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ENDORSEMENT REQUEST · 2026

A Guide to Experiential Therapy

Foundations and Tools for Clinical Practice

Matt Wade, LMFT

This pack contains sample chapters and framing materials for the purpose of endorsement review.

FOR THE POTENTIAL ENDORSER

Thank you for opening this pack.

What follows is a curated selection from A *Guide to Experiential Therapy: Foundations and Tools for Clinical Practice* — a 430-page clinical reference on experiential work across modalities, launching January 14, 2027.

Inside this pack you will find the preface, table of contents, and four sample chapters selected to represent the book's scope, clinical voice, and craft. A pitch, a personal note from the author, and the endorsement request are at the front and back respectively.

If the samples land for you, the request is on the final page.

ENDORSEMENT DEADLINE	October 1, 2026
BOOK LAUNCHES	January 14, 2027
SUBMIT AT	exptherapybook.com

01 THE BOOK

A *Guide to Experiential Therapy* is a field guide for clinicians who want to learn action-based therapy methods to bring about lasting change.

Experiential therapy — the deliberate creation of emotional experience that produces change at the level where a client's pattern is actually encoded — has never lacked for compelling texts. What it has lacked is a single working reference that treats the whole practice: the neuroscience, the clinician's stance, the foundational skills, the specific tools, the application across clinical contexts, and the professional infrastructure that sustains the work.

This book is that reference. Thirty-six chapters. Six appendices. Roughly 400 pages of clinical scaffolding drawn from Gestalt, psychodrama, IFS, EFT, AEDP, Somatic Experiencing, and the other adjacent traditions that share the same working commitment: cognitive understanding names what happened; experiential change reaches the level where the pattern was encoded.

The book is organized in six parts. **Part I** establishes what experiential therapy is and how change happens through it. **Part II** covers the clinician's stance — presence, tracking, pacing, invitation — that makes technique therapeutic. **Part III** covers the foundational skills that hold experiential work together — containment, activation, integration, repair, documentation. **Part IV** is the longest section: sixteen chapters on specific tools, from empty chair through rituals, each following a consistent nine-section template. **Part V** covers application across couples, families, trauma, cultural contexts, and telehealth. **Part VI** covers what sustains the clinician across a career.

Every chapter includes a Clinical Note naming the evidence base honestly — what is well-supported, what is well-established clinically but under-researched, what is contested. The book is not neutral about what works. What it endorses, it endorses on grounds.

A NOTE FROM THE AUTHOR

Experiential therapy has shaped me both as a clinician and as a person. There is something about seeing a client's body finally do what their words could not — reach for the empty chair,

place the stone that represents the mother they never had, drape the scarf that names the burden carried too long — that keeps me convinced this work matters and is worth teaching well.

I wrote this book for the clinicians I love investing in. Especially the ones early in their careers who are hungry for real experiential tools, and the seasoned ones ready to deepen a practice they have already built. The field needs more well-trained experiential therapists. This book is my extended contribution to their development.

Your willingness to consider an endorsement is a gift to those clinicians. When your name appears on the back cover, it tells them the book is worth reaching for. Thank you for the time and care you are giving this pack.

Matt Wade, LMFT

02 PREFACE

I love experiential therapy. The phenomenon that one can heal by bringing their pain, trauma, and suffering to the "here and now" and having a corrective experience excites me, deeply.

This book began as notes, photographs of the empty room after a session — a sculpt still standing, scarves where they landed, stones arranged on the table — diagrams I had drawn numerous times, new ideas, proven methods, conversations with my colleagues, and clinical observations. I began sharing them with new clinicians who were reaching for tools they had not been formally taught. To my surprise, seasoned clinicians took an interest too, and something in that recognition told me the material was worth pulling together.

It is often said we teach what we need to learn. This is another reason why I wrote this book. I needed to relearn, reimagine, refocus, and remember what it means to work as an experiential therapist — to gather what I had picked up across years of training programs, supervisors and cases and share it with you in one place.

I also wrote it for the clinicians I love investing in — especially eager ones early in their careers, practicing responsibly, quietly aware of the distance between what they were taught and what happens in the room. That distance is where experiential techniques live. Most of us were trained in one or two traditions and improvise the rest. The improvisation is often effective, and often accompanied by uncertainty about ground the clinician has not seen mapped.

> *This book attempts to coherently map that ground.*

It draws on Gestalt, psychodrama, IFS, EFT, AEDP, and other adjacent traditions without belonging fully to any of them, treating experiential therapy as a family of approaches

unified by a single commitment: cognitive understanding names what happened; experiential change reaches the level where the pattern was encoded. What follows is what I have found most usable across a range of clients — the stance that makes technique therapeutic (Part II), the foundational skills the tools depend on (Part III), the specific tools themselves (Part IV), the application knowledge for adapting all of this to couples, families, trauma, cultural contexts, and telehealth (Part V), and what sustains the clinician across a career (Part VI).

This is a field guide, not a training program. It sits beside formal training and clinical supervision, offering a common vocabulary and coherent framework that specific training does not always articulate. It is not a comprehensive survey of any single tradition, and it is not neutral about what works.

> *My hope is that this guide serves you in your experiential endeavors.*

I love experiential therapy. Did I already say that?

Matt Wade, LMFT

03 CONTENTS

SAMPLE CHAPTERS

Four chapters, chosen to represent the whole.

The four chapters that follow were chosen to represent, in one reading, what the book is asking of a reader.

01

What Experiential Therapy Actually Is

Establishes the framework, the mechanism, and the clinical voice.

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Presence as the Primary Intervention

Shows the stance work — why technique alone is not enough, and what makes it work when it works.

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The ethical seriousness of the book: naming what can go wrong and what to do when it does.

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A worked chapter with a full extended dialogue example — the craft and clinical depth in one place.

CHAPTER

1

What Experiential Therapy Actually Is

WHAT THIS CHAPTER IS

This is the last chapter of the book that was written, and it is the first chapter you will read. That is not accidental. Introductions to modalities usually promise more than the modality can deliver. This chapter is written after the substance is in place — the claims it makes about experiential therapy are claims the rest of the book fulfills.

Experiential therapy is not one modality. It is a broad family of approaches — Gestalt, psychodrama, emotion-focused therapy, somatic experiencing, IFS, and several others — that share a common commitment: cognitive understanding names what happened; experiential change reaches the level where the pattern was encoded. What separates the members of this family is technique and terminology. What unites them is the commitment to work at that level.

Cognitive understanding names what happened.
Experiential change reaches the level where the pattern was encoded.

This chapter distinguishes experiential therapy from adjacent modalities, defines what it is at its core, describes the mechanism by which it produces change, and orients the reader to what the rest of the book contains.

WHAT EXPERIENTIAL THERAPY IS NOT

Experiential therapy is not talk therapy done more intensely. Talk therapy — cognitive-behavioral, psychodynamic, humanistic in the Rogerian sense — proceeds primarily through language. The client tells the therapist what is happening; the therapist reflects, interprets, reframes, or provides information; the client's understanding shifts; that shift, ideally, produces behavioral change. This is not a criticism. Talk therapy works for many presenting concerns, is supported by substantial research, and remains the appropriate first line of treatment across many populations.

Experiential therapy operates on a different assumption. It assumes that some patterns — trauma-related, attachment-related, character-organized — do not change through the mechanism talk therapy relies on. Understanding, for these patterns, is insufficient. The client can name their pattern, trace its origins, articulate its costs, resolve to change it, and continue enacting it week after week, decade after decade. This is not a failure of the client or the therapist. It is a limit of the modality.

Experiential therapy is also not primarily about emotion in the surface sense. Clients who cry, express, or emote frequently in session may or may not be doing experiential work. What matters is not the presence of emotion but whether the emotion is being *worked with* in a way that updates the underlying material.

Nor is experiential therapy synonymous with any specific technique in this book. Empty chair does not equal experiential therapy. Nor do scarves, sculpts, sand trays, or rituals. These are tools. What makes them experiential is the way they are used — always in service of the mechanism the next section describes.

WHAT EXPERIENTIAL THERAPY IS

Experiential therapy is the deliberate creation of emotional experience that produces change at the level where the client's pattern is actually encoded.

That level is not primarily cognitive. It is embodied, implicit, relational, and often below verbal awareness. Different traditions describe it in different vocabulary — memory reconsolidation (Ecker, Ticic, & Hulley, 2012), transformational affect (Fosha, 2000), completing arrested cycles (Levine, 2010) — but the reality they point at is the same.

Experiential therapy works at this level by creating experiences — not descriptions of experiences, but the experiences themselves — in the room, in real time. The client speaks *to* the empty chair,

not *about* it. The client stands in the position of a family member, not merely describes them. The client feels the felt sense of grief with the therapist as witness, not accounts for it after the fact. The enactment is part of the intervention.

THE MECHANISM: HOW CHANGE HAPPENS

The neuroscience is straightforward, if incomplete. Emotional learning is stored in networks that operate largely below conscious verbal awareness. These networks were formed through experience and are updated through experience — specifically, through experiences that contradict what the network holds. Franz Alexander and Thomas French named this in 1946 as the *corrective emotional experience*. Contemporary memory reconsolidation research (Nader, Schafe, & LeDoux, 2000; Ecker et al., 2012) provides the biological grounding: emotional memories, when reactivated in a felt way, become temporarily labile. During that window, a new experience that mismatches the original encoding can update the memory. This is not metaphor. It is the mechanism.

Experiential techniques are the practical technology for opening this window. The empty chair dialogue reactivates the emotional charge of an unresolved relationship in a way that ordinary description does not. The scarf work externalizes the felt sense of a burden in a way that makes it available to be changed. The sand tray brings implicit material into visible form. Each tool, in the hands of a skilled therapist, creates the specific conditions under which the client's underlying material becomes accessible to update.

Chapter 2 covers the neuroscience in more depth. Subsequent chapters cover core principles (3), indications (4), the clinician's stance (5–8), foundational skills (9–13), specific tools (14–29), application across contexts (30–34), and clinician development (35–36). The mechanism is the same across all of it.

WHEN EXPERIENTIAL WORK IS RIGHT

Experiential therapy is not the right approach for every client at every moment. Chapter 4 covers indications, contraindications, and readiness in detail. For orientation:

Experiential work is well-indicated when a client has done substantial cognitive work on their pattern and it has not moved — when they can name it, understand its origins, articulate its costs, and still find themselves enacting it. It is well-indicated when the material is implicit rather than explicit, embodied rather than narrative, held rather than told.

Experiential work is contraindicated when the client is in acute crisis requiring stabilization, in active psychosis, in severe unstabilized dissociation, or in circumstances that make emotional arousal unsafe. It is contraindicated when alliance has not been established. It is contraindicated when the therapist is untrained in the specific technique.

Between these two positions lies most clinical work — a middle ground where experiential techniques are one tool in a larger practice that includes talk-therapy elements, psychoeducation, medication consultation, and much else. The best experiential therapists are usually not the ones who use experiential techniques constantly. They are the ones who reach for them at the moments when they are called for and use other tools at other moments.

WHAT THIS BOOK PROVIDES

This book is organized in six parts, plus appendices.

Part I (Foundations) covers the principles and neuroscience that make experiential work coherent — what it is, why it works, when to use it. If you read only Part I, you will understand the conceptual ground.

Part II (The Clinician's Stance) covers who the therapist has to be for experiential work to happen — presence, tracking, pacing, and the specific language of the experiential invitation. The tools in Part IV assume the stance in Part II is in place.

Part III (Foundational Skills) covers the skills that hold experiential work together — building containment, managing activation, integrating and landing, repairing when things go sideways, documenting the work. These are the invisible skills that separate skilled experiential practice from unskilled.

Part IV (The Tools) is the largest part of the book and the most illustration-heavy. Sixteen chapters covering the specific techniques: empty chair, two-chair, scarves, stones, sculpting, sociometry, floor mapping, role reversal, letters, sand tray, body-based interventions, timeline, genogram, guided imagery, and rituals. Each chapter follows a consistent template — what it is, when to use it, materials, setup, step-by-step, sample configurations, common mistakes, adaptation for couples and families, and clinical notes on the evidence base — with additional sections (such as sentence stems or framing questions) where the tool calls for them.

Part V (Application Across Clinical Contexts) covers how experiential work adapts to specific contexts — couples, families, trauma, cultural considerations, telehealth.

Part VI (Clinician Development) covers the therapist's own growth — pitfalls, consultation, ongoing training.

Appendices contain quick-reference cards, decision trees, consent language templates, consolidated client handouts and scripts, recommended training pathways, and recommended reading.

WHAT THIS BOOK DOESN'T DO

This book is not a substitute for training. Reading a chapter on empty chair work does not qualify a clinician to do empty chair work. What this book does is provide a coherent framework, a shared vocabulary, and the practical scaffolding that supports formal training and supervision. Use it as a reference beside your training, not instead of it.

This book is not comprehensive across every school of experiential therapy. It does not treat any single tradition — Gestalt, EFT, psychodrama, IFS, SE — in full. What it does is draw from all of these traditions to construct a working practice a clinician can actually use across a range of clients. Specialists in any single tradition will find their tradition represented in general terms rather than in tradition-specific depth.

This book is not neutral about what works. Some techniques have substantial empirical support — memory reconsolidation, expressive writing, imagery rescripting, EFT. Others have less — family constellations. Less empirical support does not mean these approaches are less effective — only that they have been less formally studied. The book represents the evidence base honestly in the Clinical Note sections of each chapter. What it endorses, it endorses on grounds. What it treats with caution, it names.

COMMON MISCONCEPTIONS

- "**Experiential therapy is about getting clients to cry.**" No. It is about creating the conditions under which change becomes possible. Sometimes that includes tears; often it does not.
- "**Experiential therapy replaces talk therapy.**" No. It supplements talk therapy at the moments when talk therapy alone cannot move the material.
- "**Experiential therapy is for trauma work only.**" No. It is used across grief, attachment, character, relational, and life-transition work as well.

- **"Experiential therapy requires specific certifications."** Some specific traditions (Sandplay, SE, some Gestalt trainings) have formal certification pathways. General experiential competencies are developed through training, supervision, and practice — the same as any clinical skill.
- **"Experiential techniques are for confident performers."** The opposite. The best experiential therapists are usually quiet, tracking, deeply present. Theatrical practitioners produce workshop demonstrations, but not always therapy.

> **CLINICAL NOTE**
>
> If you are a clinician reading this book, the practice it describes is available to you regardless of your primary orientation. You do not need to convert to an experiential-primary practice to use these tools. Cognitive therapists incorporate two-chair work into schema therapy. Psychodynamic therapists use empty chair for unfinished business with early figures. Family therapists have used sculpts and genograms for generations. What matters is not what your primary orientation is called. It is whether, when a client sits in front of you and cannot move their pattern with words alone, you have something else to reach for.

CHAPTER

5

Presence as the Primary Intervention

WHAT THIS CHAPTER IS

Part I established what experiential therapy is and how change happens through it. Part II is about the instrument that makes it happen — you. Your presence in the room is not preparation for the intervention. It *is* the intervention. Every technique in Part IV rests on this, and any technique applied without it becomes performance rather than therapy.

Your presence in the room is not preparation for the intervention.
It is the intervention.

This is the first chapter in a section devoted to the clinician's stance because it is the most consequential. A therapist with modest technique but genuine presence produces better outcomes than a therapist with sophisticated technique and rehearsed distance. The research base for this is now substantial, and the clinical experience of any long-practicing therapist confirms it.

WHAT PRESENCE IS

Presence is not concentration. It is not intense listening. It is not empathy performed carefully. Presence is a specific quality of contact: the therapist is here, in this body, in this room, with this client, right now, without agenda beyond what the client brings.

Rogers (1957) named congruence, unconditional positive regard, and empathic understanding as the necessary and sufficient conditions of therapeutic change. Later research has both validated the importance of these therapist qualities (Norcross & Wampold, 2011) and refined the description. Geller and Greenberg's (2012) framework of therapeutic presence identifies three components: being *grounded* in oneself, being *receptive* to the client's experience, and being *inwardly attuned* to what emerges within the therapist in response to the client.

Presence is more than the sum of these. It is what allows Rogers' conditions to actually land — the client feels the difference between a therapist performing empathic understanding and a therapist actually experiencing it.

WHY PRESENCE IS THE PRIMARY INTERVENTION

Three converging lines of evidence support the claim that presence is the primary intervention.

Empirical. Meta-analyses of psychotherapy outcome consistently identify the therapeutic relationship as one of the largest contributors to outcome variance, comparable to or exceeding specific technique effects (Norcross & Wampold, 2011; Wampold & Imel, 2015). Within the relationship, therapist qualities of warmth, attunement, and presence are consistently associated with positive outcome across theoretical orientations.

Neurophysiological. Geller and Porges (2014) proposed that therapeutic presence operates through the client's neuroceptive detection of safety in the therapist's nervous system. When the therapist is in a regulated, warm, attentive state, the client's nervous system registers safety and shifts toward a state in which meaningful therapy is possible. When the therapist is dysregulated, distracted, or defended, the client's nervous system registers threat regardless of what the therapist says.

Experiential. Every experiential technique — empty chair, sculpting, role reversal — requires the client to enter an activated emotional state. That is only possible when the client's nervous system reads the room as safe. The therapist's presence *is* what reads as safe. Without it, the technique cannot produce the emotional depth it is designed to reach.

The client does not choose to engage or not engage based on your technical skill. They engage or not engage based on the state of your nervous system, which they read through channels below conscious awareness.

THE THERAPIST'S NERVOUS SYSTEM AS INSTRUMENT

Musicians speak of their instrument. Their skill is what they do with it, but their instrument is what they play through. For the experiential therapist, the instrument is your own nervous system.

This is not metaphor. Contemporary affective neuroscience is clear that emotional communication between people occurs through autonomic, right-hemispheric, and interoceptive channels that operate largely below verbal awareness (Schore, 2003; Porges, 2011). The client's autonomic state adjusts to yours; yours adjusts to theirs. This is co-regulation, and it is happening continuously whether you attend to it or not.

The practical implication: your work on your own regulation is not separate from your clinical work. It *is* your clinical work. The therapist who is chronically anxious, tightly braced, or dissociated cannot produce the containment that experiential techniques require, regardless of how well they can describe those techniques.

This is why supervision, personal therapy, and body-based practice matter so much for the experiential therapist — not as professional development in the abstract, but as instrument maintenance.

CO-REGULATION BEFORE TECHNIQUE

The order of operations matters. Before you can offer empty chair work, before you can facilitate a sculpt, before you can double for a client, your nervous system must be in a state that co-regulates the client's. If it isn't, the technique will fail — not because the technique is wrong, but because the container it needs is not present.

In practice, this means:

- The first minutes of every session are about arrival. Yours as much as the client's.
- If you are dysregulated when the client walks in, the intervention for the first part of the session is your own regulation, not the client's material.
- If something happens mid-session that dysregulates you, the most important thing you can do is return to your own regulation before continuing.
- When a client is dysregulated, your first move is not to intervene with them but to remain regulated yourself. Their nervous system will detect yours before your words register.

This is not passivity. Maintaining a regulated state in the presence of intense client material is active work. It is often the hardest work in the session.

THE ANATOMY OF PRESENCE

Presence is not a mystical quality. It has concrete, observable markers — in yourself, and in what the client experiences. Learning to recognize these in your own body during session is a core skill. Figure 5.1 distinguishes what presence looks like from what its absence looks like; use it as an internal self-check.

CULTIVATING PRESENCE

Presence is a capacity that develops over years, not a switch to flip mid-session. It is built through practices outside session and cultivated in specific ways within session.

Outside session:

- Your own therapy. Not optional for experiential work. Presence with clients is limited by the presence you have with yourself.
- Body-based practice. Yoga, mindfulness meditation, somatic experiencing, tai chi — the specific modality matters less than the sustained practice of attending to your own body over time.
- Supervision. Especially with a supervisor who can help you see when your presence has left the room and what pulls you out.
- Rest. A chronically depleted therapist cannot be present. This is not a work-ethic problem. It is a nervous-system reality.

Within session:

- Arrive before the client. Take five minutes to breathe, orient to the room, and set aside whatever preceded the session.
- Notice your own body throughout the session — your breath, your posture, where your attention actually is.
- When you notice you have left, come back. This is the practice — not never leaving, but noticing and returning.
- Use the client's presence to anchor your own. Their eyes, their breath, their face are all doorways back to the here-and-now.

PRESENCE ACROSS THE SESSION

Presence is not a static state you either have or don't have for the session time. It fluctuates. Different phases of the session make different demands:

Opening. Presence here means being fully receptive to whatever the client brings, without pre-formed agenda. What you planned to work on today matters less than what walks in.

Deepening. As the client accesses emotional material, your presence becomes more focused. You track more closely. Your breathing may naturally slow and match theirs. Your body settles.

Peak intervention. During an actual experiential piece — the empty chair dialogue, the sculpt, the role reversal — your presence is the container that holds the arousal. Your steadiness is what makes the client's activation workable.

Integration. As the client returns from the intervention, your presence models regulation. Your calm, warm attentiveness is what the client's nervous system uses to come down and remain connected to the work.

Closing. Presence at closing looks like unhurried attention as the client transitions back to the outside world. Rushing here — even for legitimate scheduling reasons — undoes some of what happened in the session.

WHEN PRESENCE FAILS

Presence will leave you during sessions. This is not a failure of skill; it is what happens to all therapists sometimes. The skill is noticing and returning, not preventing.

Common ways presence leaves:

- You get pulled into your own material by something the client says
- Fatigue erodes the sustained attention presence requires
- You feel pressure to *do something* and start reaching for technique
- Something in the client's presentation activates your own defenses
- You lose track of yourself because the client's material is compelling
- Something outside the session (a personal event, the news, a difficult prior client) has left you preoccupied

Recovery is a small, specific move: notice you've left, breathe, come back. If needed, name it aloud: "*Let me pause for a moment.*" Clients rarely mind a therapist who pauses. They notice, painfully, a therapist who is chronically absent while pretending presence.

COMMON MISCONCEPTIONS

- "**Presence means never thinking about technique.**" No. Skilled therapists can hold presence while considering technical options. What matters is whether the technique emerges from what is happening in the field, or whether it substitutes for actual contact.
- "**Presence is passive.**" The opposite. Sustaining regulation while a client is in intense arousal is active work — often more demanding than any technique.
- "**Presence is either there or it isn't.**" Presence fluctuates within and across sessions. What separates experienced therapists is not permanent presence but faster noticing and return.
- "**Presence is empathy.**" Related but not identical. Empathy is understanding the client's feeling. Presence is being here, in your own body, while doing so. It is possible to be highly empathic and not present. The client feels the difference.
- "**Presence is a natural gift you either have or don't.**" Some people begin with more capacity for it, but it is fundamentally a skill that develops. The therapists most present in their tenth year of practice are usually those who worked at it deliberately, not those who were born unusually attuned.

CLINICAL NOTE

The rest of Part II — tracking, pacing, invitation, containment — all rest on this chapter. So does every tool in Part IV. If you take away one thing from this book, it should be that presence is not something you do before the work begins. Presence *is* the work. Everything else is technique in service of it.

The relationship between presence and technique is not additive but multiplicative. High presence with modest technique produces good therapy. High technique with low presence produces workshop performance that leaves clients feeling worked on rather than met. The math means that presence deserves the majority of your ongoing developmental attention.

CHAPTER

12

Repair When It Goes Sideways

WHAT THIS CHAPTER IS

Chapters 9 through 11 covered the arc of a well-run experiential session: building containment, managing activation, integrating and closing. This chapter is about what happens when that arc breaks — when arousal exceeds what you can manage, when the client dissociates, when the alliance ruptures mid-intervention. These are the moments when the therapist's response matters most, and when the difference between skilled and unskilled practice is most visible.

Things go sideways in experiential work. Not because the therapist was negligent or the client was fragile — because the work itself operates at emotional edges where the range of possible outcomes is wider than in ordinary talk therapy. What separates competent experiential therapists from harmful ones is not that the competent ones never have adverse events. It is that they recognize them quickly and respond well.

This chapter covers the three most common emergencies — flooding, dissociation, and rupture — with signs to watch for, response protocols, and specific scripts for each.

GENERAL PRINCIPLES FOR REPAIR

Regardless of what has gone sideways, several principles apply:

Your regulation comes first. If you become dysregulated by the situation, you cannot help the client return to regulation. Whatever else you do, keep your own breath, presence, and grounding intact. Chapter 5's presence work is the foundation of every repair.

Slow down, don't speed up. The instinct in crisis is to move faster — more words, more interventions, more attempts to fix. In experiential emergencies, the opposite is correct. Slow speech. Slow breath. Space between interventions.

Stop the primary intervention. Whatever experiential piece was active when things went sideways, it stops. There is no version of good repair that requires completing the intervention that caused the problem.

Prioritize the client's system over the session's arc. Session goals become irrelevant once the client is in crisis. The remaining time is for repair and stabilization, not for reaching planned material.

Repair is a full-session commitment. When you shift into repair mode, plan on it taking the rest of the session. Attempting to repair briefly and then return to the original work usually re-injures.

Follow up. Adverse events in session often echo in the days that follow. A brief check-in within 24–48 hours communicates that the container is still holding and provides an opportunity to detect trouble early.

RECOGNIZING THE THREE EMERGENCIES

The three emergencies below can occur separately or in combination. A rupture can produce flooding. Flooding can trigger dissociation. Recognizing which one is primary at any moment shapes what you do next.

FLOODING

Flooding is emotional arousal beyond what the client can integrate — hyperarousal that has moved past the window of tolerance and into overwhelm.

Response protocol

1. Stop the intervention immediately. "*Let's pause here.*" Whatever was happening — empty chair dialogue, sculpt, role reversal — stops. Do not try to complete it.

2. Slow your own breath dramatically. Longer exhales than inhales. The client's system reads yours; your slowing is often the first move that helps.

3. Return to concrete sensation. *"Feel your feet firmly on the floor. Press down." "Notice the temperature of the room." "Look around. Name three things you can see."*

4. Physical grounding, if needed. Cold water on face or hands. Standing up and moving. Pressure grounding (feet pressing floor, hands pressing chair arms).

5. Stay with them until settled. Do not rush to fill silence, and do not check the clock in a way the client can see. Your unrushed presence *is* the intervention.

6. Never continue the original intervention. Even if the client rallies quickly, do not resume. The session is now about repair.

Scripts

> *"Let's pause. Just breathe with me for a moment." "You're safe. You're here with me in this room." "This is more than we can work with right now. Let's set it down." "You don't have to do anything. Just be here." "Feel your feet. That's it. Press down."*

DISSOCIATION

Dissociation is the shutdown direction of activation gone wrong — the client has moved below the window into disconnection, numbness, or loss of contact with the present moment.

Response protocol

1. Recognize it quickly. Dissociation is quieter than flooding and easier to miss. If the client's engagement has dropped without an obvious reason, suspect dissociation.

2. Increase your presence and voice. Not aggressive — more present. Sit slightly forward. Warmth in your voice.

3. Orient to the present with concrete sensory cues. *"Look at me for a moment." "What color is that wall?" "How many windows are in this room?" "What year is it?"*

4. Movement. *"Would you be willing to stand up with me?"* Movement disrupts dissociative shutdown reliably.

5. Cold. Cold water on the hands or face. Ice held briefly. Cold air from an open window. Cold is one of the most reliable interruptions to dissociation.

6. Do not interpret the material. "*What was happening for you just before you drifted?*" is a fine question — later, after grounding. In the moment, interpretation deepens the dissociation.

7. Confirm the client is present before closing. Do not end a session with a client still partially dissociated. Extended grounding is needed.

Scripts

> *"Come back. Look at me." "You're here. This is [day, place, time]." "Feel your feet firmly on the floor. Press down until you can feel the pressure." "What do you notice around us right now?" "Take a sip of this water. Feel the cold." "Take your time. I'm not going anywhere."*

RUPTURE

An alliance rupture is a break in the working relationship — the client experiences the therapist as unsafe, misattuned, or hurtful, and the client's engagement with the work shifts. Ruptures are common. Unrepaired ruptures are what harm the therapy.

Unrepaired ruptures are what harm the therapy.

Safran and Muran (2000) distinguish two rupture patterns worth knowing:

Withdrawal ruptures. The client pulls back. Becomes compliant, distant, overly agreeable, or intellectualized. Engagement drops without direct expression of what happened.

Confrontation ruptures. The client expresses anger, criticism, or disappointment directly. Sometimes about the therapist, sometimes about the therapy.

Both are ruptures. Both require repair.

Response protocol

1. Notice and slow down. "*Something shifted just then. Can we look at it?*" Named early, ruptures are easier to repair.

2. Take responsibility for your part. Even if the rupture wasn't caused by an obvious therapist error, your part matters. "*I may have missed something.*" "*I said that in a way that landed harder than I intended.*"

3. Ask what happened, then listen. "*What was that like for you?*" "*What happened just then?*" Then be quiet.

4. Do not defend or explain your intent. "*I didn't mean it that way*" dismisses the client's experience. The client's experience is what needs to be received.

5. Reflect what you hear. "*So when I said* X, *what landed was* Y." Confirm you understood before responding.

6. Repair, don't explain away. "*Thank you for telling me. That matters.*" An acknowledgment is more repairing than a reframe.

7. Follow up in subsequent sessions. Even after immediate repair, the rupture may need revisiting. Bring it up yourself if the client doesn't.

Scripts

> *"Something shifted between us just now. Can we look at it?" "I might have missed something. What's happening?" "I said that in a way that landed differently than I intended. What did you hear?" "I'm noticing you got quieter. What's going on for you?" "Thank you for telling me. That's important. I want to understand." "What would help right now?"*

WHEN YOU CAN'T REPAIR IN THE MOMENT

Sometimes the emergency doesn't resolve in the session. Time runs out. The client leaves in a state that is not fully stabilized. The rupture is named but not repaired.

Extend the session if possible. Fifteen additional minutes may be enough. Rescheduling other appointments to make room for repair is appropriate when a client is in genuine distress.

Confirm a plan before the client leaves. Do not let the client leave without a specific plan. "*Here's what I want you to do if it stays intense…*" Contact numbers, grounding techniques, resources, or a scheduled follow-up.

Follow up proactively. A brief text, email, or call within 24–48 hours. "*Wanted to check in after our session yesterday. How are you doing*?" The follow-up is not extending therapy into off-hours; it is completing the container that broke.

Schedule sooner rather than later. If a client leaves in acute distress, an additional session that week is often warranted. Waiting a full week to repair often results in the client not returning.

Involve a consultant. For significant adverse events, contact your consultant or supervisor. Getting outside eyes is not weakness; it is standard care.

DOCUMENTATION AFTER ADVERSE EVENTS

When flooding, dissociation, or rupture has occurred, documentation matters. Your notes should establish:

- What was happening in the intervention when things went sideways
- What signs alerted you
- What you did to respond
- The client's state at the end of the session
- What plan you established for follow-up
- Any consultation you obtained

This is clinical documentation, not defensive documentation, but it also serves protective purposes. In the unlikely event of a complaint or licensing question, your notes should show that you noticed, responded appropriately, and followed up.

WHEN TO REFER OR CONSULT

Some adverse events warrant more than immediate repair.

Consult when:

- The same client has had repeated adverse events
- The event was significantly outside your clinical experience
- You are uncertain whether experiential work should continue with this client
- Your own reaction is interfering with your work

Consider referral when:

- The client's presentation appears to require specialized expertise you don't have
- Trauma content emerged that exceeds your training
- The client would benefit from a modality you don't practice
- The alliance cannot be repaired despite good-faith effort

Referral is not failure. It is what responsible practice looks like when a client's needs exceed the current fit.

COMMON MISTAKES

- **Freezing in the moment.** The therapist becomes overwhelmed and cannot act. Your regulation work between sessions is what prevents this.
- **Trying to complete the intervention anyway.** "*Let's just finish this and then land.*" No. Stop the intervention.
- **Interpreting the emergency rather than addressing it.** "*You're feeling this because…*" is a talk therapy move. In emergency, act first, understand later.
- **Rushing repair to salvage session time.** Repair takes as long as it takes. There is no shortcut.
- **Defending yourself during a rupture.** Even when the client's account of what happened doesn't match your intent, defending your intent is the wrong move.
- **Skipping follow-up because the client seemed okay at the end.** Post-session integration continues for days. A brief follow-up catches trouble early.
- **Documenting minimally to avoid drawing attention to the event.** The opposite is protective. Thorough documentation of your clinical reasoning demonstrates competent practice.

COMMON MISCONCEPTIONS

- **"If I never have adverse events, I'm a good therapist."** More likely, you're not doing depth work. Experiential therapists who do serious work have adverse events sometimes. What matters is response.
- **"Ruptures mean the alliance is damaged."** Ruptures happen in every therapy. Repaired ruptures often *strengthen* the alliance beyond its pre-rupture state.
- **"Dissociation is a sign of complex trauma."** Sometimes. But dissociation also happens transiently in clients without trauma histories, especially in response to intense material. It is a general nervous-system response, not a diagnosis.

- **"If I have to stop the intervention, I've failed."** No. Stopping when the intervention is not working is skilled practice. Continuing when it isn't working is what causes harm.

CLINICAL NOTE

This chapter, more than any other in the book, is the one you will draw on when it matters most. Every experiential therapist has sessions that go sideways. The therapists who continue to do this work — and who continue to have clients — are the ones whose response to those sessions preserves the container rather than damaging it.

The three emergencies covered here overlap with situations covered elsewhere in the book (Ch. 10 on activation, Ch. 25 on grounding, Ch. 4 on contraindications). This chapter treats them together because in emergency, you don't have time to cross-reference. You need one place to look, one framework to apply.

Read this chapter twice. Once now, to build the framework. Once again after your first serious adverse event, when the framework becomes something you actually needed.

CHAPTER

15

Empty Chair

WHAT IT IS

Empty Chair is a Gestalt technique in which the client speaks directly to a person, figure, or presence imagined sitting in a chair placed opposite them. The client may then move to the empty chair and respond from that figure's perspective — completing a dialogue that was cut off, unfinished, or was never possible in real life.

Developed by Fritz Perls in the 1940s–60s and refined across decades by his students and by Emotion-Focused Therapy researchers, Empty Chair is one of the most researched and durable techniques in the experiential field. It's what most clinicians think of when they hear "experiential therapy." The mechanism: giving voice to what has remained unspoken — grief, rage, longing, gratitude — accessible in the present moment as if the person were actually there.

Two-Chair work (Chapter 16) uses a similar setup but focuses on internal dialogue between parts of the self. This chapter covers dialogue with figures *external* to the self — the absent, the deceased, the unavailable, the symbolic.

WHEN TO USE IT

Strong indications:

- Unfinished business with someone deceased, absent, or unavailable
- Grief work that has not moved through
- Unspoken words to a parent, spouse, ex-partner, or estranged family member
- Dialogue with a person the client cannot safely approach in real life
- Anger work when direct expression would be inappropriate or dangerous

- Preparation for a real-life conversation the client fears
- Dialogue with a symbolic figure (younger self, future self, the illness, a spiritual presence)

Use with caution:

- Recent traumatic loss — may re-flood; assess timing carefully
- Active PTSD when the "chair figure" was a perpetrator — may re-traumatize
- Highly dissociative clients — establish grounding first
- Clients who cannot yet distinguish imagination from reality

Don't use when:

- The client is actively suicidal
- The dialogue could reinforce delusional or psychotic content
- The client cannot yet tolerate their own emotional intensity
- You have under 30 minutes remaining

MATERIALS

- Two chairs, similar in size and comfort
- A tissue box within reach
- Optional: a scarf or a small object placed in the empty chair (photograph, article of clothing, item that belonged to the person)

Duration: Plan for 45–60 minutes. Empty Chair should not be rushed or squeezed into the last 20 minutes of a session. Ample time is required.

SETUP

Place the two chairs facing each other, four to five feet apart. Not directly opposing — angle them slightly (15–20 degrees off-axis). Direct opposition reads as confrontation; angled reads as dialogue.

Position your own chair off to the side, out of the visual axis between the two chairs. You are the witness, not a participant. If the client brought a photograph or symbolic object, place it in the empty chair before starting, or use a scarf. A placeholder enlivens the work.

STEP-BY-STEP

1. Frame the work.

> *"I'd like to try something. Imagine [name] is sitting in that chair. It's not a role-play, and there's no right way to do this. What comes up when you look at that empty chair as you imagine [name/place/thing]?"*

2. Grounding check. Confirm the client is oriented, present, and consenting.

> *"How is this landing for you? Take a breath before we begin. You can stop at any point."*

3. Begin with what's alive.

> *"What do you want to say to [name] that you never got to say?"*

Or, if the client freezes:

> *"Just start where you are. Whatever's here."*

Do not direct the content. Follow.

4. Track and reflect sparingly. Watch for voice changes (softer, louder, tightening), body shifts (curled in, chest opening, tears), breath (holding, sighing). Reflect what you see, briefly:

> *"Your voice just softened." "Something shifted right there."*

The therapist should be speaking less than 10% of the time.

5. Offer the switch when ready.

> *"Would you be willing to sit in the other chair now, and be [name]? What would [name] say back?"*

Some clients will resist. The switch is not always necessary — sometimes speaking without receiving is complete. Follow readiness, not protocol.

6. Continue the dialogue. Move the client back and forth as the exchange develops. Do not narrate the transitions. Silence during switches is processing, not emptiness.

7. Watch for the pivot. Nearly every substantive Empty Chair session includes a moment when the client says something they didn't know they carried. Slow down there. Do not rush past.

8. Close before session ends. When the dialogue reaches natural completion — or when you're at ten minutes remaining — begin closure:

> *"Before we stop, is there anything else that needs to be said? A final word?"*

9. Integration.

> *"Come back to your own chair. Take a moment. What are you noticing? What do you want to carry from this?"*

Never end with the client still occupying the "other" chair.

10. Bridge to the week.

> *"How do you want to be gentle with yourself in the next few days?"*

Empty Chair leaves clients porous. Prepare them for it.

DIALOGUE IN PRACTICE: AN EXTENDED EXAMPLE

Below is a substantial worked example of an Empty Chair session. The presenting focus is unfinished grief with a deceased parent. The client has lost her mother two years earlier, and grief has not fully moved. Framing question: "*What I never got to say to you is…*" The dialogue is edited for length but preserves the arc of a real session — opening, deepening, switching, response, return, felt shift, and landing. Use it as a model for pacing, silence, and when to intervene versus when to hold.

Therapist: *"I'd like to try something. Imagine your mom is sitting in that chair. It's not a role-play, and there's no right way to do this. What comes up when you look at that empty chair as you imagine her sitting there?"*

Client: (*long silence, gaze on the chair*) "It's harder than I thought it would be. She's… she's just sitting there."

Therapist: *"Take your time. There's no rush here."* (*matches the client's breath, offers nothing else*)

Client: (*quietly*) "Mom. I don't even know where to start."

Therapist: "*You don't have to. Just stay with what's here right now. What I never got to say to you is…*"

Client: (*tears forming*) "What I never got to say to you is that I was so angry. For so long. That you were sick and I didn't know how to be there. That I kept my distance because I didn't know what else to do. And then you were gone. And I never told you I was sorry."

Therapist: (*gently*) "Stay with her. What else."

Client: (*voice softer, more direct now*) "I'm sorry, Mom. I'm so sorry. I thought I had time. I thought we would get to have the conversation later. And then there was no later."

Therapist: (*after silence*) "Would you be willing to switch chairs? Sit where your mom is, and let her respond."

Client: (*nods, moves slowly to the empty chair, settles, closes eyes briefly*)

Therapist: "*Take a breath. You're your mom now. You just heard your daughter say she's sorry, and that she was angry, and that she didn't know how to be there. What do you want her to know?*"

Client (*as Mom, voice shifts — steadier, slower*): "Sweetheart. Oh, sweetheart. I knew. I always knew you loved me. I never once thought otherwise. You were doing the best you could. You were scared. I was scared too. But there was never a moment I doubted your love."

Therapist: "*What else, Mom.*"

Client (*as Mom*): "I want you to stop carrying this. Please. I don't want you to spend your life sorry. I want you to live. I want you to be free of this."

Therapist: "*Come back to your own chair when you're ready.*"

Client: (*returns, sits, tears now openly flowing*)

Therapist: "*What are you noticing?*"

Client: (*long pause*) "I don't know if that was her. Or me. Or what I wanted her to say."

Therapist: "*That distinction matters less than you think. What you just heard — what did it land as? In your body.*"

Client: (*hand on chest*) "Relief. Something coming loose. Like I've been holding my breath for two years."

Therapist: "*Stay with that. Let it be true for a moment.*"

(*silence, sixty seconds or more*)

Client: "I want to say one more thing."

Therapist: "*Say it.*"

Client: (*to the empty chair*) "Thank you, Mom. Thank you for being my mom. I love you."

Therapist: (*after silence*) "How is your body right now, compared to when we started?"

Client: "Lighter. Tired. But lighter."

Therapist: "*Let's take a few minutes to land this before you leave today. Feel your feet on the floor. Feel the chair. Notice the light in the room. Take a slow breath in, and a longer one out.*"

What to notice in this example:

- The therapist speaks minimally. Most of the therapist's turns are one sentence or a silence. The client's voice carries the work.
- The switch to the mom's chair is invited only after the client has fully expressed her side. Switching too early would truncate the client's initial expression.
- The therapist does not interpret the mom's response as real communication from the dead. When the client raises the "was that her or me" question, the therapist redirects to the felt sense — where the work actually happened.
- Landing is explicit. The session does not end with the emotional peak; it ends with orientation back to the present, the body, the room.
- The whole exchange, in real time, might take 30–40 minutes. What reads as 20 exchanges here is often 40–60 in the room, with silences and settling that don't compress well to text.

SAMPLE CONFIGURATIONS

A. The Classic Setup. Two chairs facing each other at 15–20° off-axis, 4–5 feet apart. Therapist off to the side, out of the dialogue axis. The default for most Empty Chair work.

B. The Distant Chair. For a figure the client needs to keep at safe emotional distance — an abuser, a perpetrator, a terrifying parental figure — move the empty chair further away, 8–10 feet. In this configuration, the client usually does *not* switch chairs. The dialogue is one-directional, and that is the intervention. Never place a client in the seat of someone who harmed them without extensive preparation and clear clinical justification.

C. The Close Chair. For a figure the client is trying to reconnect with — a deceased loved one, an estranged adult child, a self they've lost touch with — move the empty chair closer, 2–3 feet. Physical proximity supports emotional intimacy. Switching chairs in this configuration is often profound.

D. The Anchored Chair. A photograph, wedding ring, article of clothing, or urn placed on the empty chair. Grounds the imagination in something tangible. Especially useful with clients who struggle to visualize, or with grief work where the object holds meaning.

E. The Low Configuration. For work with a deceased infant, a lost pet, or a very young version of the self, replace the empty chair with a small stool, a low cushion, or the floor itself. The client kneels or sits low to speak to what is small or gone. Small posture is not weakness here — it is honoring the size of what is being addressed.

COMMON MISTAKES

- **Interpreting.** "It sounds like you're really angry with him" collapses the client's process into your understanding. Don't.
- **Prompting content.** "What about your fear?" plants suggestions. Stay with what the client brings.
- **Rushing the switch.** Moving the client to the other chair before they're ready reduces it to role-play.
- **Rescuing.** When the client becomes emotional, the impulse to comfort must be resisted. The intensity is what they came for.
- **Skipping the switch entirely when it's needed.** Sometimes the switch is the whole point. Watch for the moment when the client has said everything they need to say and now needs to hear something back.
- **Not closing the frame.** Ending with the client still in the "other person's" chair is destabilizing. Always bring them home to their own seat before session ends.
- **Treating it as brief work.** Empty chair takes as long as it takes. Block the time.

- **Over-directing.** New therapists narrate: "Now tell him this…" The best Empty Chair work happens when the therapist barely speaks.

WHEN TO SWITCH CHAIRS

One of the most common questions from newer clinicians: *when do I invite the client to switch chairs*? Missing the switch is one of the most frequent misses in Empty Chair work, because the switch is where the dialogue becomes an actual exchange rather than a monologue.

The general principle: **the switch is usually indicated when the client asks the imagined figure a direct question, or when the dialogue has arrived at a moment that would benefit from the figure's voice.** A question hanging in the air — "*Why did you leave?*" "*Do you know how much this hurt?*" "*Would you still love me if you knew?*" — is a natural pivot. It is the reader's cue to invite the switch.

Concrete markers for switching:

- **The client asks a direct question of the figure.** This is the strongest signal. Questions expect answers. Sitting with a question unanswered can be useful in some cases (see below), but usually the client benefits from voicing what the figure might say.
- **The client's expression reaches a natural pause.** Not exhaustion — completion. The client has said what they came to say from their own side. The next move is to hear back.
- **The client has been repeating themselves.** Sometimes the client circles the same territory because they are waiting to hear something from the figure. The switch offers that.
- **The dialogue has become one-directional advocacy.** Empty Chair is not a monologue about the figure. If the client is describing what the figure did wrong rather than speaking to the figure, the switch invites the figure into the room.

Discernment matters. Not every question requires a switch, and not every session benefits from one. Situations where you should *not* switch:

- **When the figure is an unsafe person and the client is in the distant configuration.** In work with an abuser or perpetrator, the empty chair typically stays empty. Putting the client into the seat of someone who harmed them can be re-injuring rather than integrative. See the Distant Chair configuration in Sample Configurations above.
- **When the question is rhetorical.** "*How could you do that?*" said in raw grief is often not seeking an answer — it is voicing outrage. Sit with the rawness; do not rush to fill it.

- **When the client is dysregulated.** Switching under high activation adds cognitive load. Ground first, then decide whether the switch still fits.
- **When the switch would truncate the client's initial expression.** Wait until the client has fully voiced their side. Premature switching cuts off material that needed to come out.

How to invite the switch:

> *"Would you be willing to switch chairs? Sit where [name] is, and let them respond."*

Or more briefly:

> *"Come sit over here. Let's hear from them."*

Give the client a moment to physically move and settle before speaking as the figure. A brief grounding — *"Take a breath. You're [name] now. You just heard [what the client said]. What do you want them to know?"* — orients the switch.

After the response, invite the return: *"Come back to your own chair when you're ready."* Do not rush the transition either direction. The physical movement is part of the work.

COUPLES AND FAMILY ADAPTATION

Couples. Empty Chair with the actual partner present is an advanced technique — one partner speaks to the empty chair *as if* to the other, while the real partner witnesses without responding. Requires established safety in the room. Can be transformative when a partner cannot access what they need to say directly to the person's face; the witnessing partner often hears in that indirect voice what they could not hear in confrontation. Not a first-session move.

Families. With families, Empty Chair is most often used to include a member who cannot be present — the deceased grandparent, the estranged sibling, the parent who left. Provides shared witnessing of what has remained unspoken across the family. Any family member can address the chair; others witness.

Adolescents. Adolescents often engage with Empty Chair when it's framed less clinically. "That chair is your dad — what do you want to tell him?" lands better than a formal introduction. Give permission for sarcasm, anger, and language that would not be tolerated elsewhere.

CLINICAL NOTE

Empty Chair is among the most-researched experiential techniques. Emotion-Focused Therapy (Greenberg and colleagues) has produced multiple randomized controlled trials demonstrating efficacy for unresolved anger, unresolved grief, and unfinished business — with effect sizes comparable to or exceeding CBT for these targets. Neuroimaging research on emotional processing supports the mechanism: accessing implicit emotional content activates right-hemisphere and limbic structures in ways that verbal narrative alone does not. Treat as an evidence-supported technique with substantial empirical backing — one of the few experiential tools with a robust RCT base to cite.

04 ABOUT THE AUTHOR

Matt Wade, LMFT, is a marriage and family therapist and the founder of Unstuck Therapy. He serves as a couples therapist and lecturer at Onsite, and specializes in experiential work with couples and trauma. He is the author of *Secure: 90 Days to a More Connected Relationship* and creator of The HEART Model™ — a new pathway to forgiveness for couples. His work is shaped as much by his own story of marriage, repair, and growth as it is by his clinical training. Matt helps couples find their way back to one another with compassion, humor, and hope.

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PUBLICATION DETAILS

- **Title:** A *Guide to Experiential Therapy: Foundations and Tools for Clinical Practice*
- **Author:** Matt Wade, LMFT
- **Publisher:** Independently published, distributed via IngramSpark
- **Format:** Paperback, 8.5 × 11", full B&W interior
- **ISBN:** 979-8-234-17287-7
- **Launch date:** January 14, 2027
- **Approximate length:** 430 pages

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