable in therapeutic processes. Affect regulation is understood as a core dynamic of therapeutic interventions in family therapy (Gostečnik, 2017). In the therapeutic process, the therapist assumes the role of an external regulator of affect (Schore, 2012; Stern et al., 2010), responding to either exaggerated or absent emotional responses in clients. An exaggerated emotional response is recognized when the client reacts disproportionately to current relationships (e.g., family dynamics or the therapeutic relationship), especially when the individual feels powerless to influence the emotional atmosphere of the moment – leading to frustration and helplessness (Poljak Lukek, 2011). An absent emotional response, on the other hand, is often detected through the therapist's countertransference. The therapist interprets their own emotional experience as reflecting disassociated affective states in the client (Lemma, 2003; Maroda, 2004), and responds with targeted interventions and countertransference interpretations to activate emotional experiencing. In such cases, the therapeutic relationship becomes a site for the re-enactment of dissociated, denied, or hidden parts of the client's emotional experience (Siegel & Solomon, 2013), offering opportunities to name and revalue aspects of self previously unknown to the client but central to their interpersonal dynamics.

Gross (2015) describes three fundamental steps in affect regulation: (1) identification – deciding (often implicitly) whether to respond to a stimulus; (2) selection – choosing a regulatory strategy, and (3) implementation – applying a suitable emotional regulation strategy. In family therapy, these steps translate into: (1) recognition of affective states in the client and therapeutic relationship; (2) exploration of the origins of specific emotional responses; (3) implementation of new relational responses or implicit relational awareness (Gostečnik, 2017; Poljak Lukek, 2011)

Based on the above theoretical framework and the development of the TAR coding system, we have established three levels of therapeutic intervention (Poljak Lukek & Valenta, 2022):

- Identification
- Affective Awareness
- Implementation

4.1 Identification – Focusing on the Present

In identification interventions within family therapy, the therapist focuses on the present moment and encourages emotional awareness. In the process of emotion regulation, identification is said to occur in three steps: perception, evaluation, and action. During these steps, the individual assesses whether a particular bodily state is significant enough to activate further emotion regulation processes (Gross, 2015). Similarly, in therapy, the clinician gathers information and aims to evoke a bodily response in the client that will support motivation and further engagement in the regulation process. In this phase, the therapist evaluates which emotional responses are exaggerated and should be downregulated through further interventions, and which emotional responses are lacking and should be stimulated. The level of emotional awareness is crucial in the identification process (Gross, 2015). Impaired emotional awareness may result in the client assigning excessive significance to a particular bodily sensation, leading to an exaggerated regulatory response and heightened emotional reactivity, or, conversely, in ignoring important bodily cues, thereby failing to initiate appropriate emotion regulation when needed.

In the identification phase, in addition to initiating the process of emotion regulation, therapy also involves the evaluation phase, during which the therapist must adhere to the previously mentioned principles. When gathering information about the client during this stage, the therapist pays close attention to both the client's emotional and somatic responses.

Types of interventions at the identification level (Poljak Lukek & Valenta, 2022):

- systemic level,
- interpersonal level,
- current affect,
- bodily sensations.

Systemic Interventions

Key interventions at the systemic level include (Poljak Lukek & Valenta, 2022):

Describing the Current Situation

»What's going on?«; »How do you respond when an argument occurs?«; »What have you tried to resolve this issue?«; »Can you describe a typical day?«; »What did your week look like?«

Identifying Stress

»When did you start noticing something was wrong?«; »What worries you the most?«; »Who in the family do you think is most concerned?«; »Whom are you most worried about in the family?«

Naming Behaviors

»What behavior is acceptable/unacceptable to you?«; »You probably don't think that behavior is okay.«; »Hitting a child – that's physical violence.«; »The behavior you're describing indicates addiction.«; »Constant threats and humiliation are emotional abuse.«; »Arguing like this in front of the child is not acceptable.«

The primary aim of systemic identification interventions is to encourage clients to describe and narrate their experiences. This provides crucial information for assessing family dynamics, conducting crisis interventions, defining therapy goals, and planning the therapeutic process. Therapeutic listening at this level includes multi-layered analysis of communication within various contexts – considering both empathic and intervention-

focused dimensions. The goal is not to uncover the factual truth, but rather to discover therapeutically meaningful material in what is said (Praper, 2013). Interventions should move beyond data collection and emphasize joint exploration of meaning and self-understanding (Erskine et al., 1999; Modic & Žvelc, 2021). The therapist's genuine interest in the client's story can provide the essential sense of safety and self-trust needed to generate motivation for change – and the energy to achieve it.

A four-member family engaged in therapeutic treatment. They sought therapy due to the self-harming behavior of the older daughter. The therapy spanned eight months and consisted of two cycles of 12 therapeutic sessions, with a one-month break in between. The individuals involved in the therapeutic process included Gloria (G), a 15-year-old daughter; Matthew (M), a 43-year-old father; and Jane (J), a 41-year-old mother. The 11-year-old son did not participate in the therapy. The sessions were conducted by a relational family therapist with 15 years of clinical experience working with families, couples, and individuals. The assessment of family dynamics and clinical history did not indicate any apparent symptoms of mental disorders among the family members, nor did the family report significant relational difficulties. The clients demonstrated motivation to engage in the therapeutic process, with the primary goal of reducing the daughter's symptomatic behavior.[9]

T (Therapist): Good day. Welcome to our institute. You contacted us requesting a conversation. **Could you describe what brought you here today?** [10]

DESCRIBING THE CURRENT SITUATION

9 The presented therapeutic case is based on real clinical experiences. However, certain details have been modified, fictionalized, added, or omitted to ensure the anonymity and confidentiality of the individuals involved.

10 In the transcript, only interventions from the system level are in bold.Other therapeutic interventions belong to other sets of interventions (you can try to determine their code yourself).

J (Mother): I'm the one who called because we need help. Honestly, I don't even know where to begin. We're here because of Gloria. My husband and I are very worried about what's been going on. Would you like to explain what's happening, Gloria?

G (Gloria): You go ahead.

J: Gloria is in the ninth grade of elementary school. The other day, I accidentally walked into the bathroom and found her holding scissors. I noticed cuts on her legs and I was completely shocked. I had no idea this was happening. I told my husband right away, and he was very upset.

M (Father): I wasn't upset like that. I just can't believe this is really happening.

G: *(Stares at the floor expressionless.)*

T: I understand this should have been a shock. I imagine you're feeling very afraid right now. But we're here to find a way forward. What's most important is for Gloria to feel safe, understood, and supported. Gloria, I can imagine it's very hard to talk about this. I want to assure you that we have plenty of time, and that it's important for you to feel safe enough to talk about what's happening and how you feel. Would you like to say something now?

G: *(Shakes her head.)*

T: Is it okay if I continue speaking with your parents for a little while?

G: *(Nods.)*

T: **Could you tell me more about what led up to this? Was this the first time you noticed something concerning with Gloria?**

IDENTIFYING STRESSORS

J: Gloria and I talk a lot. I believe she can share quite a bit with me. She often tells me about problems she's having with her classmates.

M: I always tell her not to worry about those girls. One day they act one way, the next it's different, and they always find someone to pick on.

T: **Gloria, could you tell me more about your classmates and friends? Do you have a best friend?**

DESCRIBING THE CURRENT SITUATION

G: I used to. Monica moved away last year, so we're not in the same class anymore, but we still talk on the phone. The other girls in my class are weird. I don't care. I talk to someone at school, but that's about it. Sometimes we go biking together, but most of the time they don't even invite me. Or I go with them, but it's just boring.

T: **Do you often feel bored at school?**

G: Not really, we don't even have long breaks. We move to another classroom. During lunch, we sit together and talk.

T: You probably miss Monica a bit, right? I imagine she was someone you could always talk to.

G: Yeah, that's true.

T: **How is school going for you academically?**

DESCRIBING THE CURRENT SITUATION

G: It's going fine. It's hard though – there are a lot of grades, and this year we also have national exams.

T: **And you're also applying to high school, right?**

DESCRIBING THE CURRENT SITUATION

G: Yeah, I'm not sure where I want to apply.

T: When you think about it, does it make you anxious? I imagine it's tough with all the studying, pressure, and decision-making.

G: I don't know.

T: Sometimes a strange, unpleasant feeling just settles in the body. Like a tightening in your stomach. **What's it like for you when you get home from school?**

G: I have to study. Then there are extracurriculars, and that's it.

T: **Do you ever feel bored?**

G: Sometimes I don't feel like doing anything. I don't know. It all just feels kind of pointless.

T: **You mentioned you stay in touch with your best friend over the phone. Do you use your phone for anything else? Do you keep it with you all the time?**

G: Yes.

M: That's a constant issue. We're always negotiating screen time, and she never sticks to the agreement. It always leads to arguments.

T: Gloria, I'm sure you've talked about phones at school too, and you probably know why it's not good to use it excessively, and what content might be inappropriate for someone your age.

G: Yeah, but everyone does it. Others get to do even more on their phones.

T: I understand your phone is very important to you, but there are things that can be harmful. I'm sure you understand that, right? And some of the things happening with you might also be harmful. We're going to try to find ways to help you feel better. **We talked about what you do when you're feeling overwhelmed – that sometimes you use something sharp in the bathroom to hurt yourself. Do you know why you do that?**

IDENTIFYING STRESSORS

G: It's nothing. It's not a big deal. You can't even really see it.

T: I understand that it might feel that way. But it's important for your parents to understand what's happening so they can help you. I think you can agree that you don't need to hurt yourself – there are other ways to calm down. **Since your mom walked in on you, have you hurt yourself again?**

G: No.

T: **The behavior we're describing is very dangerous. Self-harm can escalate, and it gets harder and harder to stop. That's why it's so important that we find ways to address it right now, okay?**

NAMING THE BEHAVIOR

G: *(Nods.)*

T: Can we agree to keep it that way until next week when we meet again? Your parents will remove all sharp objects from the bathroom, and you'll just take your clothes in with you. Do you think that's manageable?
G: I'm not going to do it anymore.
T: I believe you mean that. And we – the adults – will help you make sure that's really the case.

Interpersonal Interventions

Key interventions at the interpersonal level of identification include the following (Poljak Lukek & Valenta, 2022):

Addressing the reasons for emotional experience

»How do you feel in this relationship?«; »What do you think is the reason you feel this way?«; »Could what you're describing be the reason you tend to withdraw repeatedly?«; »How do you explain this constant tension in the relationship?«

Describing the relationship or partner

»What was your relationship like when you first met?«; »How did you see your partner back then?«; »How do you perceive your relationship now?«

At the interpersonal level of identification, the therapist focuses on the couple subsystem within the family. When children are involved in the therapy session, the therapist should maintain appropriate boundaries within the family system. This means asking only those questions in front of the children that do not prompt answers of an intimate nature, especially those that the child may not be developmentally prepared to understand. If questions regarding the couple's relationship increase distress or discomfort among family members, attention should be redirected to the systemic level. If possible, the children may be temporarily excused from the session. Understanding the dynamics of all subsystems within the family is essential

to grasp the symptomatic behaviors of an individual family member. Parents under stress are less responsive to their child's needs. When the marital relationship serves as a source of support for the parents, this sense of security and compassion can also be extended to the child. Conversely, if the marital relationship is a source of stress, unresolved emotional issues may be unconsciously transferred into the child subsystem. A critical factor in the interplay between parental and marital roles is the sense of emotional security within the family (Cummings & Davies, 2010). Emotional security in the marital relationship fosters emotional security in the parent-child relationship. A lack of emotional security also impacts the child's adaptation within the family. Parents who are unable to recognize stress in their marital relationship may experience helplessness and stress in their relationship with their child. A clinical example of addressing the interpersonal level is presented below (following body-sensation-based interventions).

Addressing Current Affect

Key interventions for addressing current affect at the level of identification include the following (Poljak Lukek & Valenta, 2022):

Naming the affect in the current relationship

»This is sadness/fear/anger/shame/disgust.«; »How do you understand this sadness/fear/anger/shame/disgust?«; »You are feeling sad/ afraid/ angry/ ashamed/ disgusted because this is happening.«

Describing/amplifying affect

»When there's been so much disappointment that you just can't go on anymore.« (describing sadness); »When everything has been taken from you and it feels completely unfair.« (describing anger); »When you don't know what will happen next and everything feels uncertain.« (describing fear); »When you just want to run away and hide.« (describing shame); »When it makes you feel sick to your stomach and you can't stand it anymore.« (describing disgust)

Exploring the experience

»What does this mean for you?«; »What is it like for you to feel sad/ afraid/ angry/ ashamed/ disgusted?«; »What does it mean to you when [X] is sad/ afraid/ angry/ ashamed/ disgusted?«

When the therapist assesses that Gloria feels safe enough, she suggests spending part of the session in individual conversation with her. With the parents' and Gloria's agreement, they proceed with that portion of the session alone.

T: **How do you feel when you have to talk about yourself with an adult?**

EXPLORING THE EXPERIENCE

Gloria: I don't know.

T: If at any point you feel it would be easier if your parents were here, just say so and we'll call them back in. Okay?

G: It's okay like this.

T: **Earlier, when you were talking about your friend, there was a sense of deep sadness. Do you sometimes feel sad too?**

NAMING THE AFFECT IN THE CURRENT RELATIONSHIP

G: I do. Often. And I don't even know why.

T: **Is it a feeling where your whole body feels heavy, and you just can't do anything?**

DESCRIBING/AMPLIFYING AFFECT

G: Yes. I just want to stay in bed and I don't feel like doing anything. And there's really nothing wrong. But I'm still sad, for no reason.

T: I don't believe it's entirely without a reason. But sometimes we do feel things that we can't quite explain, and we don't know why we feel that way. When the feelings are unpleasant, we naturally want them to go away quickly. **Can you describe how you experience sadness?**

DESCRIBING/AMPLIFYING AFFECT

G: What do you mean?

T: We feel emotions in our bodies in different ways. For example, when we're angry, our whole body tenses and our muscles feel tight. When we're afraid, we freeze and our muscles go limp. When we're sad, we might feel it in our head, we may want to cry, or feel tension in our stomach**. How would you describe what happens in your body when you feel sad?**

DESCRIBING/ AMPLIFYING AFFECT

G: I think my brain just stops working. I can't focus, I can't study or concentrate, and I feel completely exhausted...

T: Can you remember a specific day when you felt like that?

G: Yes.

T: That was probably a really tough moment, and you didn't know how to get rid of that feeling. **Do you remember what you did?**

EXPLORING EXPERIENCE

G: (Looks down.)

T: Was that when you took the scissors and went to the bathroom?

G: *(Nods.)*

T: That was the only way you could interrupt that unpleasant feeling at the time. And maybe even now, as we're talking about it, you feel a little of it again. **Do you feel that same sense in your body – like you can't think, like you're getting tired?**

DESCRIBING/AMPLIFYING AFFECT

G: Yes.

T: It's okay, Gloria. **It's just a feeling. It's the sadness that was stirred up by our conversation.**

NAMING THE AFFECT IN THE CURRENT RELATIONSHIP

And just like we brought it up together, we can also calm it down together. Would you be willing to try something to work with that feeling – this sadness?

G: *(Nods.)*

T: Do you like soap bubbles?

G: Yes. *(Establishes eye contact with the therapist.)*

T: What color is this feeling – this sadness?

G: Gray.

T: Okay. Then let's blow a big soap bubble together. (*Therapist mimics blowing.*) Can you imagine how big we made it? The biggest one you've ever seen. Can you see it in your mind?

G: Yes.

T: And inside it is all the gray color that was part of your feeling. We've trapped it in the bubble. Now it's going to float up high into the sky, higher and higher, until we can't see it anymore. Way up there, the bubble will pop – and all the gray will disappear into the sky. It will be gone. (*Pause*)

T: How do you feel?

G: (*Smiles.*) I really do like soap bubbles.

Core affects are primary emotions such as anger, fear, shame, disgust, sadness, and joy, which form the emotional atmosphere within a family. Affect is co-constructed between individuals and contributes to the development of psychic structures and modes of experiencing. Family relationships create affective spaces between members, together forming the family's core affect (Gostečnik, 2022). This family affect profoundly shapes all members, influencing both self-perception and external relational patterns. Affect is present in every relationship, and our ways of experiencing ourselves and others within these emotional states are developed through significant relational experiences. Emotional awareness is a cornerstone of psychological balance. Increasing awareness and helping clients name their emotional responses – or affect – is therefore a key intervention in family therapy. The therapist's task is not to uncover objective truth but rather to explore perception, structure, and constructs that the client has internalized over time (Praper, 2013).

Addressing Bodily Sensations

Key interventions for addressing bodily sensations at the level of identification (Poljak Lukek and Valenta, 2022):

Awareness of Bodily Sensations

»What do you feel in your body when we talk about this?«; »If you are paying attention to the pain in your chest, does it get stronger or change during our conversation?«; »Where in your body do you first feel this feeling?«; »Can you describe your breathing?«

Addressing Countertransference

»It feels like a lot of tension.«; »It feels like you can't breathe anymore.«; »And then a pressure settles in your stomach and you feel like you can't do anything right.«

Emotional awareness is not only related to the ability to name and distinguish affects, but also to the awareness and recognition of bodily sensations, which serve as the foundation of all emotional experiences. Our awareness is not limited to the brain; it is closely tied to the recognition of sensations throughout the entire body (Siegel & Solomon, 2013). In therapeutic interpretation, what lies beneath the verbal content and beyond the literal or digital meaning is of critical importance. Therefore, the therapist does not investigate the factual accuracy of what is said, but rather attends to the meaning and manner of the client's narrative (Praper, 2013). Through interventions focused on bodily sensations, the therapist shifts the client's awareness from a purely cognitive level to an embodied experience.

Experiences are encoded not only in explicit (declarative and episodic) memory but also in implicit (emotional and procedural) memory (Levine, 2015). In the therapeutic process, essential information is often embedded in how the client reacts to the therapeutic interaction. Since the therapist addresses sensitive and vulnerable material, psychological mechanisms originating from emotional memory are activated in the client. Based on prior experiences, the procedural memory elicits familiar strategies for regulating

bodily tension. This activation produces various bodily sensations, which may be experienced by the client as transference feelings, or by the therapist as countertransference sensations. Procedural memory may activate what is referred to as the »emergency response,« which supports survival in the presence of perceived danger and initiates responses of approach or avoidance, attraction or aversion – instinctive mechanisms that guide decision-making (Levine, 2015). By raising awareness of bodily sensations, the therapist gains insight into the functioning of the client's implicit memory. Through observing the client's responses, the therapist assesses how procedural memory is activated, what automatic bodily responses to perceived threat emerge, and what strategies of approach or avoidance are employed.

In this part of the therapeutic session, only Jane and Matthew were present. In order to gain a deeper understanding of the family system's dynamics, the therapist invited only the parents to the third session. The therapist directed interventions toward the interpersonal level, focusing on the present affect and bodily sensations (identification).

T: **Your daughter is in significant distress. How are you experiencing this?**

ADRESSING THE REASONS FOR EMOTIONAL EXPERIENCE

J (Jane): This is very difficult for me. I honestly don't know how this could have happened to us. I thought things were going fairly well, and then this. Well, we had some disruptions in the past too, but we somehow managed to move forward.

M (Matthew): I don't understand why she's doing this. How could she do this to us? Kids these days don't even know what to do with themselves. We used to go out and get into trouble. Now they just stay at home and then...

T: **How do the two of you talk about the issues your family is facing?**

DESCRIBING THE RELATIONSHIP

J: That's a whole story in itself. Often, I lose it, he says I'm overreacting, and he leaves. I'm always the one who wants to get to the bottom of things,

talk, and find a solution. He tends to wait it out, and sometimes I feel like he believes things will just fix themselves. In this case too – with Gloria – he thinks it'll sort itself out overnight. That one conversation will be enough and everything will be fine. I don't feel supported by him.

M: I just want to find a quick solution. I don't think it's that complicated. Gloria will stop doing it, we'll supervise her more strictly, and that's that.

J: No, it's not just that. Don't you understand she's cutting herself for a reason?

M: Yeah, because she heard about it somewhere and decided to try it. And now she'll stop.

T: **Matthew, how much helplessness do you feel in these situations – when someone you love is going through something and you can't understand why?**

EXPLORING THE EXPERIENCE

M: I really don't understand why someone would do that on purpose – why someone would cut themselves intentionally.

T: **And how does that lack of understanding affect you? How do you feel when something can't be understood?**

M: I don't know.

T: **How do you feel right now – when I'm asking you for an answer you don't have?**

M: I don't know. I really don't know what to say. I'd rather just be quiet.

T: **It's like something tightens in your throat and you can't speak anymore.**

ADDRESSING COUNTERTRANSFERENCE

M: Yes.

T: **Just like every time your wife expects something from you and you don't know what she wants.**

DESCRIBING/AMPLIFYING AFFECT

M: It's not that I don't know what she wants. I feel like whatever I do, it won't be good enough. So it's better if I just let her do it her way.

T: **When everything feels so uncertain and you don't know what will happen.**

M: Yes.

T: **There's a feeling of fear – there's uncertainty, you recognize the danger, and you're unsure whether you've done everything you can to prevent something terrible from happening. What does it mean for you to hear that what you're feeling is, in fact, fear?**

NAMING THE AFFECT IN THE CURRENT RELATIONSHIP

M: That doesn't help me at all. I don't want to be afraid. I want things to be resolved and for us to go back to how things were. I don't like this.

T: You feel like you can't win. there's a tightness in your body...

AWARENESS OF BODILY SENSATIONS

M: It's all too much.

T: **Jane, you know that feeling well – when everything is just too much.**

EXPLORING THE EXPERIENCE

J: Yes!

T: **What happens in your body when everything becomes too much?**

AWARENESS OF BODILY SENSATIONS

J: I feel like my stomach is going to explode.

T: **Like a weight just settles in your stomach and won't go away.**

AWARENESS OF BODILY SENSATIONS

J: Yes. I go through periods where I have major stomach problems. It got better for a while, but now it's all happening again.

T: **Your body is experiencing helplessness again.**

AWARENESS OF BODILY SENSATIONS

J: Probably.

T: **Just like every time you feel misunderstood, when you feel like you have to do everything alone, when it's all too much.**

DESCRIBING/AMPLIFYING AFFECT

J: Sometimes I really feel like we live in different worlds. I keep trying to explain things to him, but it's always the same. He withdraws, and I have to fix whatever needs fixing. Even when he does something wrong, I still

feel like I'm the one who has to do something to make sure it doesn't happen again. And now, with Gloria – I keep thinking about what *I* need to fix so this doesn't happen again.

T: **And then a tension settles into your body.**

AWARENESS OF BODILY SENSATIONS

J: Yes, sometimes I really feel like I can't take it anymore.

T: **And it's deeply sad – realizing that you're basically alone and have to handle everything by yourself.**

NAMING THE AFFECT IN THE CURRENT RELATIONSHIP

J: (*quietly begins to cry*)

T: **What do those tears mean to you?**

EXPLORING THE EXPERIENCE

J: Defeat.

4.2 Affective Awareness – Focusing on the Past

In interventions that foster a therapy client's affective awareness, therapeutic questions are primarily oriented toward the past. At this stage in therapy, we aim to identify all existing modes of affect regulation and to support the development of affective awareness – specifically, implicit relational awareness (Stern et al., 2010). This work is grounded in the assumption that an affective state expressed in the current therapeutic relationship often exceeds the immediate moment. Within this relationship and in present-day distress, the client relives painful affective states for which they lack effective self-regulation strategies. As a result, they resort to affective constructs (Gostečnik, 2022) or defense mechanisms (Perry & Cooper, 1989). Heightened affective reactivity thus obstructs the individual's ability to regulate internal emotional experiences effectively in the here and now.

Exploring the origin and meaning of such emotional experiences is the central goal of interventions at this level. Through this process, the therapist

seeks to create conditions that enable the client to engage in more functional emotional response selection. The selection phase in emotion regulation refers to the individual's capacity to choose among available regulatory strategies – based on their perception of internal and external stimuli – that are most likely to lead to desirable emotional outcomes or to avoid undesired ones (Gross, 2015). This selection process also includes the behavioral dimension of emotional experience, in which the individual repeatedly engages in behaviors that are most likely to produce a desired emotional outcome. The choice of emotional regulation strategies is made through an implicit evaluation of available options, ultimately leading the individual to select what feels safest or most predictable (Gross, 2015).

This exploration of affective awareness also encompasses past experiences. In family therapy, there is an increasing emphasis on the holistic understanding of an individual's experience – an understanding that cannot be achieved without deeper insight into prior relational contexts. The family therapist does not approach the past analytically but rather explores it through affective dynamics as they emerge in current relationships, seeking meaning in earlier life experiences. Present relationships are thus understood as a reflection of systemic, interpersonal, and intrapsychic repetitions of perceptions and experiences – often manifesting as compulsive reenactments of specific interaction patterns and dissociated affects (Gostečnik, 2022). These reenactments function as a compulsion to repeat unresolved emotional content, reinforcing affect regulation patterns in adult relationships due to the persistent inability to achieve resolution. Simultaneously, such patterns help maintain the systemic balance within the family and preserve a sense of belonging. At this level, the therapist aims to uncover the reasons behind a client's behavior, thought patterns, emotional responses, or bodily experiences. This is done by working from the affective state as it arises in current relationships and tracing its origins and significance across the client's key intimate relationships.

Therapeutic interventions at the level of affective awareness focus on (Poljak Lukek & Valenta, 2022):

- core affect,
- defenses,
- meaning (of repetition) in present relationships,
- meaning at the intrapsychic level,
- transferences and relational patterns.

Interpreting Core Affect

Key interventions in identifying and deepening core affect at the level of affective awareness include (Poljak Lukek & Valenta, 2022):

Identifying Core Affect:

»There is a great deal of sadness/ fear/ anger/ disgust/ shame in all of these stories.«; »The feeling of sadness/ fear/ anger/ disgust/ shame keeps recurring, and it seems impossible to fully understand or soothe it.«; »Each time we begin to talk about your family, the feeling of sadness/ fear/ anger/ disgust/ shame resurfaces.«

Deepening Core Affect:

»The feeling of tightness in your stomach and the sadness seem to always be present.« »Time and again, you've hit a massive wall and felt as if something that rightfully belonged to you was taken away« (addressing anger). »You could never be fully at ease – there was always a need to be on guard, to prevent the people around you from bringing shame.«

When it becomes impossible to regulate the present affect in the therapeutic relationship – resulting in what is termed an exaggerated affective reaction (Poljak Lukek, 2011) – the therapist engages second-level interventions to explore the core affect. Core affect is conceptualized as the affective space between two individuals, which is continuously recreated based on one's intrapsychic experiences (Gostečnik, 2015). This core affect is shaped within relational dynamics, marks the individual's psychological structure and modes of experiencing, and is perpetually reenacted in new

interpersonal contexts according to that specific structure. The affective interpersonal space experienced during moments of greatest vulnerability in early life will later be actively recreated by the individual in moments of adult vulnerability. Vulnerability thus activates the deepest affects, which lie beyond conscious control, as they reside in implicit awareness and are inaccessible through cognitive processing. If this familiar affect is associated with painful experiences – whether suppressed or excessively expressed and dysregulated within the family context – the individual will, due to an internal drive for resolution, repeatedly seek out and recreate this known affect in adult relationships. The therapist's task is to respond to excessive affect by identifying and deepening the core affect, thereby creating the conditions for reinterpreting current bodily and emotional experiences. In later phases of therapy, these insights can be given new meaning, facilitating more adaptive emotional regulation.

Interpretation of Defenses

Key interventions in exploring defenses at the level of affective awareness (Poljak Lukek & Valenta, 2022):

Exploring Affective Psychic Constructs

»When we start talking about anger, it repeatedly becomes very difficult. Do you feel guilty for experiencing it this way?«; »All that remains now is a profound sense of helplessness.«; »It's much easier to convince yourself that you're worthless than to risk trusting again.«

Exploring Dysfunctional Behavioral Patterns

»The feeling of sadness is easiest to drown in alcohol.«; »When all those feelings of anger and disappointment arise, do you feel like you have no choice but to hit, scream, throw things around the room?«; »And time and again, it seems to be confirmed that food is the only way you can momentarily shift your focus – and that brings some relief.«

By identifying defenses and affective psychological constructs, the therapist seeks to uncover the underlying causes of previously successful attempts at affect regulation. Through the exploration of affective psychological constructs, the therapist addresses emotions (most commonly feelings of helplessness, guilt, despair, etc.) and thoughts (typically involving perceptions of worthlessness or narcissistic cognitions) that the individual resorts to following failed attempts at affect regulation. Affective psychological constructs consist of emotional and cognitive patterns that serve to protect the individual from the painful confrontation with feelings of rejection, neglect, or abandonment (Gostečnik, 2015). These constructs reflect a strong attachment to past experiences, as their preservation in subsequent relationships perpetuates unresolved psychological content. The deeper the early developmental wounds, the more rigid the affective constructs should be, as only this rigidity can provide protection from further emotional pain. Although dismantling such constructs facilitates contact with the core affect and provides greater agency over one's emotional, cognitive, and behavioral responses, their defensive function should not be overlooked. Destructive patterns rooted in affective psychological constructs can only be transformed through the experience of a new relational dynamic that offers fundamental safety and through addressing the core pain that these constructs were designed to protect against.

Defense mechanisms are most commonly defined as relatively unconscious psychological processes that protect individuals from painful emotions, thoughts, or situations. These mechanisms are typically triggered by internal or external stressors. Defensive behaviors are generally classified as either immature or mature defense mechanisms (Perry & Cooper, 1989). While immature defenses do serve to protect the individual from distress or internal conflict, they are less adaptive, often operate outside conscious awareness, and frequently result in negative emotional and behavioral outcomes. Immature defenses tend to be rigid and reduce one's sense of flexibility and decision-making capacity (Ambresin et al., 2007). In contrast, mature defense mechanisms are more

adaptive, more likely to be consciously recognized and intentionally employed by the individual, and thus more likely to lead to positive outcomes. Although all defense mechanisms initially serve an adaptive purpose, they may over time lose their protective function. When they begin to distort present experiences, they can become maladaptive (Evren et al., 2012). As a result, the individual may perceive threat where none exists or fail to respond appropriately to actual danger that requires protective action.

All three family members were present at the therapy session. The therapist began speaking with Gloria about her feelings.

T: Gloria, how are you? Can you tell me a little about what happened this past week?

G: *(speaking softly)*: Nothing much happened. We have a lot of tests and oral exams at school because the parent-teacher conferences are coming up. I have to study a lot. *She glances cautiously toward her parents and avoids eye contact with the therapist.* Nothing special.

J: Well, it's not entirely true that nothing happened ... (*Jane begins to cry.*)

T: I can see that something important happened and that we need to talk about it today. Gloria, is it okay if we talk a little about what happened this week?

G: *(Nods.)*

T: Is it all right with you if your parents stay while we talk?

G: *(Nods.)*

T: **I can sense a great deal of fear settled in the room as soon as we started this conversation. The feeling that something might go wrong.**

ADDRESSING CORE AFFECT

G: (*Sits quietly, staring at the floor.*)

T: **And maybe right now, Gloria, you'd rather go hide in a room and be alone. Because it feels like every question just makes things worse. You're feeling more and more exposed and ashamed.**

ADDRESSING CORE AFFECT

G: (*Blushes.*)

T: **A heavy feeling sets in, and you're just waiting for it to pass. You're afraid because you don't know what to do, and you feel ashamed because you couldn't make things right. And now everyone is looking at you again, as if something is wrong with you. It feels like no matter what you do, it won't be good enough – you can't fix it, and you're completely powerless.**

DEEPENING CORE AFFECT

G: (*Slowly lifts her gaze.*)

T: Today we're just going to talk about the feelings that led to this moment. The feelings that evoke fear and shame – when you can't escape, when you don't know what will happen, when you're exposed, when you make a mistake. Gloria, does what I'm saying make sense to you?

G: Yes, it does.

T: **Do you recognize the feeling of fear? Can you feel it in your body right now?**

ADDRESSING CORE AFFECT

G: Yes, I can. I know I made a mistake, and I'm scared about what's going to happen now.

T: **Of course. It's completely understandable to feel shame and fear after making a mistake. First, we feel exposed because we know others won't like what we did, and maybe we didn't want it to happen either. Then comes fear, because we don't know what the consequences will be.**

DEEPENING CORE AFFECT

G: Mom said we would talk about this here.

T: It's really important that we do. Only then can we find a solution, and maybe it will feel a little less scary. Can you tell me what happened? G: (*After a pause, quietly*) Yesterday, I was studying math and I used the compass ...

T: Gloria, can you look at me?

G: (*Lifts her gaze.*)

T: That happened yesterday. That unbearable feeling you had when you realized what had happened again – it's not here anymore. Right now, we're just talking and looking for solutions, okay? Just blow that gray bubble out of yourself.

G: (*Takes a deep breath in and out.*)

T: When we start talking about these hard things, it can feel even harder. **Maybe you're thinking that if you'd managed to hide it, it would all be easier. Then we wouldn't have to talk about these things today. We could just pretend nothing happened and everything was fine.**

EXPLORING AFFECTIVE PSYCHOLOGICAL CONSTRUCT

But by now, you've had enough experiences to know that if you don't do something with those feelings, it only gets worse. And that's what leads to so much grayness that, without even deciding to, you end up hurting yourself again. Suddenly, the compass is stuck in your hand.

EXPLORING DYSFUNCTIONAL BEHAVIORAL PATTERNS

G: I really don't want to do that anymore. (*Starts to cry and is embraced by her mother.*)

In addition to addressing destructive emotions and thoughts, symptomatic behavior also constitutes an important aspect of psychological defenses. At this stage, the therapist focuses on the functionality of the symptomatic behavior. Together with the therapy client, they explore how this behavior contributes to affect regulation – specifically, in what contexts the individual resorts to symptomatic patterns as a defense against excessive vulnerability or uncertainty.

Interpretation of Meaning In Current Relationships

Key interventions in exploring meaning (repetition) in current relationships at the level of affective awareness (Poljak Lukek and Valenta, 2022):

Normalization of Experience

»Your emotional experience is a normal reaction to the situation.« »If all of this were happening to someone else, you would likely understand why they feel so powerless.« »All of these feelings are a natural response to the events in your life.«

Cyclicality of Experience

»You've experienced all of this before.« »The belief that you are to blame for everything keeps recurring in your relationships.« »You repeatedly find yourself in situations where you are misunderstood.«

Interpretation of Experience

»You tend to withdraw whenever things get difficult, which means others never have the opportunity to care for you.« »People often get angry with you, and you're unsure how to respond, so you retreat.« »When you feel overwhelmed by your partner, it triggers a familiar experience – feeling completely alone and unable to rely on anyone.«

The relational paradigm posits the compulsive repetition of systemic, interpersonal, and intrapsychic perceptions and experiences, including patterns of interaction and dissociated affects (Gostečnik, 2015). Repetition emerges as a compulsive tendency to recreate past experiences with the unconscious aim of resolution. However, through the compulsive reenactment of unresolved content, affect regulation patterns, affective psychic constructs, and mechanisms of projective-introjective identification are reinforced in adult relationships. Catastrophic expectations underlie and sustain these repetitive patterns, obstructing change. For the individual, the unknown or new within relationships often elicits overwhelming anxiety and fear. It is crucial to note that a familiar relational pattern is not necessarily a safe one. In fact, relationships marked by abuse, violence, or dependency may be compulsively repeated, as only such dynamics seem to promise emotional connection at the intrapsychic level.

Through affect-focused interventions that explore the meaning (repetition) in current relationships, the therapist seeks to examine these patterns in order to challenge catastrophic expectations and cultivate new modes of experiencing affect. Normalization of experience plays a crucial role in reducing systemic tension (Patterson et al., 2009).

Continuation of the Therapeutic Dialogue (following the earlier excerpt):

The therapist waits while the mother comforts and soothes Gloria. Once the child is able to cry in her mother's arms, she begins to calm down. In the meantime, Matthew places a hand on Gloria's shoulder and gently tells her everything will be okay.

Therapist (T): »This is a safe space to talk about those feelings. Your parents are here to understand and to help you find a way forward.«

Gloria (G): *Nods.*

T: **»Your tears and fear are completely natural reactions to everything that has been going on. There's a lot to manage, and it's hard to get everything right. You've probably also noticed that other people around you sometimes cry, get angry, or feel so scared they become frozen.«**

NORMALIZATION OF EXPERIENCE

»Our bodies simply react the only way they know how. But it's also important that we help them learn something new.«

G: *Makes eye contact with the therapist.*

T: **»And this isn't the first time you've felt like this. Some experiences tend to repeat throughout our lives. Your feelings – helplessness, sadness – these probably aren't new to you, and you may feel them again in the future.«**

CYCLICALITY OF EXPERIENCE

»But today you saw that comfort is possible, that even when you make a mistake, things can still turn out okay. Every emotion, no matter how intense, eventually fades. Relationships can bring up painful feelings – fear, shame, guilt – but they can also offer comfort and understanding, if we allow them to.«

INTERPRETATION OF EXPERIENCE

By normalizing the emotional experience, recognizing its cyclical nature, and exploring its deeper meaning, the therapist helps to create conditions for increased insight into the client's own emotional functioning. This fosters the development of new affective awareness. The therapeutic relationship – and, by extension, all close relationships – offers a window into the intrapsychic experiences of the individual. Through the understanding of present emotional states, the client gains the motivation necessary to begin altering entrenched affective patterns.

Interpretation of Meaning at the Intrapsychic Level

Key interventions in exploring meaning at the intrapsychic level within affective awareness include the following (Poljak Lukek & Valenta, 2022):

Exploring Intrapsychic Experience

»As you describe this experience, how do you perceive yourself in it? How do you experience others? How would you describe the relationships involved?«; »Based on what you've shared, it sounds like the woman within you can only fall silent and wait.«; »This seems to suggest that you always end up alone, unable to fully rely on anyone.«

Exploring the Origin of Affect in Past Relationships

»Which man are you describing right now?«; »When you speak of fear … how did your mother respond to your fear in childhood?«; »This relational tension seems familiar, doesn't it? Which past relationship does it also belong to?«

Exploring Events in the Family of Origin

»What childhood memory comes to mind when you talk about feeling lost?«; »Do you remember how your mother reacted when you left for college and moved out?«; »What is your fondest memory of your parents from childhood?«

Encouraging Empathy Toward the Inner Child

»Can you picture yourself at the age of eight? How would you describe that girl/ boy?«; »As all of this was happening, how do you think that child inside you felt?«; »What would you say today to yourself as a child?«

Reevaluating Past Experiences

»Despite everything that happened, you found the inner strength and wisdom to survive and move forward.«; »None of it was your fault. The adults around you were responsible.«; »There was nothing you could have done to stop what the adults did. Only they had the power to change things.«

A core component of therapeutic work consists of interventions at the intrapsychic level. At this stage in therapy, the therapist shifts focus from present-day interpersonal dynamics to past relationships. Difficulties in affect regulation within current relationships often point to deeper psychological wounds, necessitating a move from the interpersonal to the intrapsychic level of intervention. This involves exploring primary affects associated with experiences in the family of origin and relationships with one's mother and father – relationships that remain fundamental to the intrapsychic dimension of human experience (Gostečnik, 2022).

At the conclusion of the first cycle of therapy sessions, Gloria had gained control over her behavior, and the family no longer reported any self-injurious behavior. The girl attended some sessions alone with the therapist, while others were held jointly with family members. In the

tenth session of the first cycle, the therapist spoke with Matej about his memories of the end of elementary school.[11]

T: Matthew, when Gloria talks about fear, you seem to become very thoughtful.

M: Is that so?

T: **Yes, it appears that you're very familiar with that kind of fear. The sense that something is about to happen, and there's nothing you can do about it.**

ADDRESSING CORE AFFECT

And if you were to empathize with your 15-year-old self, back when you were in your final year of elementary school – what memories do you have of that time?

ENCOURAGING EMPATHY TOWARD THE INNER CHILD

M: Oh wow, I don't have many good memories of that period. High school was actually much easier for me than elementary school. Most people say high school was a nightmare, but for me, it was much harder in elementary school. I felt much better once I started high school. I moved to Ljubljana, and everything just seemed easier. I don't really know why, but there was a lot going on, and I have fond memories of that time – even though the teachers were strict, and we had to study and retake tests.

T: **Let's stay for a moment with the end of elementary school. Can you describe what made that time harder for you than high school?**

ENCOURAGING EMPATHY TOWARD THE INNER CHILD

M: I don't know. I had good grades, and I don't recall being afraid of being called on or of tests. I was just a bit different, and others made fun of me

11 In family therapy, the transition to the intrapsychic level is conducted only with the parents, and in a safe and well-boundaried manner. It is essential not to render the parents vulnerable in front of the children. When children are present in therapy, we explore memories only up to the age of the children participating in the session (in our case, we ask the parents about their memories from the end of elementary school). If a high level of vulnerability arises, the children are removed from the session.

for that – for being a nerd and so on. I remember that. And I tended to avoid my classmates – some of them were really weird. I'm not in contact with any of them today. But I do have some really good friends from high school, and we're still in touch.

T: **What did your parents do when you started taking longer routes home to avoid those boys?**

EXPLORING EVENTS IN THE FAMILY OF ORIGIN

M: They didn't notice. They had their own problems. (Matthew's mother was diagnosed with cancer during his elementary school years. Although she eventually recovered, her relationship with her husband deteriorated significantly. She frequently threatened to leave, and their arguments were often emotionally abusive.) You know, those were different times. Boys didn't talk about that kind of thing. One time I came home with a torn backpack – they had taken it and thrown it around until it ripped. And even then, I didn't tell the truth. I made up some excuse, said it got stuck on something. And they believed me.

T: **Even now it's hard to believe, isn't it? That they actually believed you. Maybe that boy back then was also hoping they wouldn't believe him – so that he could finally say what was really happening.**

EXPLORING EVENTS IN THE FAMILY OF ORIGIN

M: *Maybe. But even if I had told them, I feel like all I would have gotten was a lesson about how I need to stand up for myself.*

T: **No one there could have said that what was happening to you was wrong – and that you weren't to blame when someone acted violently toward you.**

REEVALUATING PAST EXPERIENCES

M: *Oh please! I was always the one blamed for everything. So I just stopped saying anything about what was going on. And really, it wasn't that bad – I managed.*

T: **I believe you did. And your parents probably did the best they knew how. But that fear – that no one really understood.**

REEVALUATING PAST EXPERIENCES

Even today, you probably don't fully notice it. You just quickly take care of things and figure it out somehow. As long as no one notices – because if they do, they might blame you for doing something wrong.

M *(smiles): I'm never afraid.*

T: *But Gloria is. And that's why it's so important that you're able to feel that fear today. Because now, you can tell her she's not to blame for being afraid – and that you will protect her, so she doesn't have to face everything alone. That she can come to you and tell you what's going on. That you can allow yourself to question it when she says everything is fine. And that you'll stay with her just a bit longer – so you can really find out what's happening.*

A central element of therapeutic intervention is memory – both explicit memory of events and the accompanying experiences, as well as implicit memory, which is encoded in the body. Explicit memory refers to the conscious recollection of past events. The hippocampus, part of the limbic system, plays a key role in storing these memories, which are dependent on verbal comprehension (Howe et al., 2006). This type of memory enables the recall of autobiographical experiences and begins developing around the age of two.

In contrast, implicit memory refers to the storage of emotional and somatic experiences that cannot be consciously recalled (Cvetek, 2009). It encompasses emotional and procedural memory (Levine, 2015). Implicit memory underlies automatic responses and is shaped by classical and operant conditioning. It is largely processed by the amygdala within the limbic system, suggesting that implicit memory is fully functional from birth (Rothschild, 2017). As Allan Schore (2001) describes, the biological basis of attachment that forms in the first year of life – prior to language acquisition – shapes implicit processes in the right hemisphere of the brain.

Trauma processing involves the transformation of the sensory experience of trauma (Levine, 2015). In therapy, the goal is not to relive the traumatic event through recall, but to achieve a different emotional outcome. Addressing traumatic experiences activates implicit procedural memory, which in turn stimulates the autonomic nervous system (Levine, 2015). This reactivation can resemble the original traumatic response. Through intrapsychic-level interventions, the therapist helps reorganize the sequence of bodily responses – from those associated with threat and danger toward readiness, orientation, and equilibrium. Empathic engagement with the inner child and re-evaluation of past experiences create conditions in which the body can learn new responses to perceived danger. Based on this newly integrated experience of resolution, the body develops the capacity to regulate threat through adaptive coping mechanisms, thereby preventing the overactivation of the autonomic nervous system that would otherwise lead to automatic fight, flight, freeze, or – in extreme cases – collapse responses. As a result, the individual is able to shift from hypo- or hyperarousal into a state of balance, calm alertness, and present-moment awareness (Levine, 2015).

After twelve sessions in the first cycle of therapy, a one-month break followed. All family members attended the first session of the second cycle and reported improvements, including the absence of self-harming behaviors. Gloria herself stated that she was feeling well. Consequently, therapy continued with a focus on the couple, and at the final session of the second cycle, the entire family returned. During this phase, the therapist worked on relationship issues and it emerged that the couple had experienced a miscarriage prior to Gloria's birth. Intrapsychic themes were also explored in depth.

T: **There is a great deal of sadness when you speak about your relationship, about all the misunderstandings and experiences.**

ADRESSING CORE AFFECT

J (*with teary eyes*): Yes, but I'm tired of my sadness and tears. It's not really such a big deal. We've gone through some difficult times, but otherwise, we're fine.
T: **A lot of letting go had to happen. When you realize something is final, that it will never be the same again.**

DEEPENING CORE AFFECT

J: Yes. That I know well.

T: **What kind of letting go are you referring to? When did you first have to come to terms with the fact that things would never be the same?**

EXPLORING AFFECT IN PAST RELATIONSHIPS

J (*sighs deeply*): When my parents got divorced. I was 15.

T: The same age Gloria is now.

J: Yes, I've thought about that too. I was exactly her age. And suddenly, everything was different. My parents hadn't really gotten along before either. They argued a lot, and my father hit my mother and threw things at her when he was angry. Sometimes he disappeared for days. I remember not knowing where he was or when he'd be back. And I didn't dare ask my mom. Then one day, he left again, and my mom sat down with me and my sister at the table and told us that dad had moved out. That he wouldn't be coming back. I even remember what she was wearing that day.

T: **And you probably remember her sadness.**

EXPLORING AFFECT IN PAST RELATIONSHIPS

J: At that time, she was mostly angry. The sadness came later. When I was in high school. I remember hearing her cry, but she never cried in front of us. She was just absent.

T: **If you picture yourself at 15, what kind of girl were you then?**

ENCOURAGING EMPATHY TOWARDS THE INNER CHILD

J: I don't remember much. I was probably absent too. I just know I read a lot. Sometimes late into the night, and my mom would scold me for it.

T: **When your mom was crying in the next room, and Jane couldn't do anything to help her.**

ENCOURAGING EMPATHY TOWARDS THE INNER CHILD

J: I would distract my younger sister so she wouldn't hear. I had to be strong and brave.

T: **You had to grow up quickly and not be sad. Because if you started crying too, no one would be there to comfort you. Just like no one could comfort your mother back then.**

REEVALUATING PAST EXPERIENCES

J: She later found comfort in her work, where she was very successful. And later, when I was already in college, in her new partner. But back then, there was no comfort at all. I don't remember being sad. But I probably was, because it meant something to me. I didn't cry, though. I remember feeling strange later on because I couldn't cry. Even during movies, when all my friends cried, I just couldn't. I think I was afraid that if I started, I wouldn't be able to stop.
T: **Of course, there was no room for you to cry back then. No one would have noticed. And you had to take care of your mom, so she wouldn't feel even more helpless and sad.**

REEVALUATING PAST EXPERIENCES

J: And my little sister too.

T: **And so the feeling kept repeating – that sadness was something to avoid whenever possible.**

CYCLICAL EXPERIENCE OF AFFECT

J: Yes, that's true. And I always thought that was my strength. That I was strong because nothing could throw me off balance.

T: **That is certainly one kind of strength. But then an experience comes when you just can't hold it in anymore.**

REEVALUATING PAST EXPERIENCES

J: Yes. For me, that was definitely the miscarriage. Then I just couldn't stop crying.
T: **Did you also cry in private, like your mother, thinking no one could hear you?**

CYCLICALITY OF EXPERIENCE

J (*tears begin to flow*): Yes.

M: I heard you, but I didn't know what to do. And when I came to you, you told me to go away.

J: I know. Even now, it's easiest for me to cry alone and then move on.

T: **Just like your mom did.**

CYCLICALITY OF EXPERIENCE

J: Yes.

T: But you don't have to do that. Your tears are not too much. You can cry. People around you will understand, they'll try to comfort you – or simply wait with you until the sadness passes. Today, you are crying here, and everything is okay. Matthew didn't go anywhere. He's listening and trying to understand. You are feeling your sadness differently than your mother did, and you are allowing yourself to share it with others. And because of that, you were able to comfort your daughter Gloria when she was having a hard time. In that moment, you also comforted the little Jane inside you, didn't you?

J: It really feels like such a relief when she lets me hug her and just be with her.

Due to the crucial role of implicit memory in emotional experience and behavior, memory recall in therapy does not occur only through verbal narrative, but through all five senses – smell, taste, touch, hearing, and sight – which serve as keys to accessing the deepest psychic content (Gostečnik, 2022; Schore, 2012). Memory recall brings awareness back to the interpersonal level, where, within the therapeutic or marital relationship, a person can form new affect regulation strategies based on new insight. This allows for changes in systemic functioning on the interpersonal level to which these relationships are connected.

Exploring Transference and Connections

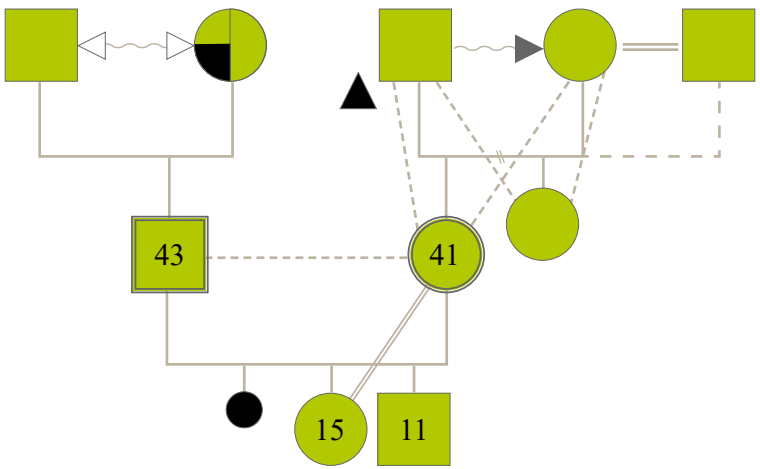
Key interventions for exploring transference and affective connections involve enhancing affective awareness through structured therapeutic techniques (Poljak Lukek & Valenta, 2022):

Drawing a genogram

»Sometimes things are easier to understand if we write them down or draw them, so I suggest that we try to draw all the events you are describing and all the relationships in your family using symbols.« »What can you tell me about your parents?« and »What kind of relationship did your parents have with their own parents?«

Exploring the connection between past and present experiences

»If you try to follow this bodily sensation, what memory does it bring to mind, what image?«; »When you imagine this event you are describing, and if it were happening before your eyes today, what would you feel? How would your body react?«; »What did you do in the past when you felt the way you are describing now?«



T: Jane, how do you feel today as you talk about your family?
EXPLORING THE CONNECTION BETWEEN PAST AND PRESENT

J: I don't know. It's a bit of a relief to be able to talk about it. But it also feels a little strange...

T: Just by talking about these things, we evoke feelings – and some of them are not pleasant.
EXPLORING THE CONNECTION BETWEEN PAST AND PRESENT

These are simply emotions rooted in past experiences. Today, you are merely reliving them. All of these feelings were already present in your body when the original events took place – you just didn't have the words to express them at the time. And as a child, you also lacked the capacity to fully regulate them.

T: Matthew, how do you see your own family now after after drawing the genogram?

EXPLORING THE CONNECTION BETWEEN PAST AND PRESENT

M: It's interesting. I never realized how interconnected everything is.

T: And now you can see that some of these feelings are completely valid. The more we understand our own emotional responses, the more quickly we can respond in the present. **When we allow ourselves to feel fear, we become better able to recognize it in our children – who, in turn, need help responding to their emotions and learning how to face life's challenges.**

EXPLORING THE CONNECTION BETWEEN PAST AND PRESENT

As previously discussed in the chapter on assessment, the use of a genogram in therapy serves purposes that extend beyond mere evaluation. It also facilitates the exploration of connections and intergenerational transmissions within the therapeutic process itself. Through the genogram, clients gain insight into the structure of family relationships, the transmission of dysfunctional patterns across generations, the degree of emotional closeness or distance among family members, and the chronology of significant events (McGoldrick et al., 2020).

4.3 Implementation – Focusing on the Future

In family therapy, implementation refers to the process by which a new mode of affective perception is transferred into present-day relationships. During this phase, the therapist adopts a future-oriented stance, creating opportunities for the client to integrate newly formed experiences of self,

others, and relational patterns into forthcoming emotional responses. Implementation thus activates a regulatory strategy that, over time, evolves into a sustainable tactic – meaning the new experience becomes internalized and generalized (Gross, 2015). At this stage, the therapist actively attempts to modify the circumstances that shape the client's experience. Building on earlier phases, during which the therapist systemically organizes family relationships and explores affective perception, conditions are created for the client to develop present emotional experiences in new contexts. During implementation, the therapist evaluates and deepens these new experiences and attempts to foster conditions that allow the client to experiment with new ways of thinking, feeling, behaving, and relating – particularly within significant current relationships. Through therapeutic interaction, the client is oriented toward the future, the search for meaning, and the construction of purpose.

»*An interpretation that misses the mark tends to just pass by.*« (Praper, 2013, p. 207). This statement underscores the importance of timing and relevance in therapeutic interpretation. An effective interpretation leads to greater self-understanding and is reflected in a shift in the emotional atmosphere of the therapy session. This often marks the moment when vulnerability, pain, and emotions become manageable – and the client experiences acceptance and appropriateness, even when confronting painful internal content. Interestingly, interpretations that evoke resistance can also be seen as valuable. In this context, resistance is not viewed as a failure of interpretation, but rather as an opportunity for deeper exploration of the client's emotional world. Only interpretations that provoke no response at all may indicate an overreliance on the therapist's own subjective experience rather than attunement to the client's inner reality. Ultimately, it is the client's reaction that determines the appropriateness of an interpretation (Lemma, 2003), and the therapist should continuously adjust and refine their interpretative approach accordingly.

Interventions at the implementation stage focus on (Poljak Lukek & Valenta, 2022):

- empathy,
- dual awareness,
- differentiation,
- psychoeducation,
- new regulation strategies,
- generalization of experience.

Empathy

Key interventions for fostering empathy at the level of implementation include the following (Poljak Lukek & Valenta, 2022):

Validation

»Mhm, I understand.«; »You've done everything in your power.«; »Despite everything that has happened, you found the strength to keep going, and today you're here because of that strength.«

Emotional Disclosure

»I'm proud of you.«; »I'm genuinely happy to see your progress.«; »I'm celebrating this with you.«

Reflection

»You speak of a persistent sense of being misunderstood, as if no one truly understands you and you are always alone.«; »If I understand you correctly, your father was consistently absent.«; »You say that you repeatedly feel as though it is never good enough.«

Trust

»You have already been through something like this once before, and I believe you will find a way through this distress as well.«; »Even though this is difficult, I trust you and believe that the right path will emerge.«; »I believe that, deep down, you know exactly what needs to be done and that all the answers lie within you.«

Providing Safety

»You can share openly here – it's safe, and no one will judge you.«; *»You can always come back here if things get difficult and you need someone to listen.«; »It's okay. I'm here for you.«*

Reciprocity

»We'll find a way forward together.«; »We're trying to understand why this is happening, and we'll explore together how to prevent it.«; »We can work together to understand this illness.«

As previously discussed in the chapter on the therapeutic relationship, the experience of empathy constitutes a vital therapeutic intervention through which the therapist seeks to repair and fulfill basic relational needs. It is essential that the therapist, by responding to the client's narrative, offers support, understanding, and encouragement. Such interventions aim to foster awareness, self-understanding, insight, and a sense of meaning (Praper, 2013), while simultaneously conveying to the client that they are accepted, understood, valued, and capable of achieving desired changes in their life. Attunement represents a crucial component of the therapeutic relationship, facilitating not only a new relational experience but also the possibility of therapeutic change. The client's experience of the therapist's cognitive, emotional, rhythmic, and developmental attunement – and thus the therapist's appropriate responsiveness to the client's relational needs – (Erskine et al., 1999; Modic & Žvelc, 2021) enables a novel relational encounter that ultimately reshapes the client's internal experience.

Empathic interventions are illustrated using the example of the last therapy session of the first cycle of therapeutic sessions. All family members were present at the therapy session. Individual parts of the therapeutic session are illustrated.

T (Therapist): What are you experiencing as we come to this final session?

J (Jane): It's a strange feeling. Of course, we're grateful for your help. And honestly, I'm also afraid – afraid of how we'll manage moving forward.

T: I believe it's a mix of emotions that comes with endings like this. And if I understand you correctly, along with some relief, there's also fear about what lies ahead.

REFLECTION

J: Yes. These sessions have felt like a kind of shelter. Whenever something wasn't working, we'd always say, »We'll bring it up and work through it here.« Now that option won't be there. We'll have to handle things on our own.

T: And I believe you will manage.

TRUST

You've shown again and again that you know how to persevere and look for solutions. You didn't give up – and that's what matters most.

VALIDATION

M: We just needed a bit of guidance. I definitely feel it's easier now that we've been through this.

T: You've already accomplished a lot just by having the courage to ask for help.

VALIDATION

M: Yeah, maybe that really was the hardest part for me. Honestly, at the beginning I resisted. I didn't really see the point – how could just sitting here and talking possibly help?

T: I understand. So if I'm hearing you correctly, it was hard to trust that anything would change just through our conversations. And probably even harder to keep going when, at first, things seemed to repeat and there wasn't much visible progress.

REFLECTION

M: Yes, exactly. Many times I didn't see any point in continuing.

T: I'm truly glad you chose to stay with it.

EMOTIONAL DISCLOSURE

By doing that, you gave us the opportunity to do something meaningful together.

RECIPROCITY

T: Gloria, how are you feeling about our time together coming to an end?

G: I don't know. I guess I'll miss having this space to come and just talk.

T: If you ever feel like talking again would help, you can always ask your parents to call and we can set something up. My door is always open for you.

PROVIDING SAFETY

G: That's great.

Dual Awareness

According to Poljak Lukek and Valenta (2022), the key interventions for facilitating dual awareness at the level of therapeutic implementation include the following:

Linking Affect to the Present Moment

»This is only the helplessness once felt by that lonely child.« »Even now, that same rage is awakened in you – rage that cannot be contained – just like in those moments when you knew there was nothing you could do and were left all alone.« »The sadness you feel today is, in part, a reflection of that old loss – when you were not allowed to feel or to cry. Today, your tears are for all those uncried losses.«

Relational Reframing

»When everyone around you remains the same, it becomes harder for you to change and take a step forward.« »Everything around you keeps recreating the conditions that perpetuate old patterns.« »Today, you can understand that you cannot change any adult who does not want to change.«

Differentiating the Past from the Present

»This is no longer happening. The violence is over. Only the feelings remain – and they are so strong that it feels as if it were all happening again.« »Today is a different time, and these people can no longer hurt you.«»You are no longer a powerless child.«

We will illustrate the concept of dual awareness through the example of evaluating Matthew's experience of peer violence during elementary school.

T (Therapist): When you recall that incident with the torn backpack, you probably just smile about it today. But you also understand that it was an incredibly difficult experience for that boy back then.

M (Matthew): It really does feel like a long time ago now, but I still remember running home – I should have been really scared.

T: And that fear still lives in you today. And as you said yourself, it has to be quickly concealed. Just like at home, when you had to pretend nothing serious had happened. Even now, fear is something you're not quite allowed to feel.

LINKING AFFECT TO THE PRESENT

M: Yeah, I honestly don't see any use in being afraid.

T: Back then, it didn't serve much purpose – because there was no one there to protect you. But today, fear *can* be useful. It can help you stay safe – and even more, it can help you protect the people you love.

DIFFERENTIATING THE PAST FROM THE PRESENT

M: Maybe. Still, it feels safer not to show fear. Otherwise, people eat you alive.

T: That was your way of protecting yourself as a child – pretending you weren't afraid. And even then, you couldn't stop those kids. **But they were just children too – caught in difficult circumstances of their own. That doesn't excuse their behavior, of course.**

RELATIONAL REFRAMING

And even though fear may not have helped you back then, today it's different. This time, it did help. Because you allowed yourself to feel it, you were able to understand your daughter and support her in facing her own fears.

DIFFERENTIATING THE PAST FROM THE PRESENT

M: I don't know. Do you really think that's the reason?

T: You didn't run away this time – you faced it. And I truly believe that made it easier for your daughter.

DIFFERENTIATING THE PAST FROM THE PRESENT

Dual awareness is recognized as a pivotal step in the therapeutic process (Poljak Lukek, 2011). It enables the therapist to create conditions in which the client can begin to link past emotional experiences with current relational dynamics. The client becomes aware that emotions rooted in the past are being reactivated in present-day relationships, often evoking a sense of helplessness and distress. This process fosters the recognition of one's own emotional experience as well as the emotional states of others. The client learns to differentiate between the feelings of others and their own, while also beginning to take ownership and responsibility for their internal emotional world. Dual awareness implies the capacity to understand present emotional reactions as echoes of earlier, unresolved experiences. The therapist's role and interpretive stance are essential in facilitating this process. Through interventions aimed at cultivating dual awareness, the therapist helps the client to distinguish between past helplessness and psychological pain on the one hand, and current agency and responsibility on the other.

Differentiation

Key interventions that support the implementation of differentiation in therapeutic work include the following (Poljak Lukek & Valenta, 2022):

Differentiation in communication

»Can you speak only from your own experience and how you perceive it?«; *»What does everything that has been said mean to you?«*; *»What would it be like for you to speak only about yourself in this session?«*

Relieving guilt

»You were not to blame.«; *»Responsibility for violence always lies with the person who commits it. You cannot carry the burden of guilt for the abuse you suffered.«*; *»You were just a small child and there was nothing you could have done to prevent what happened.«*

Addressing injustice

»It is unfair that this illness struck you.«; *»It was unfair to you as a child that your parents couldn't give up alcohol, and you lost them because of it.«*; *»It is unjust that this person is no longer with you.«*

Differentiating needs

»You need understanding and comfort.«; *»Just as others expect things from you, you too are deserving.«*; *»Just as you want to provide safety for your children, you also deserve to feel safe and protected from harm.«*

Assuming responsibility

»As an adult today, you have the capacity to care for yourself.«; *»No matter what happened in the past, today you have the strength and agency to stop the abuse.«*; *»Your children need you, and only you can give them the reassurance that everything will be okay and that they are okay.«*

Establishing structure

»Only you can take care of your children – they cannot do anything to make your pain go away.«; *»Nothing you do will change your parents. Only they can choose to change, and that change may reshape their relationship with you.«*; *»Even though it is hard to cope with the disappointment of divorce, your children cannot be your emotional confidants. They don't need to understand your pain – you need to understand theirs.«*

Awareness of self and others

»These are your feelings, and only you fully understand them.«; »The feeling of helplessness may be a sign that this sadness is not only your own – you may be carrying it for those around you who cannot or will not feel it themselves.«; »This is your husband's anger, and only he can calm it.«

Psychological stability is also supported by differentiation, understood both as the individual's ability to separate thoughts from feelings (Bowen, 1978), and as the capacity to express autonomy within relationships (Poljak Lukek, 2017). In therapy, differentiation guides the client toward a deeper understanding of the self and one's emotional experience, fosters more coherent responses, and enables new perspectives on relational dynamics. A crucial aspect of this process is the restructuring of relational patterns at the systemic level, along with the recognition and regulation of self-conscious emotions, which allow the individual to separate their own experience from that of others. Systemic boundaries are essential for protecting the individual from the unconscious transmission of unspoken emotional, cognitive, and behavioral contents. They also create conditions for psychological flexibility and resilience in the face of stress (Cummings & Davies, 2010; Gostečnik, 2015). In therapy, the therapist facilitates differentiation by reestablishing structural and hierarchical order (which also implies the therapist taking responsibility for the process), and by offering a clear model of communication and the articulation of individual needs.

To support the development of differentiation, the therapist employs appropriate regulation and acknowledgment of self-conscious emotions. These emotions are intrinsically tied to self-awareness, the recognition of separateness from others, and the ability to evaluate one's own and others' behaviors (Lewis, 2008). Guilt, for instance, can be a functional emotion when it helps an individual align behavior with social expectations, fosters responsibility, and encourages prosocial and respectful action. It also enables accountability and the capacity to offer an apology when appropriate. However, guilt can become a deeply distressing psychological burden when the individual is unable to regulate it through action. Developmentally, this occurs when a child feels powerless to change their circumstances or when guilt is not tied to a specific event but becomes generalized – leading the child to perceive themselves as fundamentally flawed (Lewis, 2008). This form of guilt is commonly linked to

traumatic experiences, in which the individual assumes responsibility in an attempt to regain control, regulate stress, or simply survive. Addressing guilt within the therapeutic process allows the client to localize it to a specific event and disrupt its global influence on the self-concept. The therapist encourages the individual to take responsibility and apologize where necessary, or to differentiate from the event by recognizing the injustice they experienced and shifting the burden of responsibility onto the appropriate party.

The experience of injustice typically elicits two primary affective reactions: shame or anger (Retzinger, 1985). Consequently, the therapeutic intervention should attend to and regulate the affective dynamics of either shame or anger. These affects are, in a sense, opposites – while anger mobilizes, shame inhibits. The therapist should therefore find effective ways to activate the client when needed and simultaneously maintain relational safety during affective inhibition. Anger arises from blocked goals and provides the necessary physiological energy to overcome obstacles (Lemerise & Dodge, 2008). As such, it is a vital emotion that enables agency and motivation toward change. In therapy, the process of naming and addressing injustices can create space for the healthy mobilization of anger and the emergence of motivation. Shame, by contrast, emerges in the context of significant relationships, when an individual experiences their painful or threatening emotions as being linked to someone who is psychologically close or developmentally important (Tangney & Dearing, 2002). The origin of shame lies not in the event itself, but in the interpretation of the event. The experience of shame is often accompanied by the urge to hide, disappear, or even die. In response, individuals may resort to reinterpretation, splitting, or dissociation as defense mechanisms (Lewis, 2008). A key therapeutic intervention in the presence of shame – especially when it arises in the context of guilt – is the preservation of the therapeutic relationship. The therapist strives to restore the connection, particularly through reestablishing eye contact and relational engagement, even when shame-related emotions threaten to sever the bond.

We will illustrate differentiation interventions through the example of evaluating Jane's experience of her parents' divorce.

T: Every time you mention your parents' divorce, there seems to be a heavy weight.

J: I don't know if I'll ever be able to talk about it. It doesn't feel right when I have to speak about their divorce. It happened, and I couldn't do anything about it.

T: Perhaps that weight remains because part of you doesn't fully believe that there was truly nothing you could have done. There may still be some guilt – that feeling from the little girl inside, that if only she had been better behaved, her parents might have decided differently.

RELIEVING GUILT

J *(tears up)*: Maybe.

T: And then comes the feeling that, if she's good enough, Mom will be less sad, cry less. That was the only way Jane could make sense of the situation at the time. She was good, helped out, took care of her sister, and didn't cry.

RELIEVING GUILT

J: What else could I have done?

T: Absolutely nothing. You did everything you could. And it still wasn't enough. Your parents separated, and your mother was angry, and then sad. And there was nothing you could have done to help her – just as her anger and sadness were not in any way caused by you.

RELIEVING GUILT

Those were *her* emotions – *her* anger and *her* sadness. They came from somewhere else. It was never within your power to calm her down. That was something the adults should have taken care of.

ADDRESSING INJUSTICE

J: So that's how it was.

T: Exactly. But she did what she did for herself. And by taking care of herself in that way, she also relieved you and your sister of that burden.

ESTABLISHING STRUCTURE

J: Yes, that's true. When she met her new partner, it was strange at first. But then things started to feel easier – her relationship with us, her overall mood – it all became more relaxed. We have a great relationship today.

T: And what about your relationship with your father?

J: That's a different story. After he moved out, we barely saw each other. Sometimes he'd pick us up for cake or ice cream. When I started high school, we saw each other even less. My sister would occasionally visit him for the weekend, but I never did. We did run into each other, but it was never really relaxed. Things changed a bit after my wedding and the birth of my children. He became somewhat more involved, but I wouldn't say we have a deep connection. It's calm, but very distant. **T: And today, you're allowed to give yourself permission not to be the one responsible for your relationship with your father. That's *his* responsibility. And also *his* fault that he's not closer to you – not yours.**

RELIEVING GUILT

J: But now he's getting older, and someone will have to take care of him. **T: Of course. But you'll do that in a way that is best for *you* and *your* family**.

ESTABLISHING STRUCTURE

J: I hope so.

T: Because what your father needs from you now is exactly what *you* needed from *him* when you were growing up – someone to take care of you, to be there when you felt helpless, to give you a sense of security and acknowledgment that you mattered.

DIFFERENTIATING NEEDS

J: Yes, that's something I only felt from him occasionally. There were moments when I sensed it, but they were too rare.

T: And that was unfair to you. Every child deserves to be cared for.

ADDRESSING INJUSTICE

Just as you now care for your own children. No matter what, you have to find the strength – even when it's hard – to give your children the sense that they're okay and that they matter. Sometimes that's difficult because you yourself don't feel that you matter to them.

ASSUMING RESPONSIBILITY

J: Sometimes I really do feel the same way I felt around my dad – that they don't care, that I don't exist for them.

T: But that's not true. A child doesn't have that kind of power. No matter what pain parents may cause, a child *does* care. They may learn to live without a sense of safety, but they never become indifferent.

ESTABLISHING STRUCTURE

And regardless of everything we've talked about – you are a good mother, one who experiences her children differently than your own mother or father were able to. **They did the best they could. But now *you* can do even better.**

ASSUMING RESPONSIBILITY

J: I hope so *(weeps).*

Psychoeducation

Key psychoeducational interventions at the level of implementation (Poljak Lukek & Valenta, 2022):

Information about Mental Disorders and Abuse

»We speak of depression when …« »When a person behaves in such a way …, then we can speak of …« »Physical abuse is any use of force against someone weaker and it radically alters our experience – even our brain functioning.«

The Relational Meaning of Experience

»Human beings are relational by nature, and we continually seek connection. We never stop longing; we keep seeking understanding and acceptance – even if we go about it in deeply dysfunctional ways.«

»Your threat to leave is, at its core, the strongest cry for connection.«
»Addiction is the absence of relationship. By restoring connection, you give yourself the chance to live free from addiction.«

Providing basic information about mental illnesses, the stages of grief, and signs of abuse and violence can be crucial in helping the therapy client find a sense of calm. Addressing symptomatology fosters a sense of safety on the one hand, while also enabling the assumption of personal responsibility on the other. Both of these elements can play a key role in establishing motivation for change.

New ways of regulation

Key interventions for achieving new modes of regulation at the level of implementation (Poljak Lukek & Valenta, 2022):

Soothing

»Everything is okay; you are safe now. Look around – there is no one in this room who wants to hurt you.«; »Just focus on your breathing. Everything is manageable, and nothing bad will happen to you.«; »If it helps, you may stand up, take a few steps, drink a glass of water, and take some deep breaths...«

Setting Boundaries

»You don't need to worry about the time. I'll make sure we end on schedule.«; »That type of communication is not acceptable. In this space, we will aim to speak more quietly, avoid profanity, and refrain from making threats.«; »I would like us to use formal address in our sessions.«

Supporting a Symptomatic Partner

»You now have ways to support one another.«; »All that is needed is an understanding that your partner needs you.«; »Can you, in this moment, offer your partner some assurance that you've chosen to stay and that you are willing to try to understand?«

Fostering Connection

»You have each other, and you all want the same thing – to feel better in your family life.«; »There was a time when you both saw meaning in this relationship. Together, you can rediscover that.«; »You've mentioned several times that you need each other – and that's a strong starting point for reconnection and seeking shared moments again.«

Interrupting Emotional Atmosphere

»That's enough sadness for now. Today is a new day – we can look around and find a new sense of meaning.«; »This is just anger, and there's nothing wrong with feeling it. You can experience it without letting it escalate into rage and a loss of control.«; »Today, you don't need to look away anymore – you did nothing wrong, and no one is judging you now.«

Ineffective affect regulation refers to the imbalanced modulation, maintenance, or escalation of a particular emotional state. Affect regulation encompasses both the regulation of one's own emotional state – experienced and recognized as a physiological shift within the individual (self-affect regulation) – as well as the influence one exerts on another's emotional experience, affectivity, and behavior (other-affect regulation) (Gross, 2008).

Affect regulation is a form of implicit, non-verbal communication between two individuals and also takes place within the therapeutic relationship. Schore (2008) describes an intense regulatory process occurring throughout the course of therapy. Both the client and the therapist enter the relationship carrying their own emotional experiences, which co-construct the intersubjective therapeutic space. The regulation of emotions in the therapeutic relationship mirrors the regulatory process between a parent and child and can be understood through the following steps (Gross, 2013): (1) The child externalizes distress or emotion; (2) The parent receives and internalizes this distress, taking on a sense of responsibility for transforming it; (3) The

parent tolerates, transforms, and names the emotional state; (4) The parent then returns the processed affect to the child in a form that conveys safety; (5) The child receives this processed affect and experiences their original distress as manageable. Within the therapeutic relationship, this interpersonal regulatory process can be repeated and thus provide an opportunity for the restructuring of established affect regulation patterns. The reactivation of a primary affect, when met with empathic attunement by the therapist, creates the possibility of reshaping an old regulatory model. The therapist's regulatory interventions involve: (1) Identifying the client's emotional arousal; (2) Receiving and internalizing the affect through empathic responsiveness; (3) Containing, transforming, and naming the affect; (4) Returning the affect in a form that fosters safety (via interventions such as soothing, boundary-setting, emotional support, connection-building, or emotional redirection); (5) Creating a therapeutic environment that enables the client to internalize this processed affect as their own – fostering a sense of emotional mastery within a secure relational context.

Affect regulation in therapy often occurs through transference and countertransference dynamics, wherein the therapist uses their own subjective experience and bodily perceptions to interpret the client's inner world and gain insight into the roots of their ineffective affect regulation. Transference reflects the client's internal object relations and manifests in their emotional experience of the therapeutic relationship. Through this, the therapist gains access to psychic material that is unavailable to the client, or that the client cannot yet articulate (Lemma, 2003). Therapeutic responsiveness that offers new perspectives and emotional experiences enables the client to gradually develop more effective modes of affect regulation. Thus, in the therapeutic setting, affect regulation becomes a framework for understanding recurrent dysfunctional relational patterns and recreating familiar emotional atmospheres, offering targeted opportunities for therapeutic intervention.

Continuation of the therapeutic session from the previous excerpt:

T: And regardless of everything we're talking about – you are a good mother, one who feels her children in a way your mother or father could not. **They did the best they could, and now you can do even better.**

J: I hope so (she begins to cry).

T: It's okay. These are just tears. I believe you wish they weren't there. But it's right that they are. Here, you can let them come. Just allow them to flow. You can take a deep breath and receive this sadness. There's nothing wrong with it.

SOOTHING

There are many experiences held in your body – moments when it was time to say goodbye, when you should have cried but couldn't, or when farewells were simply too heavy. This sadness may always be a part of you in some way.

J: I know. It helps when I allow myself to cry. It's just hard every time the tears come again...

T: Matthew, what could you say to your wife when she's feeling this sadness?

SUPPORTING A SYMPTOMATIC PARTNER

M: I don't know what to say. I'm sorry she's going through this.

T: I believe you. We've seen here time and again that this sadness is not dangerous. That it passes, that it can be calmed. **And you can help with that.**

SUPPORTING A SYMPTOMATIC PARTNER

M: Hmm, I won't cry though (smiles).

T: You don't have to. Just being here next to her, while she feels this and talks about it – that's enough.

SUPPORTING A SYMPTOMATIC PARTNER

M: Aha.

T: You know more than anyone about the experiences your wife is describing. About the grief left behind after the miscarriage of your

child – you know it too. You also had to mourn a future that could have been. I understand that men often feel it differently. Still, it's grief you can share. You don't have to fix it, but you *can* understand it – and that's how it begins to soften. And you too know what it's like to feel sadness when your parents weren't there for you in the way you deserved. And you too know the sorrow of having to let go of the belief that your firstborn would always be safe. That's a grief you can share – even if each of you expresses it in a different way.

FOSTERING CONNECTION

M: I don't feel sadness in all this you're describing. I feel more angry – that this happened to *us*.

T: And that anger is entirely valid. It helps you find solutions and keep going. Just as sadness, in its own way, allows us to say goodbye and make space for something new.

J: It's just that I don't want to be someone who's always crying. And I don't want Matthew to constantly have to deal with my tears and sadness.

T: That sounds a bit like anger too, doesn't it?

J: (smiles)

T: You're right. Enough of holding onto the sadness. You can move forward. You can take a deep breath in and out and let the sadness go.

INTERRUPTING EMOTIONAL ATMOSPHERE

But not to spare others your crying – rather because your body deserves to feel something else too. It doesn't mean the sadness isn't there – just let it pass. Feel it, and then release it.

J: (takes a deep breath) Yes, that helps. Not having to run away from it anymore, but knowing I now have a way to let it go.

T: And look – you can see how your experiences are actually quite similar. How you make it possible for each other to shift what you're feeling. You even got angry when we started talking about anger.

FOSTERING CONNECTION

> And that anger isn't dangerous. It's the kind of anger that helps us set boundaries, find new paths, be innovative and creative. It energizes the body – keeps us from staying stuck.

A key element in the process of affect regulation in therapy is the quality of the therapist's presence within the therapeutic relationship. The therapist is actively present and engaged in the therapeutic process, which means they are open to being affected by the client's story and respond to it in the present moment (Modic & Žvelc, 2021). The core experiences that the therapist is meant to convey to the client include: an awareness of what is happening within the therapist and what they are feeling; a message that the client's experience is meaningful and valid; the understanding that the client's emotional response is a normal reaction to their circumstances; and the reassurance that the therapist is present and working for the client's benefit (Erskine et al., 1999; Modic & Žvelc, 2021).

Generalization of Experience

Key interventions for facilitating the generalization of experience at the level of implementation (Poljak Lukek & Valenta, 2022):

Generalization to Other Relationships

»You were able to express your wishes here – this means you can do the same in other relationships.«; »All the experiences you have gained in this therapeutic relationship can also be applied in your other relationships.«; »In therapy, you have repeatedly shown yourself that you are capable – remember this experience when you feel powerless again.«

Generalization of Direct Communication

»Just as you found the courage to speak up here, you can also speak in other relationships.«; »Just as you were able to show your vulnerability here, try to be as open and sincere about your feelings in other contexts as well.«;

»Even though it is difficult to begin, it is important that you always find someone to talk to when things get hard.«

Self-Evaluation

»How do you see yourself in relation to...?«; »How do you perceive yourself next to your partner?«; »In what way do you think others experience you?«

Encouraging Positive Activities

»Since you've experienced that talking helps, try to find someone to talk to when needed.«; »Regular exercise has often helped you to function – so it's good to maintain that routine.«; »You have mentioned how important it is to have time for yourself – so it's perfectly valid to take that time.«

The generalization of experience is a crucial step in the process of therapeutic change (Stern et al., 2010). Family therapy is oriented toward changing the relational patterns that are significant for the client; thus, an internal change within the individual is not sufficient on its own. The therapeutic goal is always to facilitate transformation within all key relationships. It is therefore essential that the therapist actively supports the generalization of new modes of communication, behavior, emotional experience, and even implicit relational awareness beyond the therapeutic setting.

T: How do you think you might be able to use the experiences you've had in our sessions?

GENERALIZATION TO OTHER RELATIONSHIPS

J: What helps me most is that I can talk. I always have this need to say everything, and maybe that makes me a bit overwhelming for other people. But here, I also listened more often, and that was good too. So I'll definitely try to wait more in other situations, let others speak. That'll come in handy at work, especially.

M: And at home too (laughs). Sometimes it's really good when things slow down a bit.

T: **And what about you, sir? What's something new for you? What would you like to carry into your other relationships?**

GENERALIZATION TO OTHER RELATIONSHIPS

M: Probably the opposite of Jane. I apparently need to speak more (smiles). It's hard for me, but here I've seen that it's easier for everyone when I join in. And sometimes it really is better to do something than to do nothing and just wait.

T: Even though it's hard – your whole body would rather withdraw and wait for it to pass – **it's important in those moments to find the strength to engage. And you've seen here that nothing terrible happens when you do. Others may not always agree with you, and that's okay. What matters is that you let yourself and others know that you matter. Especially in your family, that you are involved, that you ask questions, that you notice when something is going on with the children – when they might want to tell you something but don't know how.**

ENCOURAGING POSITIVE ACTIVITIES

T: **Gloria, how do you see yourself now and the fact that you used to self-harm?**

SELF-EVALUATION

G: It's not as hard to think about it anymore. I know it happened. And it's easier now that it's not happening. Looking back, I don't even know why I was doing it.

T: And how would you describe Gloria today?

SELF-EVALUATION

G: I don't know (smiles shyly). But I do know which high school I want to go to, and I'm already a bit excited that primary school is almost over. I can't wait for summer vacation.

T: That's wonderful. It's good to hear that new possibilities are opening up for you. **And that's great – that you can plan ahead and feel excitement about new things, even if they might also bring some fear or uncertainty.**

ENCOURAGING POSITIVE ACTIVITIES

And what do you think helps you most when things get tough?

ENCOURAGING POSITIVE ACTIVITIES

G: I always have some soap bubbles in my room now. I really love them, and sometimes I just blow them for no reason, and I feel better right away. And it helps if I can talk to mom. Well, not always (smiles). And sometimes I write or draw something. That's okay too.

T: We all need to blow out bad feelings from time to time. It's great that this helps you. And everything you described are good ways to get through a tough day. I'm sure you'll find even more things that you enjoy. Just remember these when things get hard, and try something that works in that moment – so you don't always have to turn to your phone or hurt yourself again.

ENCOURAGING POSITIVE ACTIVITIES

G: *(Nods.)*

T: And you've shown here many times that you're brave, and that you talk – even when it's hard. Of course, when we're not feeling well, it's difficult to find someone to talk to and start that conversation, but often all it takes is one sentence, one word, and it gets a little easier. That's why it's so important to talk, to find people you can trust.

GENERALIZATION OF DIRECT COMMUNICATION

Through interventions that encourage self-evaluation, the therapist helps the client become aware of important internal changes and then supports the client in trying out these changes within their relationships. Successful generalization of experience enables the client to maintain therapeutic change, as they are able to maintain internal balance despite shifts in their internal psychological experience (Stern et al., 2010). The mechanisms of maintaining change in therapy are discussed in greater detail in the following chapter.

5

Maintaining Therapeutic Change

Change in family therapy can be conceptualized on several interrelated levels:

- **Behavioral change** (e.g., cessation of addictive behaviors, regular weekly family meetings, changes in how dissatisfaction is expressed, improved communication patterns);
- **Change in cognitive schemas** (e.g., a new understanding of the self, interruption of cycles of negative thinking, revised interpretations of past experiences);
- **Change in emotional experiencing** (e.g., expressing emotions differently, managing affective states in new ways, altered labeling of emotional experiences, different responses to others' emotional expressions);
- **Change in relational perception** (e.g., shifts in the implicit experience of self, others, and relationships).

Through interventions that address these levels, the therapist simultaneously engages both the individual and the wider family system. Behavioral interventions in particular have a direct impact on family structure. Changes in family structure, hierarchy, and newly established family rules lead to transformation within each individual member (Minuchin, 1974). Once a sense of safety and a functional hierarchy is restored within the family, tension subsides. As a result, individual family members are released from

the emotional burden imposed by dysfunctional relationships and are better able to experience change within themselves. Family therapy also includes interventions targeted at the individual, with the aim of transforming relational perception. This, in turn, alters the entire family system to which the individual belongs. When individuals experience, regulate, name, and process emotions differently, they begin to behave differently in relationships. This changes not only themselves but also all the relationships in which they are embedded. Furthermore, the new relational experience offered in the therapeutic setting allows the individual to perceive themselves, others, and relationships in new ways – again leading to transformation on both the personal and systemic levels.

According to Stern et al. (2010), two primary therapeutic goals emerge from the dynamics of the therapeutic relationship: (1) change through interpretation, reflection, and the reorganization of conscious, verbal information; and (2) change through the understanding of the intersubjective environment, which involves implicit relational awareness and what they term the »shared implicit relationship.« From the perspective of relational theory, the therapist attempts to explore why individuals compulsively repeat certain experiential patterns, and how these patterns shape the relationships they form (Gostečnik, 2015). The aim of therapy is thus no longer the uncovering of unconscious content per se, but rather the transformation of **implicit relational perceptions.** These are absorbed through multiple channels, unfold rapidly, and are subject to constant fluctuation. Because of their rapid and unconscious nature, they are largely inaccessible to verbal expression. The exchange of implicit perceptions therefore occurs constantly and swiftly within relationships, regardless of our conscious understanding or linguistic capacities (Stern et al., 2010).

> The Boston Change Process Study Group (Stern et al., 2010) outlines several foundational assumptions behind this view of therapeutic change, grounded in dynamic systems theory:

- The so-called »two-person psychology« approach emphasizes that individual behavior, symptomatology, and adaptation should be understood within relational contexts;
- Developmental psychology research plays a crucial role in informing therapeutic processes;
- From a dynamic systems perspective, the therapeutic relationship either facilitates or impedes change;
- Intrasubjective (i.e., intrapsychic) experience is a key factor in understanding change;
- Communication in therapy occurs not only at the explicit (verbal) level, but also through implicit, nonverbal, and unconscious channels;
- Intention is considered the primary regulator of therapeutic change.

In the sections that follow, we will focus on this understanding of therapeutic change in family therapy – as change that occurs within the interpersonal space of the therapeutic process and enables the individual, through new relational experiences, to transform their behaviors, emotional responses, and thought patterns, thereby reshaping the relationships to which they belong.

5.1 Change in Implicit Relational Awareness

The foundational premises suggest that examining therapeutic interpretations alone is insufficient for defining change in therapy. Stern (2010) and colleagues in the Boston Change Process Study Group conceptualize therapeutic change as a transformation in implicit relational awareness.

The Process of Changing Implicit Relational Awareness (Stern et al., 2010):

- The Present Moment – This represents a pivotal moment that enables change within the therapeutic process. It is characterized by an affective attunement between the therapist and the client, during which

a familiar relational atmosphere is re-evoked. The present moment serves as a relational pattern that, through a sequence of misattunements, disruptions, and eventual repairs, can give rise to a new form of implicit relational awareness.

- The Moment of Meeting – Affective attunement alone is not sufficient to generate therapeutic change. What is also required is the active contribution of both therapist and client in co-constructing a unique intersubjective space. The moment of meeting constitutes this mutual contribution and marks the emergence of a previously unknown relational dynamic, which opens the possibility for development and transformation. Importantly, the therapist's contribution is not solely rooted in professional expertise but also includes their personal presence and subjective experience. Therapy unfolds through the repetition of familiar relational patterns in present moments and culminates in moments of meeting, where the therapist's personal engagement leaves a lasting impression on the client's perception.
- The Open Space – This refers to the moment in therapy when the client is able to integrate the impact of the moment of meeting. It is the point at which the individual can maintain internal equilibrium despite altered intrapsychic experience, signaling the consolidation of therapeutic change.

Through the therapeutic relationship, which offers a qualitatively different relational experience, the client can begin to form a new mode of implicit relational awareness. This form of knowing consists of internal representations of relational experiences that are encoded in a non-symbolic form – meaning they emerge as early as the first year of life and are reinforced through ongoing adaptive interactions between the child and primary caregivers (Schore, 2001; Stern et al., 2010). In therapy, the therapist facilitates change in these internal representations by perceiving and interpreting transference-related affective experiences, thereby enabling the

transformation of implicit relational awareness. Change thus occurs within the therapeutic relationship itself, wherein both the client and the therapist undergo evolving processes of behavior, thought, affect, perception, and understanding (Stern et al., 2010). From the perspective of the relational paradigm, development in family therapy is understood not merely as a shift in cognitive perception, but more fundamentally as a transformation in affective perception within relationships (Gostečnik, 2015). Therapeutic change entails the client's experience of a new kind of relationship – one that allows for the naming and evaluation of deeply embedded emotional experiences, and facilitates the transfer of this newfound relational insight into the client's marriage, parenting, and other significant family and social relationships.

Case Example from the Therapy Room

Thomas, age 35, and Sabina, age 33, entered couples therapy due to Thomas's infidelity. The therapist addressed the affair and guided the couple through the stages of relational recovery: stabilization (breaking off all contact with the third party, taking full responsibility for the infidelity, interrupting cycles of negative communication between the partners…), narrative reflection (exploring what was happening in the relationship during the period of the affair, how they experienced their connection, as well as their family-of-origin dynamics…), and the attempt to consolidate new perspectives (developing pathways toward renewed connection and intimacy). During the first six sessions, the couple succeeded in establishing stabilization, which enabled the therapeutic work to shift toward exploring the emotional processes that had allowed emotional distancing to take hold in their relationship.

In the ninth session, the therapist focused on their interactional dynamic. Sabina expressed deep despair, convinced that she would never be able to trust again. She shared how nothing seemed to change – that Thomas

still withdrew and failed to communicate. While she believed that the affair had ended, she nonetheless felt that he was not truly emotionally present. She experienced him as distant and inaccessible. Thomas, in turn, interpreted her feelings as accusations and positioned himself in the role of the victim. He repeatedly said that everything was his fault, that the blame was always placed on him. The therapist addressed this dynamic:

T: We keep returning to the same dynamic. We begin discussing your relationship, and immediately all the blame lands on you.

Th (Thomas): It's true. That's how it feels. I'm the only one expected to change everything.

T: **And it seems like no matter what you do, it will never be enough.**

Th: Exactly. It's never enough.

T (*sensing his helplessness, the urge to run*): **And in the face of that overwhelming helplessness, the only thing that seems possible is to run.**

Th (makes eye contact): That's exactly right.

T: **You just want to get away – as far as possible. You have to, because it's all too much. You can't take it anymore. You can't stand being in it. The same feeling arises here, in this room. You'd rather not be here. It's overwhelming. You just want to run…**

Th: That's completely true, yes.

PRESENT MOMENT

T: Sir, it seems to me that you know a lot about running. Have you had to run often?

Th: Yes, I have.

T: Did that feeling of terror – what you had to run from – just come back to you now?

Th: *(Nods.)*

T (sensing fear): We don't need to talk about it today if you're not ready.

Th: I'd rather not.

In the following sessions, Thomas began to recount experiences of severe violence at the hands of his father. As the oldest child, he had to protect his younger brother, sister, and mother, who was frequently the target of the father's abuse. He spoke of memories where they all had to flee from him – how he and his siblings would hide in the forest. As he got older, he sometimes confronted his father in order to protect the others, but would then run away, afraid that his father would kill him. When his sister left for high school and moved into a student dormitory, he too left home. His mother stayed behind with the father, and over time the violence lessened somewhat. But he continued to carry guilt – guilt that he had not done more to protect her.

T: I understand. It's not the right time yet. That's okay. But maybe we could just stay for a moment with that feeling of terror you remembered – the urge to run. Can we do that?

Th: Yes.

T: I imagine you're feeling it even now. You'd rather not be here. You'd rather get up and leave.

Th: *(Nods.)*

T: I understand you. Because here too, so much blame is being placed on you, and you don't feel like you can manage it. It's all too much for you, even here. But Thomas, **I don't blame you for what you're feeling.** Your feelings are entirely valid. And you don't need to fix this situation. We'll find a way forward together. You don't need to run, because no one in this room is threatening you. **Your wife is here – she loves you and wants to find a way back to you. And I'm here to help you make sense of your reactions.** There is no longer the same violence and chaos that could not be stopped. You are no longer a powerless child, unable to do anything and who did nothing to deserve such treatment. Today, you are not powerless. You can calm the chaos. You can look at your wife and see that she is here – and that she is afraid you will run again.

Th: Okay.

T: Can you say something? What are you thinking? What's going on in your body?

Th: I don't know what I'm thinking. But I feel better. I didn't even realize I was running. (He looks at Sabina and takes her hand.)

MOMENT OF MEETING

T: **What does this mean to you today?**

Th: That I need to talk. That I need to stay.

T: That you somehow need to move beyond the sense of injustice you're experiencing. Because that's what drives you to run. When you feel powerless to change anything, running seems like the only option, right? **But when you manage to move past that feeling of being a victim – as you just did here – you can begin to talk in a different way.**

OPEN SPACE

The present moment, as a moment of affective encounter between the therapist and the client, becomes possible within a spontaneous and creative interpersonal space (Stern et al., 2010). The authors explain spontaneity by emphasizing that therapy does not follow a predetermined script. Therapeutic interpretations reflect the client's experience and, as such, cannot be preformulated. The therapeutic relationship, which is not fixed in advance but takes shape through the connection between therapist and client, is inherently subject to therapeutic errors or mis-attunements. Yet, it is precisely these therapeutic errors that open the possibility for a reorganization of the relationship, enabling new ways of relating between therapist and client (Stern et al., 2010). The natural human drive toward connection fosters change and development. Drawing on dynamic systems theory, the authors underscore that the therapeutic relationship is shaped by reciprocal interpersonal influence. Both therapist and client affect one another, often

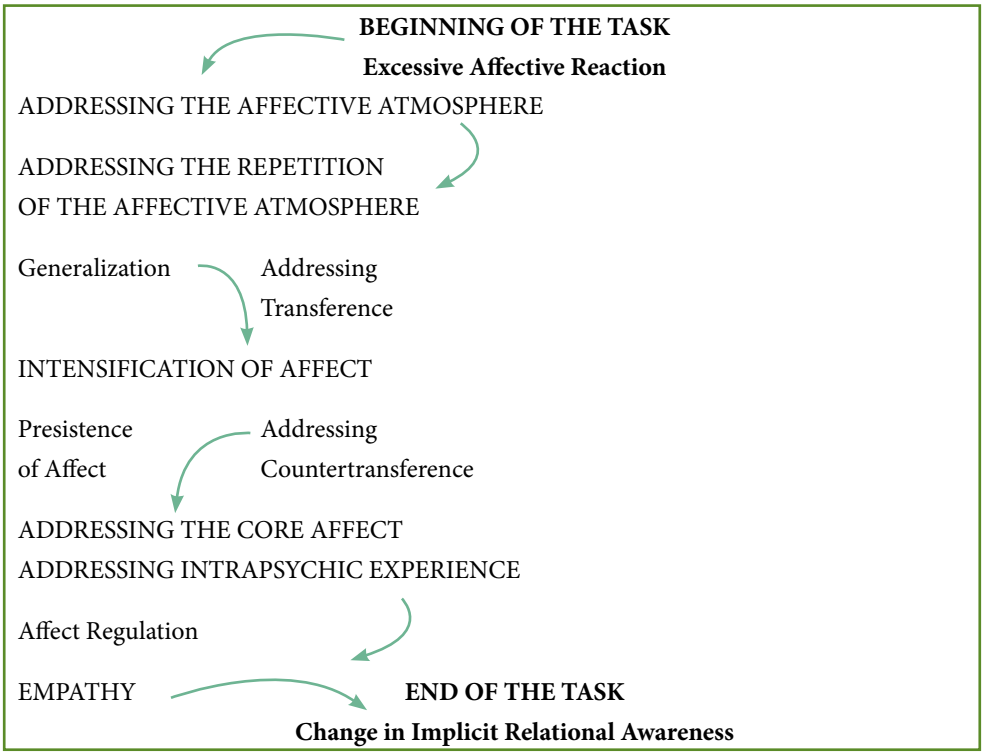
evoking deep psychological content in each other. These responses are not merely reflections of the present interaction but also expressions of inner psychological experience. Through therapeutic errors – or the reenactment of deep psychological experiences within the therapeutic relationship – and the therapist's capacity to attune to repeated relational perceptions, new responses, insights, and changes can emerge.

The process of change in therapy unfolds within the therapeutic relationship, where the client – through the repetition of familiar emotional atmospheres and perceptions of the other – is given the opportunity to reinterpret internal experience. Therapeutic change is facilitated by bringing into awareness core affective states that define relational patterns, the regulation of affect that shapes how distress is processed, and affective-psychological constructs that serve as defenses against psychic pain and maintain symptomatic states. Change in therapy thus entails the transformation of internal psychic structures through their reenactment within the therapeutic relationship and the internalization of a new relational experience – one that enables more functional modes of self-awareness and perception of the other (Gostečnik, 2022; Schore, 2012; Stern et al., 2010).

5.2 A Map of Therapeutic Interventions

Research into the transformation of implicit relational awareness in family therapy (Poljak Lukek, 2011, 2015, 2016, 2021b) has resulted in the development of a map of therapeutic interventions that can be traced throughout the therapeutic process – from the emergence of heightened affective intensity to the moment of change.

Map of Therapeutic Interventions (Poljak Lukek, 2011, p. 213):



The beginning of therapeutic work within the process of change is typically marked by the reactivation of a familiar emotional atmosphere in the present moment. This known affective climate may resurface within significant current relationships, shaped by the client, or within the therapeutic relationship itself, where emotional exposure can evoke feelings of threat, thus activating deeply ingrained defensive mechanisms or affective psychic constructs. The aim of therapeutic change is to foster awareness and transformation of these affective psychic constructs (Gostečnik, 2015), or, in other words, to facilitate a shift in implicit relational awareness (Stern et al., 2010). This recurrence of affective experience is observed in a client's excessive emotional reaction to current relational contexts (e.g., family relationships or the therapeutic relationship). When the individual feels unable to influence the emotional atmosphere in the present, and experiences frustration and helplessness, we speak of an

excessive affective reaction. A specific memory or experience triggered in the present may be perceived as threatening, reactivating psychic pain that the client attempts to defend against through affective constructs. These constructs both protect against re-exposure to pain and simultaneously shape present-day relationships. Thus, the protective function against vulnerability gives rise to excessive affective responses. Intimate family relationships – and the therapeutic relationship itself – provide a context where such reactivations of vulnerability and the psychic content associated with it are likely to occur.

The beginning of therapeutic work is thus characterized by the reappearance of a familiar affective atmosphere for the client, expressed through an excessive emotional reaction (such as intense emotion or feelings of helplessness, distress, or despair) to a current situation within the family or as a result of the therapeutic relationship.

Therapeutic interventions following the client's excessive affective reaction aim to identify compulsively repeated experiential patterns and to understand how these recurrences shape present relationships (Gostečnik, 2017; Poljak Lukek, 2021b). The re-enactment of familiar patterns within the therapeutic relationship, along with the internalization of a new relational experience, can lead to changes in intrapsychic structures. These changes allow for more functional modes of self-awareness and interpersonal perception (Poljak Lukek, 2015, 2016). Thus, therapeutic interventions at this stage offer the client the possibility of recognizing, evaluating, and transforming established patterns. The foundation of these interventions is affective attunement (Finlay, 2016), which refers to the therapist's ability to identify, verbalize, and evaluate the client's emotional responses and to offer an experience of effective affect regulation.

At the beginning of the task – that is, upon the reactivation of the familiar affective climate – the therapist addresses the affect and initiates its transformation by helping to distinguish between the current situation and the repeated emotional experience (Poljak Lukek, 2011). This transformation of the client's experience offers a new perspective on the distress they are

currently undergoing. The therapist asks about the client's emotions, thoughts, and behaviors in the present context, attempting to co-create a clearer understanding of the recurring affective state and foster affective attunement. The aim of transforming the affect is to introduce a differentiation in subjective experience, which allows the client to shift from a sense of threat to a sense of control over their current affective states.

Through the generalization of the affective climate, the therapist identifies recurring emotional patterns in the client's relationships (Poljak Lukek, 2011). The therapist explores interpersonal contexts where the same affective climate repeats, in order to evaluate compulsive repetitions that the client cannot presently control. This repetition may also occur within the therapeutic relationship. In such cases, the therapist's intervention involves addressing transference feelings, understood as repetitions of early, unarticulated experiences (Lemma, 2003). The generalized affective atmosphere thus reflects the client's internal experience and marks all present-day relationships. When this nonverbalized affective atmosphere becomes generalized to the therapeutic relationship, the therapist can address the transference by exploring what the client experiences in the therapist's presence. Addressing transference feelings is also a step toward deepening affective attunement between the client and the therapist (McCluskey & O'Toole, 2020).

After addressing the affective atmosphere and its repetitions, it is crucial for the therapeutic process to persist within the affective state. The therapist supports this by evaluating the emotional state, thereby intensifying the affect and allowing the client to establish deeper links with intrapsychic experiences. This intensification also entails that the therapist remains present with their own countertransference reactions, which provide valuable insight into the implicit communication and projection mechanisms at play – experienced by the therapist as emotional responses evoked by the client (Lemma, 2003). The therapist then communicates these countertransference feelings in a processed and meaningful way, helping the client understand how such projections serve to maintain the affective atmosphere.

Transformation, generalization, and intensification of affective states represent a critical evaluation of compulsive repetitions and the ways in which affective constructs enable the client to maintain familiar experiential modes that now contribute to their distress and helplessness. Through the recognition of these repetitions, therapy creates the opportunity to address the core affect – the primary emotional state that the client, due to past experiences, has not learned to regulate effectively and thus seeks to defend against (Schore, 2001). The therapeutic setting offers the possibility of experiencing effective regulation of this core affect. At this stage, the therapist's interventions are directed toward the client's intrapsychic experience. The therapist asks questions that link present experience to memories of the client's emotional life as a child within their family of origin. The unmanageable affect experienced in the present is connected to the helplessness the client felt as a child with their caregivers. By showing compassion toward the inner experience of the helpless child, the therapist implicitly supports the client's current emotional experience and offers a new experience of affect regulation (Poljak Lukek, 2021b). The therapist inquires into what the client experienced as a child and how they had to protect themselves from psychological pain.

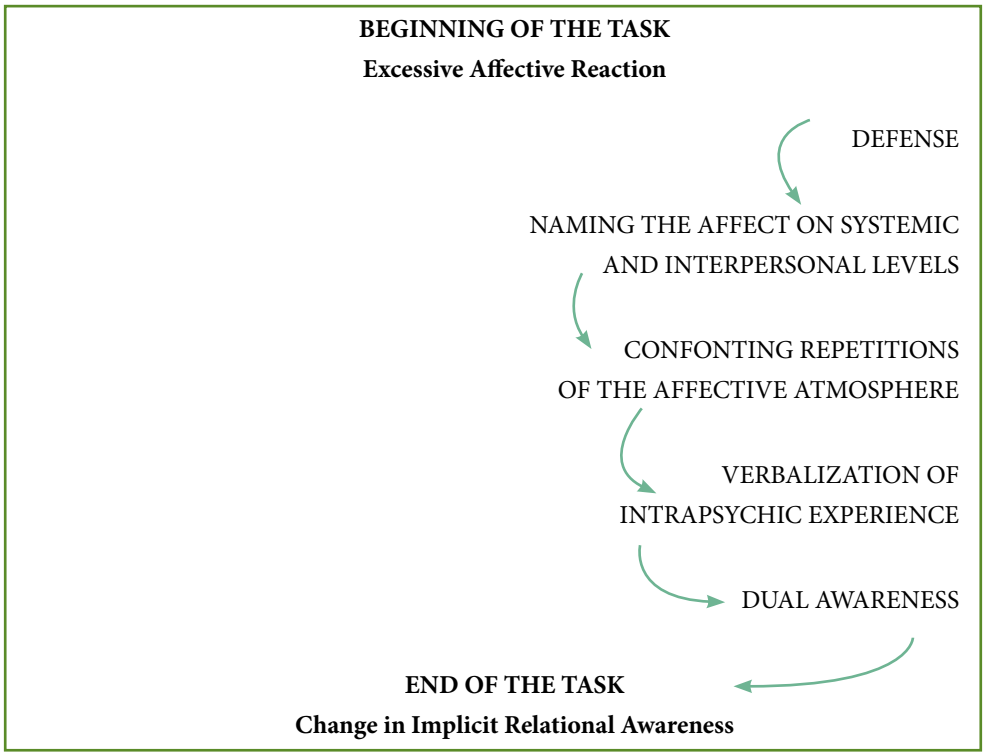
Raising awareness of affect at the intrapsychic level through an understanding of past experiences makes it possible to continue the process of connecting past experiences with present emotional states (Poljak Lukek, 2011). The therapist continues by guiding the client to confront the repetition of emotional states from early relationships with parents as they manifest in current relationships. The therapist helps identify connections that the client can recognize as recurrences. The goal is to raise awareness of how the emotions of the helpless child are repeated in the present and to identify constructs that originated from past psychological pain but now trigger distress and helplessness. Through these confrontational interventions, the therapist offers the client a new way of understanding their emotional, behavioral, and cognitive functioning in the present.

In the final phase, therapeutic interventions aim at setting compassionate boundaries between past experiences and present emotional life. The affective attunement cultivated throughout the process of working through emotional states enables the therapist to offer a compassionate understanding of the client's distress. This, in turn, provides a foundation for new experiences and a transformation of implicit relational awareness (Finlay, 2016; Poljak Lukek, 2016).

5.3 A Map of the Client's Process

Research on the transformation of implicit relational awareness in family therapy (Poljak Lukek, 2011, 2015, 2016, 2021b) has led to the development of a map of the client's therapeutic process, which can be followed from the moment an excessive affective atmosphere emerges to the moment of change.

Map of the Client's Process (Poljak Lukek, 2011, p. 220)



In parallel with the therapist's interventions, the client's internal process of change can also be observed. The recurrence of an affective atmosphere in the client is understood as a renewed attempt to resolve distress. In the initial phase, this repetition of affective experience activates psychological defense mechanisms or affective constructs that serve to protect the client from re-experiencing psychic pain (Poljak Lukek, 2011). These defensive reactions are a natural human response to the perceived threat of repeated relational injury. The client may experience guilt, helplessness, confusion, grandiosity, obsessive thoughts, feelings of worthlessness, or other disruptive emotional states that hinder contact and evoke distress that feels unmanageable in the present. These affective constructs or defense mechanisms initially provide a false sense of safety, as they enable avoidance of core traumatic experiences and protect the individual from painful encounters with rejection, neglect, or displacement (Ambresin et al., 2007; Gostečnik, 2015). However, in relational contexts, they lead to disconnection and distress, for which the individual feels unequipped.

The process of change begins when the client is able to face the recurring patterns of affective atmosphere in present relationships (Poljak Lukek, 2011). By verbalizing the distress, the client gains the opportunity to reflect on how they experience themselves in current relationships, how they perceive others, and how they believe others perceive them. These reflections shape emotional, behavioral, and cognitive responses in relationships, often eliciting further distress and feelings of helplessness. Awareness thus involves understanding how familiar affective atmospheres are re-enacted in present relational dynamics. By becoming aware of affective responses and emotional patterns, the client can recognize the repetitive dynamics they co-create in relationships (whether family or therapeutic) and identify how these patterns are sustained. With guidance, the client begins to explore which affective construct prevents their emotional response from leading to greater relational connection rather than to distress and disconnection.

The therapist's attuned presence in moments of distress offers the client a new experience: that these intense emotions can be held and contained. This containment enables deeper exploration of the sources of psychic pain. It is essential that the client feels affirmed in their subjective experience by the therapist. When they come to experience their own emotions – including transferential reactions – as manageable within the therapeutic relationship, they become more open to vulnerability and to confronting the most painful internal content.

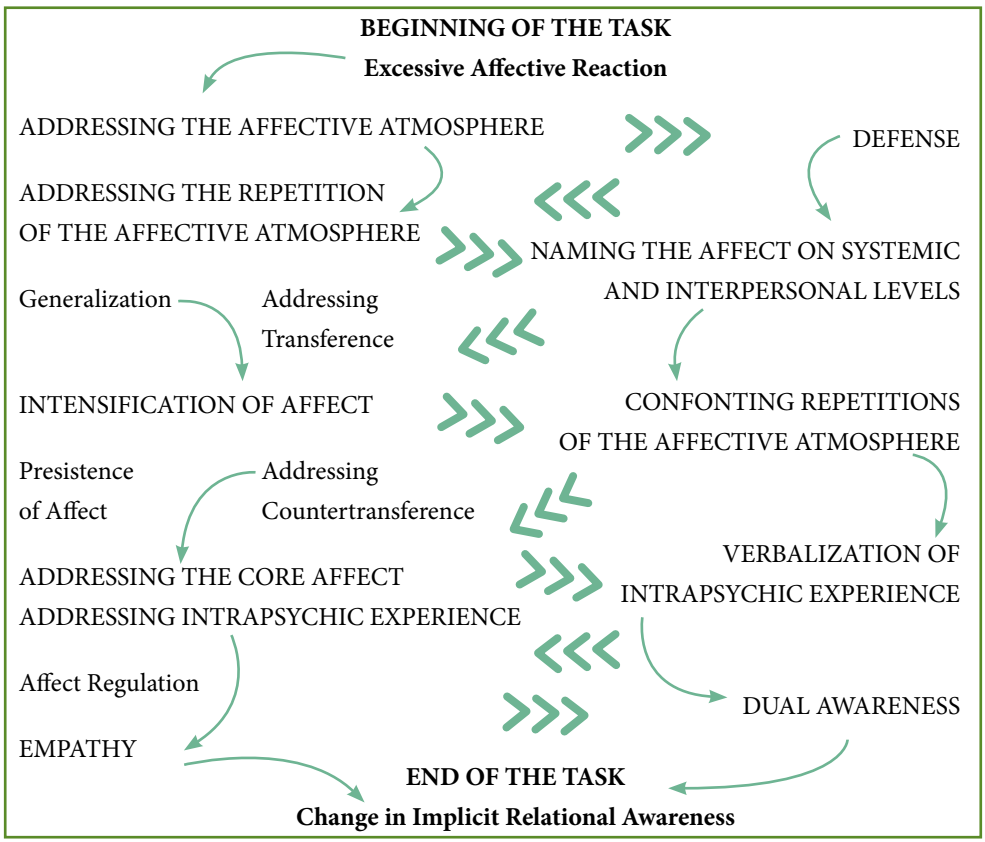
When the client implicitly experiences affective attunement with the therapist, they are emotionally able to allow the change process to continue. Affective attunement enables a shift toward reflecting on intrapsychic experience, as the sense of relational contact facilitates movement through the psychological defenses or constructs that had previously protected against psychic pain (Finlay, 2016). In the next phase of therapy, the client begins to evoke memories of early relationships with the mother and father, through which they develop compassion toward the self (Poljak Lukek, 2011). This self-compassion emerges from understanding the experience of the helpless child that still marks the intrapsychic world. Insight at the intrapsychic level allows the client to connect this experience with relational and systemic levels (Gostečnik, 2015). Through the experience of self-compassion, the client comes to a new, implicit understanding of themselves in relationships. They begin to interpret the reactions of others differently and experience new ways of perceiving how others experience them. This shift enables them to distinguish between current relationships and the affective atmosphere shaped by past relational trauma. This differentiation restores a sense of control over the present situation, reducing distress and feelings of helplessness. The client thereby achieves what is known as dual awareness – the capacity to recognize the affective atmosphere present in current relationships as being triggered by psychic pain rooted in significant past experiences.

5.4 Reciprocity Between Therapist and Client

The therapist's process and the client's process unfold reciprocally, as both respond to each other's movements. The therapeutic space is a creative interpersonal field, co-constructed by therapist and client (Gostečnik, 2015; Stern et al., 2010), which enables transformation in the client's and therapist's experience. The therapist's interventions at various steps of the therapeutic process correspond to distinct stages in the client's process. When the therapist addresses the affective atmosphere, it may trigger the client's defenses and reinforce affective psychological constructs that serve to protect against vulnerability. By experimenting with new forms of inquiry and evaluation, a space emerges in which affective expression becomes safe for the client, allowing progression to the next phase of the process. At this point, the therapist begins to address the repetition of affective atmospheres, which may again elicit defensive psychological reactions in the client. Through the experience of affect regulation within the therapeutic relationship, the client becomes capable of verbalizing affect and engaging with repetitive relational patterns. This engagement is further supported by the therapist's persistence with affect and attention to both transference and countertransference dynamics as they unfold in the therapeutic process. Such transference and countertransference interventions often evoke defensive behavior in the client. As the therapist continues to reflect and evaluate, the client progresses to the next stages of the process. When therapeutic interventions shift toward the intrapsychic experience – accompanied by a softening of defenses – the client becomes capable of articulating and becoming aware of their internal psychic states. This marks the emergence of affective self-regulation, which lies at the heart of implicit relational awareness. Awareness of intrapsychic experience, coupled with the therapist's interventions that offer understanding and compassion, enables the client to develop dual awareness of their emotional functioning.

The completion of the task is marked by the capacity of both client and therapist to attune to the affective atmosphere that has emerged. This includes the ability to recognize, evaluate, and dismantle defenses (i.e., affective psychological constructs) within relational contexts. The therapist's sustained presence with affect, despite recurring defenses, allows the client to experience the relationship in a new way – transforming the implicit relational awareness that shapes their relationships. This process is sustained by responsive attunement between therapist and client, characterized by active interaction and dialog in which the therapist is open, present, sensitive, accessible, and positively responsive (Watson & Wiseman, 2021)

Reciprocity of the Therapeutic Process and the Client's Process (Poljak Lukek, 2011, p. 223)



5.5 Domains of Integration in the Process of Maintaining Change in Family Therapy

Psychological integration refers to the formation of a sense of wholeness across multiple levels of experience – behavioral, intrapsychic, relational, mental, and spiritual (Finlay, 2016). Daniel Siegel (2020) defines nine domains of integration, which provide a framework for understanding how maintained change occurs within the individual and consequently influences relationships and the broader family system. The integration of each domain describes how initially differentiated elements of experience can become interconnected and coherently organized (Siegel, 2020).

The Nine Domains of Integration (Siegel, 2020):

- **Integration of Consciousness**

This domain refers to the integration of sensory perception (through the five senses), bodily awareness, awareness of internal psychological processes, and awareness of one's connectedness with others. It involves the differentiated perception of these components and the capacity to bring them together into a coherent conscious experience.

- **Bilateral Integration**

This involves linking the functions of the left and right hemispheres of the brain. Bilateral integration allows individuals to access both logical, linear thinking (left hemisphere) and imaginative, metaphorical, and symbolic processes (right hemisphere), and to integrate these differentiated modes of processing into a coherent whole.

- **Vertical Integration**

While bilateral integration connects left and right, vertical integration connects the brain to the rest of the body. It includes subcortical activity and the conscious attunement to information flowing from the body, brainstem, and limbic system into cortical awareness. This domain fosters embodiment and awareness of bodily-based emotional experiences.

- **Memory Integration**

Memory integration refers to the linking of differentiated implicit memory with explicit, declarative memory. This integration enables more conscious and intentional recall of experience and can help transform traumatic memory into opportunities for post-traumatic growth.

- **Narrative Integration**

As narrative beings, humans are naturally inclined to construct stories that make sense of life events. Narrative integration involves the creation of coherent life stories, linking cause and effect, logic, and meaning-making, thereby helping individuals to organize and understand their lived experience.

- **State Integration**

Internal states – modes of being that define how we perceive, feel, and act – shape our personality and identity. Individuals experience different mental states that reflect diverse needs: comfort, novelty, connection, mastery, and exploration. State integration involves differentiating and linking these mental states over time to develop a flexible and coherent sense of self.

- **Interpersonal Integration**

This domain refers to the movement from a sense of »I« to a sense of »we.« Interpersonal integration fosters empathy, mutual recognition, and the capacity for authentic relational connectedness.

- **Temporal Integration**

Temporal integration addresses our awareness of time and mortality. It involves differentiating our desire for certainty, permanence, and immortality from the lived reality of impermanence and death. By integrating these experiences, individuals can live with greater existential awareness and acceptance.

- **Transpirational Integration**

Described as the »integration of integration,« this domain entails a sense of belonging to something greater than oneself. It surpasses bodily wholeness

(as in vertical integration) or relational belonging (as in interpersonal integration) and touches upon spiritual or transpersonal connection to a larger whole – be it nature, the cosmos, or a transcendent reality.

The nine domains of integration – namely, integration of consciousness, bilateral integration, vertical integration, memory integration, narrative integration, state integration, interpersonal integration, temporal integration, and transpirational integration – will be employed here as conceptual frameworks for understanding how therapeutic change can be maintained over time.

Integration of Consciousness enables individuals to cultivate awareness and, more specifically, the capacity to direct focused attention intentionally. A core capacity developed through this process is mindfulness – a state of consciousness characterized by paying attention in a particular way: deliberately, in the present moment, and non-judgmentally (Ludwig & Kabat-Zinn, 2008). The psychotherapeutic process naturally fosters this kind of awareness, as clients are repeatedly invited through various interventions to reflect on themselves, their emotions, and to develop a reflective mode of thinking. Moreover, focused attention contributes to a more integrated perception of both the physical and social environment, and enhances decision-making and anticipatory skills (Shonin & Van Gordon, 2016). Such directed attention facilitates differentiation in conscious awareness and thus enables integration of consciousness – that is, the ability to consciously attend to specific aspects of one's experience. This integration strengthens self-regulation and emotional modulation, improves stress reactivity, and enhances social skills (Siegel, 2020). In therapeutic contexts, sustained attention to the present moment supports maintenance of change by enabling clients to repeatedly access more functional modes of experience, emotion, and behavior. Furthermore, integration of consciousness heightens empathy and interpersonal sensitivity, as attending to one's own internal states activates the fundamental processes of empathic resonance and responsiveness

(Kohut, 1984). New experiences of focused awareness within the therapeutic relationship contribute to the formation of new synaptic connections in the brain, altering neural functioning and thus facilitating durable transformation in perception and behavior (Schore, 2019).

Bilateral Integration, or the integration of the brain's left and right hemispheres, reflects a person's capacity for more complex and adaptive modes of experience. While hemispheric integration typically occurs naturally over the course of development, in some cases this process may be compromised, leading to fragmented functioning and a failure to develop the differentiated and cooperative activity of both hemispheres (Siegel, 2020). For instance, a predominantly right-hemispheric mode of experience is often observed in individuals with autistic traits, whereas a left-hemispheric orientation may characterize those with avoidant attachment styles. Integrated functioning requires the ability to hold together vulnerability and reason, or, put differently, to be both emotional and rational. In psychotherapy, left-hemispheric functions are supported through exploration of meaning and self-understanding, while right-hemispheric functions are fostered through the development of an empathic and authentic therapeutic relationship. The search for meaning is essential in processing traumatic experiences, as it enables insight and resolution (Levine, 2015). Rational understanding of one's experiences, relationships, and sense of self facilitates new modes of experiencing, thereby supporting lasting change. This is especially critical in trauma work, where affective understanding should be integrated with meaning-making. Linking emotional and cognitive processing deepens comprehension and enables transformation of one's lived experience. The therapeutic relationship provides a context for bilateral communication between therapist and client (Schore, 2019), which not only reshapes cognitive interpretations but also alters affective responses. Bilateral integration thus contributes to the enduring consolidation of new ways of experiencing both self and others.

Vertical Integration involves the development of the »embodied brain,« meaning that awareness becomes attuned to somatic experiences. Disruptions in vertical integration are often associated with early childhood trauma (Mate, 2010) or experiences that interrupted the flow of energy and information throughout the body (Levine, 2015). The ability to perceive bodily sensations – particularly when processing early relational trauma – enhances vertical integration, allowing the individual to become aware of embodied feelings and to generate more appropriate responses to them. In the therapeutic relationship, vertical integration is supported through the working-through of transferential feelings. Transference represents the projection of emotionally charged experiences from earlier developmental stages onto current relationships with significant others (McCluskey & O'Toole, 2020). Addressing such transferential material allows for the re-evaluation of the early experiences that disrupted vertical integration. By making these experiences conscious, the individual can discern their meaning, assess their significance, and recognize their present-day bodily correlates. This process facilitates the linking of conscious awareness with somatic experience, thereby strengthening vertical integration. As a result, individuals gain greater awareness and control over their embodied emotional states.

Memory Integration helps clarify and resolve the somatic residues of traumatic past events. By integrating memory, implicit relational perceptions – crucial for personality change – are transformed. Through embodied experiences within the interpersonal space of the therapeutic dyad, including affective attunement and novel relational engagement, individuals reformulate their implicit sense of self, others, and relationships (Stern et al., 2010). This process fosters integration between implicit and explicit memory systems. During periods of vulnerability and post-stress recovery, both consciousness and the body are especially receptive to new implicit and explicit experiences. In the safety of the therapeutic relationship, clients encounter new experiences of emotional regulation, novel responses to distress, new relational strategies, and enhanced safety. These reparative relational experiences reshape early regulatory models,

recalibrate autonomic nervous system responses (Schore, 2001), and forge new integrations between consciousness, brain, and body (Siegel & Solomon, 2013), ultimately strengthening memory integration (Siegel, 2020).

Narrative Integration, or the capacity to reflect upon traumatic events, is a key factor in achieving personal growth and relational transformation (Basham & Miehls, 2004). Through reflective storytelling, individuals link cognitive beliefs with embodied, implicit experiences in the present moment. This leads to memory re-integration and allows individuals to process and reinterpret their experiences in a new light. Storytelling enhances memory integration and transforms psychological rigidity or chaos – often seen as barriers to mental health – into greater experiential flexibility. Additionally, reflecting on personal narratives facilitates the development of *dual awareness*, allowing individuals to distinguish between past and present emotional states, to separate their own feelings from those of others, and to take responsibility and ownership of their emotional lives (Poljak Lukek, 2011).

State Integration refers to the capacity to meet one's needs in meaningful ways and to construct coherence among various internal experiences. Shifts in perception and awareness of relational needs foster further integration of internal states or postures. During recovery, individuals may connect for the first time – or reconnect – with basic relational needs: the need for safety, affirmation of personal significance, acceptance by a stable and protective figure, validation of personal experiences, self-awareness, impact on others, initiative from others, and the ability to express love (Erskine et al., 1999). As individuals come to feel seen, accepted, affirmed, and loved – and as they experience their ability to positively influence others and take initiative – they gradually differentiate new internal states and integrate them into a transformed self-concept. This new internal coherence supports the release of dysfunctional patterns of thinking, feeling, and behavior.

Interpersonal Integration can be described as the adult's capacity to express autonomy within relationships – to maintain both individuality and relational

connectedness. Impaired interpersonal integration may manifest as either an excessive need for autonomy or an overdependence on relationships. In the former, individuals struggle with intimacy; in the latter, they sacrifice their authentic selves in favor of others' expectations. Thus, psychological maturity involves not only the development of autonomy and self-other differentiation but also the manner in which one connects with others through one's autonomy (Poljak Lukek, 2017). Relational paradigms underscore the centrality of integration within relationships, where individuals grow through insight, reflection, and new relational experiences (Finlay, 2016). The capacity to form and maintain relationships promotes psychological stability, connection, and harmony.

Temporal Integration entails an awareness of time and transience. It is closely linked to the exploration of existential questions and the development of spirituality. Through therapy, clients often deepen their sense of life's meaning and cultivate existential well-being. In doing so, they integrate their established beliefs with the uncertainty inherent in the human experience. A key component of spiritual integration is the process of forgiveness, which, particularly in addiction recovery, enables individuals to transcend unresolved experiences and relationships (Webb et al., 2011). In this sense, spiritual coping allows individuals to confront life's impermanence and the organizing force of time, redirecting their focus to deeper questions of life's purpose that transcend temporal reality. A shift in how time is experienced leads to lasting transformation across all dimensions of life and existence.

Transpirational Integration fosters a sense of connection with a greater whole – beyond one's immediate life – which replaces earlier experiences of isolation from others and even from oneself.

Case Example from the Therapy Room

The levels of integration will be illustrated using the case of addiction recovery. The therapeutic process involved Bogdan (36) and Erika (35). Bogdan had been addicted to cocaine. One year prior, he had successfully

completed outpatient treatment at the Center for Treatment of Illicit Drug Addiction at the University Psychiatric Clinic in Ljubljana. The couple entered therapy due to difficulties in their relationship.

1. **Integration of Consciousness**

   The therapist encouraged Bogdan to focus on his bodily sensations and emotional states and to verbalize and describe them as precisely as possible. Over time, Bogdan developed skills to attend to his internal bodily experiences and emotional responses. This focus on present-moment awareness helped him more effectively regulate stress, respond more adaptively to emotional arousal (including substance cravings), and make more deliberate decisions.

2. **Bilateral Integration**

   Bogdan predominantly operated from a »left-hemisphere« mode – avoiding emotional closeness and vulnerability, which he found difficult to manage. The therapist guided him toward greater awareness and tolerance of his emotional experiences. His self-disclosure through narratives about his past supported the regulation of emotional vulnerability in his current relationships. Integrating emotional experience with meaning helped Bogdan make more reasoned decisions. A pivotal moment involved the regulation of shame related to his father's addiction. As Bogdan shared stories and accessed feelings of shame, he created a space of vulnerability that allowed the therapist to introduce a new relational experience – one in which he was accepted, understood, and valued, despite his past. This experience showed that relationships need not be ruptured by painful feelings. His self-disclosure thus became a pathway to new emotional experiences and the capacity to be both vulnerable and discerning in the present.

3. **Vertical Integration**

   Linking addictive behavior with childhood trauma led to the therapeutic processing of early adverse experiences. Bogdan recalled how his father, due to alcoholism, was violent toward his mother. He also remembered the

stigma and social exposure he experienced as a child due to his parents' behavior – feeling as though everyone was pointing fingers at him, and that their family was seen as »different« in their neighborhood. Working through these experiences, particularly the sense of exposure he felt at school and among peers, enabled Bogdan to understand their impact and, crucially, to develop more adaptive shame regulation in present relationships.

4. **Memory Integration**

   As trust in the therapist deepened, opportunities arose to integrate implicit and explicit memory. Bogdan began to share more of his personal history, and the therapist used affect regulation to introduce new relational experiences into those narratives. Shame had previously prevented him from speaking about many events in his family. Even Erika had been unaware of much of his past. As Bogdan's ability to regulate shame improved, so too did his capacity for remembering and thus for memory integration. His growing vulnerability also made him more receptive to new implicit experiences. Over time, he reshaped his implicit relational awareness: no longer seeing himself as unworthy, others as threatening, and relationships as spaces of exposure and humiliation.

5. **Narrative Integration**

   Through the process of remembering, Bogdan began to bring coherence and understanding to previously chaotic memories. A critical developmental step was internalizing dual awareness: understanding and feeling that painful emotions originated in the past and are merely reactivated in the present, where he now has more control over them than he did as a child.

6. **State Integration**

   Developing new ways of meeting emotional and relational needs is essential for maintaining abstinence. The capacity to regulate one's mind in meeting those needs is central. The therapist encouraged Bogdan to focus particularly on how these needs could be fulfilled within his relationship with Erika. He explored ways of experiencing pleasure, challenge, connection, initiative,

and calm within the relationship – an essential shift from substance-centered gratification to relationally grounded satisfaction.

7. **Interpersonal Integration**
   Seeking satisfaction in relationships turns attention outward. A constant relational focus in therapy was critical for Bogdan to include Erika in his recovery. He learned to allow her to support him – even when he stumbled – and to apologize for his past actions. Bogdan also joined an AA group, which helped him establish new, more functional relationships. He reconnected with his siblings, whose support proved vital to his recovery. Their pride in his progress gave him powerful motivation to stay on course.
8. **Temporal Integration**
   Therapy also opened space for existential questions that Bogdan sought to answer. He and Erika enjoyed engaging in conversations about the meaning of life and other existential topics. These discussions were invigorating for both, and the therapist actively encouraged and supported their joint reflections. They also engaged in a therapeutic process of forgiveness – Bogdan forgave himself for his descent into addiction, and Erika forgave him for the harms he had caused during that time.
9. **Transpirational Integration**
   Occasionally, moments of peace and tranquility would emerge in the therapy sessions.

Integration across these nine domains enables the development of a harmonious mode of experiencing, characterized by the individual's capacity to transform patterns of chaos or rigidity into flexible, adaptive, coherent, energetic, and stable patterns of experience and behavior (Siegel, 2020). These integrative changes support the attainment of mental health, a sense of harmony, and emotional and spiritual stability. In this context, change is understood as the individual's movement toward more integrated and harmonious information processing.

6

Termination in Family Therapy

Termination is a fundamental component of the therapeutic process. It offers an opportunity to evaluate the entire course of therapy, reinforce the client's self-confidence, restructure implicit experiences of separation, provide a meaningful experience of closure, and assess the therapist's professional conduct. Termination in therapy is not a singular event but a process (Patterson et al., 2009), which requires special attention. Moreover, the way in which therapy is terminated reflects the client's level of psychological stability and serves as a strong indicator of therapeutic progress (Lemma, 2003).

Recommendations for ensuring Effective Termination of the Therapeutic Process (Vasquez et al., 2008):

- At the outset of therapy, inform clients about the structure of the therapeutic process, including the termination phase;
- Establish mutual agreement on therapy goals and the anticipated process of termination;
- Provide regular evaluations throughout therapy and ensure at least one final termination session;
- Develop a contingency plan in case of sudden events that prevent the therapist from continuing the work (e.g., death, incapacity);
- Assist the client in creating a plan for the post-therapy period;

- Be aware of the psychological consequences of termination for the client;
- Create a professional will that outlines who will take over your practice in the event of death or disability;
- Reach out to clients who terminate prematurely;
- Adhere to ethical guidelines in your professional practice (e.g., the Code of Ethics of the Slovenian Association for Marital and Family Therapy) to guide termination practices;
- Familiarize yourself with other international ethical standards that address termination;
- Incorporate termination practices into your professional training and ongoing development;
- Evaluate your own termination practices.

6.1 Termination as a Mutual Agreement between Client and Therapist

Research shows that the most common reasons for terminating therapy include the achievement of therapeutic goals or dissatisfaction with the therapeutic process. However, other significant factors can also play a role, such as a client's increasing desire for autonomy or the development of an important intimate relationship during the course of therapy (Roe et al., 2006). Family therapy is typically structured as a time-limited process, with a predetermined end date agreed upon at the outset. Clients give informed consent regarding the planned duration, although the process may be extended at the therapist's discretion or upon client request. When the termination date is known from the beginning, the termination process in fact begins in the initial phases of therapy (Finlay, 2016). Throughout the therapy, the therapist should remain attentive to themes related to termination as they emerge and guide the process in a way that supports a collaborative ending. Nevertheless,

achieving full consensus about when and how to end therapy can be challenging. Ideally, termination occurs with mutual agreement and offers an opportunity to evaluate therapeutic outcomes beyond the therapeutic setting.

According to Patterson et al. (2009), the therapist should pursue the following key goals during termination: (1) Support the client in evaluating the benefits of therapy; (2) Empower the client with confidence in their ability to cope with future challenges independently; (3) Address the experience of separation as a central theme of the termination process with sensitivity and care.

A core emotional task during termination is managing the process of saying goodbye and the associated experience of grief. The therapist should help the client navigate through the stages of grief – denial, anger, sadness, fear/anxiety, and ultimately acceptance (Finlay, 2016). Clients may also attempt to negotiate or delay the ending of therapy as a natural response to impending separation. The therapist should raise awareness of these reactions, interpret them within the transference and countertransference dynamic, and normalize them as valid responses to loss (Schlesinger, 2014). Special attention should be paid to the client's previous experiences with separation and loss in order to anticipate the emotional responses that the termination might evoke and to address these reactions explicitly. Termination should be gradual and supported by strategies that help regulate sadness, anger, and anxiety. In doing so, the therapist provides the client with a new, reparative experience of separation – one that supports mental health and maintains therapeutic gains. The therapist's task is to facilitate the client's internalization of the therapeutic relationship and enhance their capacity for ongoing self-reflection. This is only possible if the client can accept the end of the therapeutic relationship and come to terms with its emotional consequences (Lemma, 2003). The ability to regulate the distress associated with separation is rooted in early attachment experiences, especially in the capacity to delay the gratification of needs. For clients with unmet early needs, the passage of time does not bring calm but rather intensifies anxiety and insecurity. In contrast,

clients with a history of secure attachment are more likely to experience the time of separation as manageable and tolerable. Thus, termination can evoke foundational experiences of need satisfaction. Regardless of how successful therapy has been, the process of termination may trigger anxiety that the client should face anew. The therapist plays a critical role in helping regulate this experience and fostering a sense of self-efficacy during the period of separation.

Termination also frequently evokes feelings of gratitude (Lemma, 2003), to which the therapist should respond appropriately. The expression of gratitude is one of the core relational needs (Erskine, 2011), and the therapeutic setting should make space for it during the termination phase. In therapy, gratitude reflects a recognition of the significance of the other, coupled with an awareness of autonomy and separation. The client's ability to express gratitude is an indication that the therapeutic relationship has left a meaningful imprint on their emotional experience.

6.2 Therapist-Initiated Termination

Termination of therapy at the initiative of the therapist is a particularly sensitive matter for the client. The reasons for such termination can vary widely – from highly personal to more objective factors related to the structure of the therapeutic process. In either case, the therapist should ensure a proper and ethically sound termination process and guide the client toward the support they need.

Whenever possible, the therapist should arrange for a final session, which may include the following elements (Vasquez et al., 2008):

- A clear statement regarding the termination of the therapeutic process and mutual agreement about the final session,
- A review of the therapeutic goals that have been achieved,

- Consideration of the possibility of symptom recurrence and discussion of strategies for coping,
- Identification of goals that the client may still need to work on, either independently or within another therapeutic process,
- Referral to another therapist, if the client requires or requests such support.

A key issue that should be addressed in this context is the feeling of abandonment. The client should be able to regulate feelings of envy and personal significance without devaluing the therapeutic process itself (Lemma, 2003). Depending on their personal history, the client may perceive the end of therapy as a diminishment of their own worth. In confronting this painful emotion, they may resort to defense mechanisms such as rationalization or devaluation. The therapist, therefore, should offer a space and opportunity to help regulate these emotional responses.

From the Therapy Room

Due to the unexpected and sudden death of a family member, the therapist was required to temporarily suspend all therapy sessions. She informed her clients via email, as there was no possibility of meeting with them in person. In her message, she communicated clearly and concisely that the interruption of therapy was solely related to her current family situation and in no way connected to the clients themselves. She explained that she would be unresponsive to messages and phone calls for a period of time. She also arranged for a colleague to be available should any of her clients require support and shared that colleague's contact information with them. She noted that she would reach out in a month to provide information regarding the potential continuation of therapy.

After one month, and in consultation with her supervisor, the therapist decided to resume her therapeutic work. All clients responded positively, resumed their sessions, and for most, the interruption became an

opportunity to realize their own capacities for resilience. In many cases, their concern for the therapist deepened the therapeutic alliance. From the first session upon resuming therapy, the therapist ensured that the focus was redirected toward the clients. Nonetheless, the fact that clients had been present in her life during such a vulnerable and difficult period left a distinct and meaningful imprint on her relationship with them.

6.3 Client-Initiated Termination

Clients may terminate the therapeutic process for a wide variety of reasons – including a perceived lack of purpose in continuing therapy, loss of motivation, financial constraints, dissatisfaction with the therapeutic process, feelings of being misunderstood, or external factors that hinder further participation (Patterson et al., 2009). Whereas therapist-initiated termination is typically a planned and negotiated process, client-initiated termination may occur quite abruptly, without prior notice or discussion. When a client simply does not appear for a scheduled session, the therapist is confronted with multiple ethical dilemmas and complex countertransference reactions. In such instances, the therapist may attempt to reach out to the client to schedule a final session, though this is not always feasible.

When a final meeting is not possible, it is considered best practice for the therapist to send a written communication to the client, which should include (Vasquez et al., 2008):

- an assessment of the client's needs (i.e., the therapist's view of therapeutic goals that remain unmet, based on the most recent sessions),
- an invitation to resume therapy in the future, should the client desire,
- recommendations for next steps (e.g., continuing therapy with another provider or seeking alternative forms of support),
- guidance for handling crisis situations,
- and an offer to assist in locating appropriate therapeutic resources.

Abrupt termination on the part of the client can often be understood as an expression of emotional vulnerability, manifesting through anxiety, aggression, or dissociation and emotional shutdown (Finlay, 2016). These affective states may provide insight into the underlying reasons for discontinuation. For example, the client may be experiencing heightened anxiety – whether directly related to the therapeutic process or arising from external circumstances – or may feel pronounced dissatisfaction or anger, which could be linked to unresolved experiences both within and outside the therapeutic setting. In some cases, emotional numbing or dissociation may allow the client to sever the therapeutic relationship in an apparently indifferent manner.

From the Therapy Room

A couple in their thirties came to their first session due to issues related to infidelity. The husband had been unfaithful to his wife multiple times, and this time they decided to seek therapy. The therapist experienced the session as productive. She addressed responsibility for the infidelity and attempted to secure the husband's commitment that it would not recur. She believed she was offering significant empathy and support to the wife. However, a few days later, the wife emailed the therapist to say that they had decided not to continue therapy and would attempt to resolve their issues on their own. The therapist was surprised, as she had felt the session had gone well and anticipated that the couple would continue the process. In supervision, the therapist came to understand the dynamic that had led to the wife's decision to discontinue therapy. Through awareness of her countertransference, she realized that, in fact, she had been angry not at the husband, but at the wife. She could not comprehend how the wife could continue to tolerate such behavior. Although this anger was not consciously felt, her body language may have communicated a subtle judgment – an unspoken disbelief that the wife would remain in

the relationship. Despite the therapist's verbal expressions of empathy, the wife likely perceived disapproval of her decision to stay, as well as contempt toward her husband. Since she still loved him, the wife may have decided to protect him by ending the therapeutic process.

The Implicit Meanings of Therapy Termination (Lemma, 2003):

- **Paranoid experience:** The client experiences termination as rejection by the therapist, projecting hostility onto the therapist and perceiving them as someone who is inflicting further pain.
- **Manic experience:** The client departs without any expression of gratitude, perhaps as a way to leave the therapist with a sense of failure or incompetence. This is the only way the client feels able to exit the relationship.
- **Depressive experience:** The client is preoccupied with the belief that the termination is their fault. They may feel they were too boring or too demanding for the therapist, and that this explains the ending. Anger toward the therapist becomes internalized as guilt, which the client is unable to regulate.

Termination is a challenge not only for the client but also for the therapist (Lemma, 2003). Just as clients are confronted with themes of parting, loss, gratitude, and rejection, so too are therapists. The therapist's experience of termination is shaped by both their personal history of separation and the specific dynamics of the therapeutic relationship.

Clients' departure from therapy can stir up a range of countertransference reactions in the therapist. A sense of longing or missing the client may indicate that the client had served to meet the therapist's narcissistic needs. Conversely, a feeling of relief might suggest that the client evoked unresolved psychological material in the therapist. Naturally, there exists a broad spectrum of possible meanings within the therapist's emotional response to termination. It is the therapist's responsibility to be aware of these emotional

impulses and, where possible, to use them in service of facilitating the client's process of ending and saying goodbye in the most constructive way possible.

6.4 After the Termination of Therapy

Maintaining contact with clients after the conclusion of therapy is a common practice among therapists. It enables them to follow up with clients, evaluate the long-term effects of therapy, and leave the door open for re-engagement in the therapeutic process if needed. However, it is essential that the therapist continues to uphold the structure of the therapeutic relationship even after formal therapy has ended (Lemma, 2003). Post-termination contact often carries the greatest risk of undermining this structure. The client may, often unconsciously, begin to expect a more personal relationship, while the therapist may unintentionally engage in increased self-disclosure. Even after the formal termination of therapy, the relationship between therapist and former client should remain professional.

It is crucial to emphasize that professionalism should be upheld in all other forms of personal interaction as well even after the therapy has ended. If former clients return for occasional sessions, these sessions should also adhere to the structure of therapy: they should take place exclusively in a professional therapeutic setting, be time-limited, and conducted with due attention to clinical competence, ethical standards, and confidentiality. If former clients maintain contact with the therapist through emails or phone calls, the therapist's responses should remain structured and consistent with the ethical principles of therapeutic practice.

7

Conclusion

Much more could be written about the therapeutic process. New questions continually arise, and new insights and understandings never cease to surprise us. Yet the essence of therapy can be described in a very simple way: the establishment of a relationship. Everything that has been written here ultimately rests on the therapeutic relationship – on how the therapist, as a human being, can enter into a relationship with the client and, despite trauma, difficulties, or disorders, genuinely and sincerely recognize their humanity. It is only within such a relationship that interventions can be effective. It is only within such a relationship that we truly touch the essence of an individual's mental and emotional health. It is from this place that ***a family can begin anew.***

At the core of every person lies goodness. Psychotherapy should strive to discover this essence. As family therapist Richard Schwartz (2023) points out, we need a new research and therapy paradigm that convincingly argues that the human core is inherently good and deeply connected to other beings. Such an understanding lays the foundation for overcoming egocentric, familial and ethnocentric ways of existing and opens the way to a consciousness that is species, biocentric and planetary. This shift requires not only a psychological and therapeutic reorientation, but also an integration of ecological and ethical perspectives that enable humanity to recognize its shared responsibility.

When we realize that we are not threats to one another, but profoundly connected, we can begin again. This, too, should be the fundamental task of the therapist: to recognize connection, to give it words, to embody it, and to maintain it. Regardless of the life stories people carry within their bodies, we all share the universality of experience. We all face trauma. We all encounter failure. And we all do our best to find a way out of broken bonds and painful emotions. Just as trauma is experienced universally, so too are feelings of safety and acceptance in relationship. We all know what relationship is, because it is from relationship that we became human. And just as nature can grow the tallest tree from the most fragile seedling, so too can a person – out of the most isolated experience – build strong, lasting connections and create a sense of safety for themselves and others. No matter the injustices, abuses, or traumas that have distorted human nature, we can always return to the authentic core of human experience.

Gabor and Daniel Maté (2022) have written that in today's society, every expression of personal distress should be seen as an expected – and even normal – consequence of the unnatural conditions in which we live and raise our children. Psychological distress, difficulties, and even disorders are not to be seen as signs of individual pathology, but as reflections of a society riddled with trauma and conditions that are unhealthy for growth and relationships. Contemporary society increasingly pressures people to conform to demands and expectations that no longer align with our natural human needs, and this causes harm on every level of well-being.

Understanding human vulnerability is arguably one of the greatest challenges facing modern psychotherapists. Today, it is not only the hardships of life – those trials that are part of survival and growth – that make us vulnerable. Society itself contributes to our fragility. Thus, recognizing and understanding the client's vulnerability is a fundamental condition for creating the possibility of change in the therapeutic process. This is not about pity or reinforcing a victim identity, but about truly understanding the nature

of the human being as one who seeks connection. Recognizing a client's vulnerability means establishing a genuine, authentic therapeutic relationship in which both therapist and client grow. It is a relationship in which both can meet as vulnerable human beings, and where the therapist supports the client's return to natural, authentic ways of behaving, feeling, and thinking. It is a form of therapy in which the relationship itself becomes the healing force.

Empathetically engaging with human nature and cultivating sincere curiosity about all expressions of humanity and societal influence should drive the continued development of family therapy. When a family, a couple, or an individual walks into our office, we as therapists should be prepared to face every form of pain anew – and to continually seek paths of relief and understanding. Likewise, the entire field of family therapy should repeatedly return to its foundations, approaching theoretical and clinical exploration with renewed curiosity. Despite all that we know and all we can now demonstrate, both therapists and researchers should allow themselves to be continually surprised by human nature. For while it is, in some ways, deeply predictable, it is also endlessly adaptive – and it is in that adaptiveness that it surprises us most. It surprises with the extremes to which the human body can go, and with the resilience that brings a person back, even from the most difficult circumstances, toward nature, authenticity, and relationship.

My message to All Family Therapists

I hope this book will help you feel more at ease in the therapy room. That you will truly believe in yourself, in your professional knowledge, and that you will use this competence to create a safe space for everyone who comes to you for help. As you care for others, don't forget to care for yourself. Stay curious, for it will lead you to seek new knowledge, skills, and competencies needed for this work – and this, in turn, will help you form authentic relationships with the people you serve. Be vulnerable, because vulnerability makes you not only a better person, but also a better therapist.

My message to Those Considering a Career in Family Therapy

Make an effort to gradually let go of your expectations about this profession, and allow yourself to learn from those who have deep expertise in this field. This path will lead you to a deeper understanding of how the human body and psyche function, to empathy for human suffering, and to the confidence that you truly can help others.

My message to Everyone Who Picked Up This Book

I am deeply grateful for your trust.

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